This is a pre-publication version of the following article: Quartel, Lara (2021) Reflecting on mental health, postgraduate psychology and the cognitive dissonance they bring. PsyPAG Quarterly, 119, pp. 34-35.

Reflection Piece

Reflecting on mental health, postgraduate psychology and the cognitive dissonance they bring

In theory, we as psychologists know that mental health does not make someone weak, it does not make someone incompetent. Yet in practice, we often challenge these ideas with fears of disclosure, stemming from a cognitive dissonance between being a patient and practitioner of psychology. But how do such issues arise? And how can we as psychologists address this? This article is reflection on navigating the world of postgraduate mental health from both sides of the fence.

The divide between patient and practitioner in psychology first became apparent to me in my first year at university in London whilst studying the subject. I was also in contact with mental health services for the first time. A few months into my studies, I was invited to participate in a clinical study as a patient. My first question was, 'will my university find out that I am taking part?'. Throughout my degree, I lived a 'Spider-Man of psychology' existence. I went to my lectures as one identity and attended my psychology appointments as another. I kept them very mutually exclusive, with a strong inner sense of cognitive dissonance to accept that I could be both a worthy psychologist and face personal mental health difficulties.

Disclosure

For me, the strength of this divide and cognitive dissonance was further made clear when I sat in my PhD supervisor's office in the first month of starting my degree and disclosing my mental health difficulties to her. She is an associate professor in psychology with a specialisation in mental health. Yet my hands were shaking, and I was stumbling on my words. If I could not tell her, who could I tell? Despite the fact that I was accepted into my first choice PhD programme (where I wrote the successful application from a psychiatric hospital) I still doubted myself as a worthy student. I know I am not alone in this sense of cognitive dissonance. This both comforts me and saddens me in equal measures. When coupled with the overpowering imposter syndrome, one can feel very alone on their PhD journey.

But why does this cognitive dissonance exist?

Despite the fact that one in four of us will experience a mental health problem at some point in our lives, independent and irrespective of our degree choice, or letters after our name, a certain level of invulnerability seems to be attributed to psychologists and we are upheld on a pedestal (Good et al., 2009). It appears that this perceived incompetency stems from the history books of psychology. Dictated by old, white, middle class men casting judgment over those seen as unable to live substantial lives. Despite the advancements and modern approaches in the field dating from around the early 1970s, which began to recognise that psychologists are not impervious to such issues (Mausner and Steppacher, 1973), the 'us and them' mentality still prevails, with a lag existing between theory and implementation of these fundamental ideas.

How do we as psychologists address this?

Only by challenging the ideas that purpurate stigma early can change occur. After all, it is our collective experiences, for better or worse, that shape us as people. Indeed, as psychologists it is important to remember this. We are just as human. This vulnerability, ability to empathise

and understanding gained from our own experiences makes us competent and worthy psychologists. If we as psychologists fail at the first hurdle of addressing the stigma of mental health, then how can we expect our non-psychology colleagues not to do the same?

Reflection and my advice

With hindsight, I would love to tell my 18-year-old self to talk to my university about my struggles from the start. I often wonder how my life would have panned out differently if I had admitted that I needed support from my university and taken their support. Let us normalise these conversations, let us normalise taking 'mental health days' and let us start having conversations with our colleagues, but also more fundamentally our supervisors. It is ok to say that I am not ok to those that support us the most in this PhD journey. And of course, there is ample support for both as an alternative and adjunct to speaking with our supervisors if we choose not to disclose for personal or conflicting reasons. This help can be both within the university from well-being/psychological and similar services, as well as external through formal medical routes, such as a GP. Furthermore, there are more informal means from mental charities who can also offer support. It is important to reiterate that there is help out there and you are not alone at any stage of your PhD.

Conclusion

The very fact that writing this piece for the PsyPAG Quarterly with full transparency scares me demonstrates that I and the majority of us still have a way to go in normalising mental health in postgraduate studies. But this is a message and reflection that needs to be shared. Mental health does not discriminate. Despite our empirical knowledge that this does not make us less competent than our peers, it is a notion hard to shake off at the psychological level. But it something that needs to be done and only starts with normalising disclosure to those closest to us in our PhD journey.

Correspondence

Lara Quartel
[Current position e.g., MSc candidate, PhD candidate etc.]
[Lab/department]
[University]
Twitter: [OPTIONAL]
Email: L.Quartel@kingston.ac.uk

References

Good, G. E., Khairallah, T., & Mintz, L. B. (2009). Wellness and impairment: Moving beyond noble us and troubled them. *Clinical Psychology: Science and Practice*, *16*(1), 21-23.

Mausner, J. S., & Steppacher, R. C. (1973). Suicide in professionals: A study of male and female psychologists. *American Journal of Epidemiology*, *98*(6), 436-445.