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Education Students' Perceptions of Instructors Who Disclose Mental Health and Well-Being Experiences in Post-Secondary Classrooms

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Abstract

This mixed-methods study documents the collaborative autoethnographic experiences of two Faculty of Education instructors who disclose mental health and well-being details in their classrooms and reports on the perceptions of 117 education students across six of the instructors' Bachelor of Education and Master of Education courses. Students completed an online survey concerning their instructors' approachability, competency, sensitivity to student struggles, and trustworthiness after their mental health disclosures. Interrelated frameworks of well-being, student-teacher relationships, and inclusive learning environments informed the analysis. Findings indicate that students found their instructors to be more competent, understanding, and worthy of respect after disclosing mental health experiences. Students also perceived their instructors as role models, as working to destigmatize mental illness, and recognized their instructors' disclosures as intentionally contributing to inclusive classroom spaces. Notably, students who had personal experiences with mental illness (over half of

participants) shared an increased view of their own competence resulting from their instructor's disclosures. For students who were already knowledgeable about mental health and held low levels of stigma, perceptions of their instructors were relatively unchanged. Instructors reaffirmed their beliefs about the need to use their positions of power strategically to destigmatize mental illness, and about the benefits of modelling inclusive classroom practices for future teachers.

Keywords: well-being, mental illness, teacher education, role models, inclusive education, mental health disclosure, destigmatization

1. Introduction

> **Jake:** *In my first semester of full-time university teaching, a student came to my office to explain that she had recently suffered a brain injury, and this would be her first semester back after taking time off. She had questions about the workload and possible accommodations. I told her about my own brain injury in 2015, taking time off from work and my graduate studies, how hard I found it returning due to cognitive fatigue and memory problems, and that we could work together to accomplish her goals for my course. I remember at one point she had tears in her eyes, and I was fighting mine back as we continued to talk. Going forward, she excelled in my course, won awards for her academic excellence, and quickly secured a job as a teacher. Reflecting on her experience, she said that our conversations allowed us to "connect ... on a human to human basis. It wasn't like, you're the student and I'm the professor ... it provided such a holistic perspective of what it's like to be the teacher of a student that needs a little bit of extra help" (Groves as quoted in Hinther, 2021). This encounter serves as one of the moments that helped me realize that being open about my mental health experiences could have more of a meaningful and generative impact than staying silent.*

Mental health challenges among post-secondary students in Canada are rising (Moghimi et al., 2023; Rashid & Di Genova, 2020), and increasingly, attention is also being paid to instructor and faculty mental health (Gulka et al., 2025; Halat et al., 2023; Horowitz et al., 2025). Recognizing that the well-being of students and instructors within post-secondary institutions are interrelated (Kiltz et al., 2020; Roffey, 2012), we affirm calls to better understand this connection and to increase support for both groups (Hammoudi Halat et al., 2023; Moghimi et al., 2023). While broader well-being can encompass emotional, psychological, social, physical, cognitive, and spiritual dimensions (Kiltz et al., 2020; Woloshyn et al., 2021), mental health, as a core component of well-being, includes an individual's capacity to cope with life's stresses, realize their abilities, learn and work effectively, and contribute to their community (WHO, 2025).

Post-secondary instructors can strengthen students' well-being through fostering student-teacher relationships (Kiltz et al., 2020), cultivating a sense of belonging (Ragoonaden et al., 2025), creating inclusive learning environments (Woloshyn et al., 2019), emphasizing equity and psychological safety in their classrooms (Hammoudi Halat et al., 2023), and through the supports that they offer their students (Lindsay et al., 2023). Student well-being can also be indirectly affected by changes in the learning environment resulting from an instructor's well-being (Schwind et al., 2022). For their part, post-secondary instructors' well-being can be impacted by student behaviours and stress (Kiltz et al., 2020), in addition to factors such as: institutional cultures of competitiveness and employment instability (Smith et al., 2022); whether or not their psychological needs and lived experiences are acknowledged and valued by administrators (Clem & Buyserie, 2023; Larson et al., 2019); the receipt of peer support or having supportive colleagues; and, perceptions of stigma at interpersonal and institutional levels (Smith et al., 2022).

As post-secondary instructors in teacher education, we questioned the potential benefits and drawbacks of being open about our own well-being with students in our courses. More specifically, living with mental health challenges is a significant part of our identities, and not one that we regularly disclose to students. However, some instructors assert that disclosing mental illness in academic settings has become a political and moral responsibility (Fox & Gasper, 2020), particularly since the COVID-19 pandemic (Bergen et al., 2022b), and that these disclosures can show support for students with mental health challenges and provide an opportunity to direct students to relevant campus resources.

Following from this context, and as part of a larger research group studying the complexities of mental health disclosures in post-secondary classrooms (see de Barros et al., 2026), we designed this study to explore two key questions: 1) Is there evidence that mental health disclosures can contribute to relationship-building between post-secondary students and instructors? and; 2) How does talking about our own mental health and well-being in the classroom influence students' perceptions of us, their beliefs about mental illness, and their experience of the classroom environment? We employed a mixed-methods, collaborative autoethnographic approach to examine these questions, integrating our own experiences as instructors who disclose mental health and well-being experiences in our classrooms with survey data from 117 students across six education courses.

2. Literature Review

To contextualize our research questions, we examine existing literature on disclosures in workplace and educational settings, focusing on stigma, rationale for instructor disclosures, mechanisms of stigma reduction, the role of visible role models, and the limited research on student perspectives.

Outside of academia, workplace disclosures of identity factors or health conditions (i.e., sexual orientation, pregnancy, or arthritis) often yield positive outcomes (e.g., Follmer et al., 2020; Ito & Bligh, 2016; Nittrouer et al., 2014; Peters & Brown, 2009), including enhancing safety and trust (Ito & Bligh, 2016), improving job satisfaction, increasing visibility, and positively influencing organizational social norms (Nittrouer et al., 2014). However, this is not always the case when disclosing more stigmatized conditions or identities, such as mental illness (Adams & Webster, 2017; Brohan et al., 2014; Gibson et al., 2018; Gignac et al., 2021; Hancock, 2021; Jiang et al., 2020). Stigma refers to negative beliefs and structural barriers directed at specific groups (Government of Canada, 2022; Stuart, 2016). Professionals who disclose mental illness, for example, may be judged as less competent, reliable, or productive by potential employers and colleagues (Batastini et al., 2014; Elraz, 2017; Krupa et al., 2009). In addition, stigma levels vary based on the perceived rarity of a mental illness and the extent to which someone is held personally responsible for their own illness (Feldman & Crandall, 2007). Recently, however, White et al. (2023) reported that, although employees anticipated stigma and compromised employment upon disclosure of mental illness to employers, participants were met with understanding, receiving workplace accommodations and respect for privacy upon their disclosures.

In their collaborative autoethnography, Horowitz et al. (2025) demonstrated that post-secondary instructors who disclose mental illness or neurodivergence in their classrooms are motivated by managing their own well-being, ensuring their teaching effectiveness, increasing student success and well-being, and goals of destigmatizing mental illness and neurodiversity. 'Disclosures' in this context included relaying details about personal mental health experiences to students individually, in small groups, or to an entire class during part of formal instruction. Similarly, Gulka et al. (2025) found that instructors disclosed mental health experiences to students with the goals of destigmatizing mental illness and to provide opportunities to connect students to support. Personal benefits of disclosure have also been documented, including not having to mask part of one's identity (England, 2016), and increased feelings of authenticity in the classroom (Koch, 2022).

Studies suggest that contact-based interventions, which involve interactions with individuals living with mental illness, can effectively reduce stigma in educational settings (Carroll, 2018; Strassle, 2018; Waqas et al., 2020; 2023). These interventions can include guest lectures, case studies and conversations, and role-playing (Waqas et al., 2020). For example, Carroll (2018) found that students' negative attitudes toward mental illness significantly decreased following guest lectures by individuals who were successfully managing mental health conditions, and Joshi (2023) has emphasized the role that classroom conversations can have in reducing mental health stigma on university campuses.

Visible role models can also significantly influence student success in higher education, particularly for students facing systemic barriers. Effective role models typically embody competence, similarity to students, and attainable success (Gladstone & Cimpian, 2021). Examples have included increases in women in economics following exposure to a female role model (Porter & Serra, 2020), enhanced academic success of racially minoritized students who seek help from professors with similar racial backgrounds (Mishra, 2020), and increased motivation across all students when exposed to role models in STEM from underrepresented groups (Gladstone & Cimpian, 2021). In the field of mental health, Campbell (2018) specifically advocated for instructors to discuss mental health openly, which can cultivate supportive learning environments and foster students' self-efficacy. However, there is limited literature documenting instances where instructors who disclose mental health experiences act as role models.

Research on post-secondary students' perceptions of instructors who disclose mental health experiences is sparse (de Barros et al., 2026), and largely draws from instructors' autoethnographic accounts. Skogen (2012), for example, expressed concerns that students would lose respect for them following their mental illness disclosure, while Uthappa (2018) worried students might view them as irrational or incapable. Alternatively, some accounts report encouraging results, including that students view instructors as more approachable and understanding after disclosures (Bergen et al., 2022a; Meluch & Starcher, 2019; Koch, 2022). Both Quijada (2020) and Koch (2020) experienced gratitude from students when they disclosed their mental illnesses, becoming support access points for these students. Koch (2022) discussed how their disclosure resulted in students disclosing their own experiences with mental health. This phenomenon, known as 'mirrored disclosures' (Gulka et al., 2025),

has been documented as a common result when instructors discuss mental health experiences with post-secondary students. Although benefits have been identified, Gulka et al. (2025) also outlined the emotional toll that receiving distressing or traumatic accounts from students can have on instructors over time, including contributing to compassion fatigue and burnout.

For teacher candidates entering the K-12 system, understanding and implementing strategies for personal well-being are vital to their success and retention in the profession (Akash et al., 2026; McCallum & Price, 2010; Sokal & Eblie Trudel, 2023). However, little is known about students' perspectives of instructors who disclose mental health experiences in their post-secondary classrooms, and what impacts this might have for destigmatizing mental illness, fostering relationships between students and teachers, or promoting student well-being.

3. Methodology

This study integrates collaborative autoethnography (CAE) with quantitative and qualitative survey research. As an approach, CAE engages researchers as participants by reflecting on their lived experiences and critically analysing these experiences in a shared, structured process (Chang et al., 2013; Breault, 2016). CAE enables researchers to integrate personal narratives into a broader cultural, institutional, or systemic analysis, making it an ideal framework for understanding the intersections of teaching and learning from both personal and professional perspectives (Chang et al., 2016). Collating our own experiences alongside student survey responses also created a different form of research rigor than is possible in single-participant autoethnographic work. Contextualizing our own data with student responses allows for a more systematic investigation of the social context and impacts of our mental health disclosures (Ellis et al., 2011; Hernandez et al., 2017; Roy & Uekusa, 2020).

CAE weaves ongoing autobiographical experiences with related context to analyse, interpret, and describe research results (Ellis et al., 2011). We (Jake & Judy) begin with autobiographical narratives to position ourselves as researcher-participants, and we integrate narrative interpretations throughout the article to share our experiences and analysis (Chang et al., 2016).

> **Jake:** *I am an educator who has worked across a number of sectors; briefly as a teacher in the K-12 school system, with more significant roles through non-profit organizations engaging elementary, high school, and post-secondary students in action around social and environmental justice issues. As an extension of this work, I began working with teacher candidates to develop global citizenship, anti-racist, and 2SLGBTQIA+ inclusive pedagogies, and have now been teaching and researching in teacher education for close to ten years. Before joining our well-being research group, I did not intentionally integrate my own mental health journey into my educational praxis, but quickly began to see the importance, complexity, and benefits of doing so (Bergen et al., 2022a; 2022b).*
>
> **Judy:** *Through my work as a lecturer and a well-being coordinator, the relevance of*

mental health challenges comes up a lot in lectures, clinical practice, and casual conversation. I teach 'The Human Curriculum', a therapeutic and healing-centered lens for pre-service teachers and now lawyers (Jaunzems-Fernuk, 2021; Jaunzems-Fernuk, 2022), rooted in my work as a K-12 educator and 25 years in the classroom and as a mental health practitioner. To normalize, destigmatize, and support people with mental health issues and concerns, I sometimes share my own experiences with mental health and self-care. Mitigating burnout, vicarious trauma, and healing through mental health challenges has been the focus of my work for over two decades.

3.1 Data Collection and Participants

To track our experiences throughout the project, we kept research journals that served as both data sources and tools for ongoing analysis (Holly & Altrichter, 2011). We used three types of entries: memos (short thoughts, ideas, and questions in real-time), descriptive sequences (recording detailed accounts of classroom environments and the contexts of our disclosures), and interpretive notes (flagging areas for joint discussion; Holly & Altrichter, 2011).

Together, we made direct disclosures of mental health experiences in six of our undergraduate and graduate courses over the span of one four-month semester. All students registered in the courses were invited to complete a survey at the end of the term. The survey contained 72 questions, and students completed it in approximately 20-25 minutes. The survey collected consent and demographic information and asked Likert-scale questions to measure students' knowledge of mental health. These questions included the Mental Health Knowledge Schedule (Evans-Lacko et al., 2010), the Mental Health Literacy Scale (Jorm et al., 1997; O'Connor & Casey, 2015), and the Mental Illness Stigma Scale, including treatability, anxiety, visibility, and recovery subscales (Day et al., 2007). Assessing students' mental health knowledge, literacy, and levels of stigma allowed us to contextualize and validate their responses about us and our disclosures. The survey then asked students about their perceptions of our qualities as instructors and their intentions for future interactions with us. Following this, students were asked whether they recalled us disclosing mental illness to them. Students who remembered our disclosures were additionally asked if their perceptions of us shifted after learning we lived with mental health challenges. All students were asked about whether and how instructors should disclose mental illnesses. The last page of the survey contained articles and links to resources.

There were 130 participants in total, including 124 (95.4%) undergraduate and 6 (4.6%) graduate students, all enrolled in education courses (94 from Jake's courses and 36 from Judy's courses). Demographic information was collected for 80 students (46 from Jake's and 34 from Judy's); all questions were optional and therefore had different student completion rates. Ages ranged from 19 to 55 (M = 25.67; SD = 6.43), and almost all participants were domestic students (n = 79; 98.8%). With respect to gender, 55 (68.8%) participants were women, 22 (27.5%) were men, and 3 (3.8%) were genderqueer, non-binary, or transgender. Participants identified their ethno-racial backgrounds as White/European (n = 63; 81.8%), Chinese (n = 2; 2.6%), Filipino (n = 2; 2.6%), First Nations or Métis (n = 3; 3.9%), South

Asian (n = 1; 1.3%), Black (n = 1; 1.3%), Arab (n = 1; 1.3%), or self-described as mixed/other race (n = 3; 3.9%).

3.2 Disclosure Experiences

> **Jake:** *Prior to the COVID-19 pandemic, I was not publicly open about my struggles with mental health and well-being, neurodivergence, or various diagnoses throughout my life. In part, external and internalized stigma played a role in constructing my groups of symptoms, such as anxiety, depression, ADHD, and impacts from a traumatic brain injury (TBI), as being something 'wrong' with me that I should hide and manage alone. But as the pandemic progressed, I wondered if it was ethical for me to continue to maintain a 'strong' exterior, given the rates of students who were struggling.*
>
> *During subsequent courses, including those covered in this research study, I used my own experiences as windows into how a student with anxiety, depression, or ADHD might experience a particular teaching strategy, assignment, or field trip (how instructions are written, providing exemplars, types of unit summative tasks, etc.). I hosted guest speakers who spoke about how to have mental health conversations with students in K-12 settings, and discussed the well-being research group with students. In all cases, I was explicit that my experiences shouldn't be assumed to be universal of all people who shared similar diagnoses, but were to prompt teacher candidates to consider experiences that might be different than their own.*
>
> **Judy:** *My journey with anxiety has been a slow evolution from complete denial to complete acceptance with a 'hide it' mentality to – wait a minute – when I share these parts of myself, most accept it, and some feel genuinely empowered. I experimented with this loop of disclosure as an elementary and secondary school educator for many years, where I would disclose a bit of anxiety, mostly in private/personal communications with students; however, usually only if students expressed it first or if they asked about mental illness. In the summer of 2017, I began teaching at the post-secondary level and, guarded once again, I tread carefully when it came to vulnerability. The 2017 version of me used my stories and life experiences with anxiety to aid students in pushing through their own anxiety challenges or to befriend anxiety in the hope that it might empower them. However, I had never, to this point, presented anxiety upfront as part of my identity.*
>
> *With the educational and well-being repercussions of the COVID-19 pandemic, I realized I had a bigger job to do than simply providing academic support or accommodation. I began to talk openly and honestly about my anxiety without hesitation for the first time – and I shared the tools I used to manage it and tried to provide support based on my personal familiarity and through my professional therapeutic lens. I have not looked back – except to consider what it was that held me back from being completely myself and open about my experiences in the first place. I now know that hesitation as stigma and I actively work against it.*

In the courses covered in this study, I chose to disclose aspects of my mental health journey with students in a way that was open, honest, and purposeful. I speak generally about my experiences with anxiety, panic attacks, phobias, and challenges related to attention and focus, framing them as part of the broader human condition that shapes our diverse learning and growth. My goal is to normalize conversations about mental health while modelling vulnerability as a form of strength. At the same time, I am intentional in setting boundaries, steering away from details that may be triggering, with the hope that my disclosure remains supportive rather than burdensome. This balance allows me to connect authentically with students while maintaining a safe and respectful classroom environment.

4. Findings

4.1 Quantitative Findings

Table 1. Students' Experiences of Mental Health

Mental Health Condition	Personal	Family/Friends
Anxiety disorder(s)	46 (57.5%)	58 (72.5%)
Depressive disorder(s)	34 (42.5%)	54 (67.5%)
Schizophrenia or other psychotic disorder(s)	--	7 (8.8%)
Bipolar disorder	3 (3.8%)	22 (27.5%)
Obsessive-compulsive disorder	8 (10.0%)	11 (13.8%)
Post-traumatic stress disorder	7 (8.8%)	16 (20.0%)
Autism spectrum disorder	--	6 (7.5%)
Learning disorder(s)	1 (1.3%)	10 (12.5%)
Dissociative disorder(s)	2 (2.5%)	6 (7.5%)
Feeding/eating disorder(s)	20 (25.0%)	21 (26.3%)
Sleep-wake disorder(s)	3 (3.8%)	10 (12.5%)
Disruptive, impulse-control, or conduct disorder(s)	1 (1.3%)	3 (3.8%)
Substance-related or addictive disorder(s)	3 (3.8%)	26 (32.5%)
Personality disorder(s)	--	11 (13.8%)
Attention-deficit/hyperactivity disorder	11 (13.8%)	24 (30.0%)
Other (e.g., audio processing disorder)	2 (2.5%)	--

Descriptive statistics were computed using SPSS Version 30. Findings indicate that over half (n = 55; 68.2%) of students that answered the demographic questions personally experienced one or more mental health conditions, with the most common being anxiety (n = 46; 57.5%) and depression (n = 34; 42.5%; see Table 1). Of those students who reported experiencing a mental health condition, 41 (74.5%) reported experiencing more than one (participants could

select as many as they experienced). Most students (n = 67; 83.8%) reported having a family member or close friend who has experienced one or more mental health conditions; the most common of these were also anxiety (n = 58; 72.5%) and depression (n = 54; 67.5%).

To get a sense of how students viewed mental illness, we asked participants questions measuring their mental health knowledge, literacy, and stigma levels. As illustrated in Table 2, alpha coefficients for the Mental Health Literacy Scale (MHLS), Mental Illness Stigma Scale (MISS), and MISS Anxiety, Visibility, and Recovery subscales were acceptable (i.e., > .70). For the two-item MISS Recovery subscale, Pearson's correlation coefficient was 0.51, $p < 0.001$, indicating good reliability. The only exceptions were the alpha coefficients for the Mental Health Knowledge Schedule (MAKS) and MISS Treatability subscale, which were both below .70. However, the designers of the MAKS indicated the measure is not expected to have high internal consistency, as it assesses multiple aspects of mental health knowledge and participants may have knowledge in some domains and not in others (Evans-Lacko, 2010). The low alpha coefficient for the Treatability subscale is likely due, in part, to the fact that the subscale only has three items.

Table 2. Students' Mental Health Knowledge, Literacy, and Stigma

Measures	*M* (*SD*)	Midpoint	α(95% CI)
Mental Health Knowledge Schedule (MAKS)	54.37 (5.50)	30	.53(.40-.64)
Mental Health Literacy Scale (MHLS)	15.61 (2.74)	12	.77(.69-.83)
Mental Illness Stigma Scale (MISS)	40.65 (9.84)	64	.80(.74-.85)
Treatability	6.26 (2.53)	12	.60(.47-.71)
Anxiety	15.94 (6.56)	28	.88(.84-.91)
Visibility	13.99 (3.86)	16	.70(.61-.78)
Recovery	4.46 (2.04)	8	--

Total mean scores were above the scale midpoints for both the MAKS and MHLS (Table 2), indicating that students were knowledgeable about mental health issues overall. On the MISS and subscales, mean scores were below midpoints, suggesting that mental illness stigma was relatively low among our participants.

A summary of students' assessments of us as instructors are presented in Table 3, and details are presented in Table 4 - Perceptions, Table 5 - Behavioural Intentions, Table 6 - Shifting Perceptions, and Table 7 - Shifting Behavioural Intentions. Alpha coefficients for all four scales were above .70, indicating good reliability.

Table 3. Summary of Professor Assessment

Measures	*M* (*SD*)	Midpoint	α(95% CI)
Perceptions	27.25 (3.37)	17.5	.90 (.87-.92)
Behavioural Intentions	16.62 (3.13)	12	.87(.83-.90)
Shifting Perceptions	23.66 (3.62)	18	.87 (.82-.91)
Shifting Behavioural Intentions	15.12 (2. 89)	12	.90(.86-.93)

The Perceptions scale (Table 4) asked students to rate us on approachability, competence, trustworthiness, ability to inspire, sensitivity towards students' struggles, and levels of respect. The total mean score for the Perceptions scale (see Table 3) was above the midpoint, suggesting that, overall participants had positive perceptions about us as instructors. Mean scores for each individual Perceptions scale item (Table 4) were also all above the midpoint (i.e., 3), indicating positive perceptions of us in all six areas.

Table 4. Perceptions

Scale Items	*M* (*SD*)
1. My instructor is approachable.	4.55 (.75)
2. My instructor is competent.	4.68 (.61)
3. My instructor is trustworthy.	4.55 (.62)
4. My instructor is inspirational.	4.25 (.84)
5. My instructor is sensitive to students' struggles.	4.57 (.66)
6. How would you rate your respect for the instructor?	4.64 (.63)

Response options for items 1-5: 1 = Not at all, 2 = Slightly, 3 = Moderately, 4 = Very, 5 = Extremely

Response options for item 6: 1 = No respect, 2 = A little respect, 3 = Moderate respect, 4 = A lot of respect, 5 = Extreme respect

The Behavioural Intentions scale (Table 5) asked students questions about their intentions for interacting with us in the future. The total scale mean score (see Table 3) and individual scale item mean scores (Table 5) were above their midpoints, suggesting that students viewed us as approachable for all four questions.

Table 5. Behavioural Intentions

Scale Items	*M* (*SD*)
Would you be interested in taking another class with this professor, assuming it fit within your degree plan?	4.70 (.71)
How likely would you be to approach this professor for:	4.29 (.83)
… academic assistance, now or in the future?	
… professional assistance, now or in the future?	4.22 (.86)
… help with personal issues, now or in the future?	3.42 (1.21)

Response options: 1 = Definitely not, 2 = Probably not, 3 = Neutral, 4 = Probably yes, 5 = Definitely yes

The Shifting Perceptions (Table 6) and Shifting Behavioural Intentions (Table 7) scales asked students to indicate the extent to which their perceptions and behavioural intentions shifted after learning we lived with mental illness. Total mean scale scores (see Table 3) were above

the midpoint for both scales, indicating that student perceptions and behavioural intentions increased after our disclosures. Mean scores for all individual items on the Shifting Perceptions (Table 6) and Shifting Intentions (Table 7) scales were also above the midpoint, suggesting that participants' views of us became more positive in every aspect after our disclosures (e.g., competency, approachability, respect, etc.). No students reported decreased perceptions across any items. Instead, student perceptions either remained stable ('did not change') or shifted positively ('increased a little,' or 'increased a lot').

Table 6. Shifting Perceptions About Their Professor

Scale Items	*M* (*SD*)
My sense of their approachability.	4.25 (.77)
My sense of their competency.	3.61 (.81)
My desire to do well in the class.	3.44 (.75)
My sense that they are an inspirational.	4.05 (.79)
My sense of their sensitivity to student struggles.	4.38 (.67)
My respect for the instructor.	4.00 (.88)

Response options: 1 = Decreased a lot, 2 = Decreased a little, 3 = Did not change, 4 = Increased a little, 5 = Increased a lot

Table 7. Shifting Behavioural Intentions

Scale Items	*M* (*SD*)
My desire to take another class with them.	3.71 (.82)
My interest in approaching them for **academic help.**	3.79 (.85)
My interest in approaching them for **professional help.**	3.73 (.85)
My interest in approaching them for **help with personal issues.**	3.89 (.82)

Response options: 1 = Decreased a lot, 2 = Decreased a little, 3 = Did not change, 4 = Increased a little, 5 = Increased a lot

We also looked at whether students' perceptions of us differed based on personal or relational (friends or family) experiences with mental illness. Students with personal mental health experiences showed significantly greater positive shifts in their behavioural intentions toward us compared to students without such experiences. No other statistically significant differences were found based on personal experiences, though this is likely partially due to the low number of participants (*n*s = 57-80) in each analysis.

4.2 Qualitative Findings

We asked students seven qualitative questions in the survey, and these were analysed using Creswell's (2012) six-step thematic approach. This approach works to identify general ideas and underlying meanings in raw data, progressing from coding to theme development

through iterative analysis. The five major themes that we identified included: 1) relationship-building pathways, 2) being viewed as a role model, 3) creating and modelling inclusive classroom practices, 4) de-stigmatization and risks of visibility, and 5) unchanged or only slightly changed student perspectives.

> **Jake:** *I began to cry reading through my students' responses for the first time, and cried multiple times as we coded the data and wrote up the themes. I think part of this initial response was relief - knowing that my disclosures had the opposite effect than my fears had assumed: students found me more – not less – competent after disclosing, they felt more safe in the classroom space, and had more – not less – respect for me. Many students also had unchanged views; they respected people with mental health challenges prior to the course and continued to afterwards. Importantly, students found me more relatable, and many indicated that talking about my own mental health challenges helped to normalize their own.*

> **Judy:** *Reading the student reflections was eye-opening and heartwarming. I wasn't sure what to expect from anonymous comments and it was great to see some of my thoughts confirmed and fears dispelled. Disclosing issues surrounding mental health and neurodivergence normalized mental illness and struggle, and students' worries or concerns were minor and more related to my needs vs. that of concern for their education or well-being. This tells me I need to be sure that my disclosures also communicate boundaries. Most powerfully, my students felt more connected and related to me as their instructor, which I believe contributes greatly to our relationships, connections, safety, belonging, and comfort in the classes I teach.*

4.2.1 Relationship-building Pathways

Relatability. When asked how they felt upon learning that we had a history of mental illness, students wrote, "I think their experiences with mental illness made them more relatable and approachable," that "it helps connect students to professors," and "It makes them seem more human, relatable, and approachable." In addition, many students wrote about other characteristics that contribute to relationship-building, including perceptions of us as more understanding and supportive, and an appreciation of our vulnerability and willingness to open up spaces for mutual concern.

Understanding. Many students made general comments about our understanding, such as "I felt like my professor could better understand me," and "they seem understanding." This also extended to students thinking we would be more understanding of those who needed support or classroom accommodations, as students wrote that "if I needed an extension or needed help, I felt I could ask for it easily," or that it would be "easier to approach them about struggles and extensions." As well, students wrote that we might better understand "the struggles that go along with dealing with a mental illness while in a university program." These responses were consistent with the quantitative results that found that students with personal experiences of mental illness had more positive shifts in their behavioural intentions with us after mental health disclosures.

Vulnerability. Students wrote that "I think their experiences with mental illness made them more relatable and approachable. It also made me see them as even more brave for being vulnerable like that in front of the class." Students' perceptions of us as more vulnerable extended to feeling like they could trust us: "I felt like I could trust [them] more because they could sympathize with students' struggles," and "it was comforting to know and made the prof seem more relatable and I felt built trust/relationship." Students also appreciated opportunities for mutual care. For example, one student wrote that "I felt glad that they were willing to share this information and [I] could relate to them. It made me feel like in a way they cared about me and trusted me," while another wrote that "it made me … be more open and vulnerable as she was being open and honest and vulnerable with us."

4.2.2 Role Modelling

Inspirational for students with mental health disorders. In relation to our mental health disclosures, students wrote that "it helps us see ourselves in others," and that it "help[s] students like me have positive role models who struggle with similar issues, and disrupts narratives about the abilities of people with mental illness." Students also indicated that our disclosures impacted how they saw themselves, writing that "it helped me feel that people with mental illness could be successful and achieve all the things I want to achieve … learning that they experience mental illness made my attitude more positive by influencing my ideas about my own capacities," and "hearing respected people disclose mental illness shows me that I can achieve things despite my own health struggles." Some students also referenced that we were academic role models, specifically, noting that "as someone who also has ADHD and is currently struggling through university it was reassuring that someone like me could get a doctorate," and "I felt that if they could succeed in this field then maybe I could too."

Increased respect and unchanged perceptions of competency. Following our disclosures, students wrote that "sharing their struggles allowed me to respect them even more." In response to the question, 'What worries or concerns did you have upon learning that your instructor lives with and/or has a history of mental illness?', the majority of students did not have concerns (n = 56; 86.2%), and several students commented that their perceptions of our competency had not changed (n = 7). Their responses included "they seem extremely competent, approachable," and that "[the instructor] demonstrated several times that they were extremely competent." One student additionally wrote that they felt their instructor was "*more* capable and competent to talk about certain topics (emphasis added)" after their disclosure.

4.2.3 Inclusive Classroom Practices

Students' answers showed two themes consistent with inclusive classroom practices, including describing feeling more comfortable, safe, or a sense of relief upon our disclosure of our own mental health experiences, and that they recognized our disclosures were part of broader classroom practices that strove for inclusion of people with stigmatized or minoritized identities.

Increased comfort and relief. In answer to the question, 'How did you feel upon learning that your instructor lives with and/or has a history of mental illness?' all students (including those who had personal experiences with mental illnesses and those who did not), noted that our disclosures made them feel more comfortable. One student remarked that "…they still have struggles like everyone else. This creates an inevitably more comfortable and supportive environment," and another wrote: "it allows students to see they are not alone and that someone in power gets it." Students who indicated that they had experiences with mental illness wrote, "I felt relief knowing that they would understand what it's like. A lot of people and professors will say one thing about their views on mental illness, but act differently," while another wrote, "because I deal with mental health issues … I felt more comfortable with them and in the class when this information was disclosed."

Help seeking. Students also said our disclosures encouraged them to share about their own mental health or to seek help. As one student indicated, "I felt comfortable to share about my own mental health. By having them share honestly, it allowed me to open up and do the same," while another noted that, "it makes them seem more relatable and like a human rather than someone who has power over you in the position that they are in. To me, it makes me feel more comfortable approaching them with personal needs or questions."

Recognition of inclusive classroom pedagogy. When asked how our mental illness experiences might influence our teaching, positively or negatively, the majority of students said that they thought it would positively impact our teaching. Many students perceived that our mental health experiences impacted our choice to (or was the rationale for) modelling inclusive classroom practices. Students noticed that the "class [was] structured to minimize unwarranted stress," and that because we shared our own experiences, it increased "the engagement among students through a judgement-free and supportive classroom environment." Other students noted more specific parts of our pedagogy, writing that we could better support our students "through [our] teaching approaches and methods," that we "understood things like executive dysfunction," and that we "give concrete examples of what would help a student like them be able to complete an assignment efficiently and to the best of their ability." They also wrote about our knowledge benefitting our ability to support students with mental illness, specifically, writing that we understand "that students need a break to control their mental illness," or that we "are likely more aware of signs and symptoms of mental illness as well as strategies and resources that could help students." Students also made assumptions connected to our specific diagnoses, asking "are my lesson plans within the unit plan that I will submit equitable for students with or without ADHD?" with others noting that "people who understand ADHD will have more engaging teaching strategies," and that "instructors can ensure that their lessons and their teachings work for those who have [their particular] mental illness."

4.2.4 Destigmatization and Risks of Visibility

Increased normalcy. Many students indicated that it was destigmatizing for us to share about our mental health: "by being open about it, [they] modelled to me that it was okay to discuss mental health issues and to destigmatize it." Another student wrote they "feel a little more

comfortable towards people with mental illness." Students also suggested that they appreciated the normalcy of these conversations, writing that "I was happy that she was open and honest about it, it helps normalize the conversations around mental illness," and "I think hearing their struggles made it seem more normal."

Risks of visibility. Although they welcomed our disclosures, some students also recognized that our visibility could carry personal risks. They indicated that "people don't always have a positive attitude towards people with mental illness, and they could receive backlash" or about the "potential stigma they could face from students after disclosing." Some wrote about ways this could manifest, noting that "some students might use their mental health against them," or that "…there are a lot of colleges and professions that I believe students would try to use this to undermine their professors or discredit them." These comments indicated that students were aware of the negative stigma surrounding mental illness, and also the potential impacts of this stigma on us, with some even writing that they hoped we "are okay," and that we "had supports in place" should this be the case. A few students also noted that our disclosures might pose risks for other students, writing that "talking about these experiences can be triggering for some students," or wondering if "anything that could be potentially triggering" would always be appropriate to talk about in class.

4.2.5 Unchanged Perspectives

Students were asked whether having an instructor with a mental health challenges influenced their attitudes toward mental illness. In response, many students indicated having more positive attitudes toward people with mental illness, writing "I feel comfortable now being surrounded by people who struggle with mental illness and I also feel more competent and capable of providing resources and support for them," and "I had already known about a lot of mental health challenges, but it made me have a better attitude seeing people with mental health issues being at a high level of education." However, over half of students indicated experiencing no change in their attitudes. Many students wrote comments reinforcing their unchanged views, such as "zero worries or concerns," "I was interested to hear more about it, but it did not drastically affect me in any way," or "I already had positive attitudes toward people with mental illness," and "I've worked with and have many friends with mental illness and my opinion of them never changes."

When asked whether they think instructors should disclose their personal experiences of mental illness to their students, the majority of students either believed their instructor should disclose their experiences of mental illness if they chose to, or were unsure, because they thought disclosures should be up to the discretion of individual professors, and not mandatory.

5. Discussion

> **Jake:** *Being honest with my students about my past and present challenges with my mental health and well-being continues to be an evolving journey. Some semesters I will disclose parts of my experiences or diagnosis to entire classes when appropriate,*

while others, I choose to do this on a small-group or individual basis. Although I am in a position of power and occupy several socially constructed dominant identities, such as being white and middle-class, I still find myself making calculations about my relative safety in some situations as someone who is agender-nonbinary and queer. These social negotiations change from course to course, and my internalized stigma remains as a constant pressure to not disclose. In this way, being open about my mental health and well-being helps with the process of destigmatization in two ways – both for me and for my students.

Judy: *I truly feel our disclosures strengthen students' views of us as strong educators and leaders. Moving forward, I feel that educational institutions might consider incorporating training for instructors on how to effectively share personal experiences in a way that enhances learning and supports student well-being. These insights highlight the potential benefits of openness about mental health in educational settings, both for educators and students, and this underscores the importance of creating environments where mental health can be openly discussed as part of the human condition. In sharing my personal experiences with mental health, I feel a strong sense of empowerment, knowing my life experiences can have a profoundly positive impact on students and promote empathy, understanding, and a more inclusive environment.*

5.1 Visibility of Role Models

Judy: *Prior to this study, I knew that disclosure was helpful to our classroom conversations and relationships, and to destigmatizing mental illness; however, I had no idea of the depth of influence this would have on students' sense of self.*

Over half of our students had personal experiences with mental health disorders, and in addition, they were knowledgeable about mental health and well-being and had low levels of stigma towards people with mental illness. In the survey, they indicated that they viewed us as inspirational, competent, approachable, trustworthy, likable, sensitive to students' struggles, and worthy of respect. After disclosing our own mental health and well-being experiences, almost all students' views of us remained unchanged or became more positive, and unchanged perceptions often reflected students' already-positive views of people with mental illness.

Students with personal mental illness experiences showed greater positive shifts in their perceptions of us, perhaps because they better understood the challenges associated with certain mental health experiences. In their qualitative answers, these students indicated that our disclosures contributed to relationship-building and to our visibility as role models. Students' perceptions of our competency as educators were unchanged, and many noted that our success led them to positively reconsider their own abilities or chances of success. These characteristics (similarity to students, competence, and attainable success), are some of the primary characteristics embodied by effective, visible role models (Gladstone & Cimpian, 2021). This visibility seemed particularly significant for our students, most of whom were pre-service teachers, who begin to form their professional identities during their training and

are greatly influenced by positive or exemplary educators they encounter during this time (Cohen-Azaria & Zamir, 2021).

5.2 Relationship-building

> **Jake:** *If I am open and honest, perhaps students will, in turn, be open and honest with me and their students in meaningful ways. If I take steps to build relationships with them, perhaps they will see the value of these efforts in their future teaching.*

Students overwhelmingly indicated that our disclosures contributed to relationship-building with them. They perceived that we were more understanding in general, supportive of all students' needs, and particularly empathetic towards students with mental illness. They also indicated that our vulnerability made us more trustworthy and that they appreciated opportunities for mutual care and concern. Fostering meaningful relationships between students and teachers is one of the main goals of relational pedagogy (Crownover & Jones, 2018), and is also a central part of creating culturally responsive and anti-racist classrooms (Ladson-Billings, 1995; Mirabile et al., 2025). Relationship-building between students and teachers can foster a sense of belonging (Ragoonaden et al., 2025), enables a deeper understanding of course content (Zins et al., 2004) and also increases student learning outcomes (Palmer, 2017). Students' answers reflect that we were successful in implementing some of the key characteristics of relational pedagogy, including building trust, empathy, mutual respect, and understanding (Hollweck et al., 2019; Noddings, 2005). This approach can be particularly useful for conversations about complex topics, mental health and well-being included, given that it creates opportunities for students and teachers to examine personally relevant questions and to create meaningful ways of sharing what they have learned through life experiences (Kuhlthau et al., 2015).

5.3 Creating 'Safe' Classroom Spaces

The Mental Health Commission (MHC) defines a 'safe space' as an environment in which people can "express themselves and share experiences without fear of discrimination or reprisal" (2019, p. 1). Many students used the language of safe spaces in their answers, emphasizing that our disclosures contributed to the creation of supportive environments where students felt seen, understood, and a sense of relief that 'someone in power gets it.' In academic contexts, where cis-heteropatriarchy, ableism, and racism exclude many students, intentional spaces are needed to include those who have been historically excluded (Bramberger & Winter, 2021). According to hooks (1994/2014), a space becomes safer when its leaders both reflect and represent students and actively invite all students to contribute. hooks describes 'safe learning communities' as environments in which every voice matters and where engaged pedagogy empowers both teachers and students to take risks that foster well-being, enlightenment, and self-actualization.

In educational settings, psychologically safe environments, characterized by instructor qualities such as approachability, accessibility, honesty, inclusivity, and empowerment, significantly improve student engagement and academic persistence (Turner & Harder, 2018; Mishra, 2020). While hooks (1994/2014) is writing specifically about the experience of Black

students and students of color, and 'safe spaces' have recently referred more to supporting 2SLGBTQIA+ students (Bramberger & Winter, 2021; Rosenfeld et al., 2014), hooks' call to educators can be applied intersectionally: by building a foundation of mutual understanding, students from all backgrounds and identities can learn from one another. Consequently, we observed that by disclosing our experiences with mental health, we can enhance the safety and authenticity of the classroom. At the same time, we are also mindful that safe spaces are aspirational; safety is relative, and due to structural factors, a truly safe space is not a goal that can be met, but is instead a process of striving towards safety for all (MHC, 2019, p. 2).

5.4 Inclusive Practice Modelling

> **Jake:** *As an instructor in teacher education, I am very aware that I am modelling values and practices for my students at all times, whether intentional or not.*
>
> **Judy:** *Because I teach mostly future educators, vulnerability and strength can be modelled as inherent parts of a human-centered pedagogy.*

While serving as a role model through visibility can sometimes be unintentional, our modelling of inclusive classroom practices is deliberate and pedagogically intentional. Teacher educators can significantly influence pre-service teachers' pedagogical development through modelling, which has been described as one of the most 'powerful teaching tools' (Cruess et al., 2008). Through their survey responses, many students recognized that our choice to disclose mental health experiences was part of our efforts to model broader, inclusive classroom practices. By using student-centered practices, teacher educators can also create more inclusive learning environments (Timmerman, 2009). As educators, we both seek to model the types of student-centered and flexible practices that align with Universal Design for Learning (UDL) principles, a framework that promotes diverse ways of engaging in learning, reduces stigma associated with different forms of representation and classroom accommodations, and encourages the use of various strategies to support student learning and well-being. This approach supports instructors in adapting lessons for diverse learner needs, including those related to mental health and well-being challenges, while also modelling resilience and adaptability for students (CAST, 2024).

5.5 Destigmatization

> **Judy:** *Sharing my mental health journey is not just an act of self-disclosure; it is now a deliberate pedagogical choice that seeks to dismantle the stigma around such feelings of ill health to foster a safe learning space where more people feel less isolated and alone.*

Giroux (2004; 2013) argues that teachers' authority can be used ethically and strategically, since it cannot simply be levelled or negated. Instead, teachers' authority "can be used to intervene and shape the space of teaching and learning to provide students with a range of possibilities for challenging a society's commonsense assumptions" (Giroux, 2013, p. 81). Although some students recognized that our disclosures could put us at risk of judgement from less accepting students and colleagues, many noted that our choice to talk openly about mental health experiences helped to normalize and destigmatize these discussions and

conditions. For both of us, this aim is intentional; a recognition of the authority we hold in the classroom and an ethical choice to use that power to challenge stigma. Our disclosures exemplify Giroux's vision of using teacher authority to challenge societal assumptions about who can be competent, credible educators, and how to create more inclusive educational spaces.

6. Limitations

We recognize how common our diagnoses are (i.e. anxiety and depression), that this might impact students' perceptions, and that instructors with mental health experiences that hold more societal stigma may receive different feedback from students. Familiarity with our diagnoses (either personally or through others) and increased familiarity with us as instructors throughout the semester could also have contributed to the exposure effect, where people may unconsciously like something more with increased exposure (Hansen & Wänke, 2009). While we tried to craft survey questions to ask specifically about our mental health disclosures, we cannot rule out that students' increased perceptions of us were unconsciously intermingled with the exposure effect or other biases.

We also acknowledge that the teacher education program we were both teaching in at the time was quite homogenous; many students could likely identify with other parts of our identity, whether they be race, language, or gender identity. Faculties with more diverse student populations, and certainly other post-secondary disciplines, may not have the same positive or consistent results. We suspect, for example, that a racialized colleague would not receive the same responses, and that both our whiteness and similarity to students may have served as mitigating factors against negative perceptions. Future research must attend to the ways that intersecting identities impact students' perceptions.

7. Implications for Practice

Our experiences and the student survey results show that the benefits of our disclosures outweighed our fears. In educational contexts increasingly marked by mental health experiences and barriers, these insights highlight the importance of relational teacher education practices that embrace instructor vulnerability as a pedagogical and personal strength, demonstrating that in such cases, students respond with understanding and respect, hopefully carrying these lessons forward into their own classrooms.

Recommendations for those who seek to strike a similar balance in their teaching might include:

- Deciding before a course begins how and when you will disclose your experiences to students. Judy began their course by disclosing their own experiences with the whole class, as discussing mental health was relevant to the ongoing content of the course. Jake integrated their experiences more gradually, talking about them as examples in whole-class and smaller group settings within the first month of the course.

- Considering what aspects of your mental health experiences you will disclose and how you frame these disclosures. Both authors maintained some boundaries with the types of experiences we disclosed. For example, while Jake would talk about mental health experiences as they were related to aspects of teaching and learning, they did not disclose aspects of their past or current treatment. Judy would discuss current experiences (i.e. what she was experiencing in class), but would frame her disclosures as part of her relational pedagogical practice. Both authors were also cautious not to talk about experiences that could be potentially triggering for students or ourselves.
- Being prepared for reciprocal student disclosures, including setting expectations with students about your role as an instructor (and not a counsellor), and the limitations on your ability to help. Additionally, expecting and making space for the increased emotional labour that reciprocal disclosures from students can accrue. In some cases, it may be helpful to take account of how much time this actually takes (i.e. for tenure and promotion processes), including time emailing and meeting with students, time spent connecting students to relevant resources, and the intentional energy these conversations require compared to everyday interactions with students.
- Ensuring that you prepare and share all of the well-being resources that your faculty and university offer to students, as well as highlighting services provided by non-profit or low-cost organizations for specific groups (like 2SLGBTQIA+ students or newcomer students).
- Potentially making space for students to inquire about what it might look like for them to disclose parts of their identities with their own K-12 students, and how the context of these disclosures would vary significantly depending on grade level, years of teaching, and their school and community contexts.

8. Conclusion

This study provides student-centered evidence on the effects of instructor mental health disclosures, which challenges deficit narratives in academia. Following our disclosures, student perceptions either became more positive or remained unchanged across all dimensions, and students with personal mental health experiences showed significantly greater positive shifts in their views of us and behavioural intentions toward us.

Recognizing the interrelatedness of students and instructors within any classroom, our findings make important contributions. They provide empirical evidence that disclosures of mental health experiences may enhance instructor credibility and can function as part of effective relational pedagogy in teacher education. While there are risks associated with conversations about well-being, this study demonstrates that instructor mental health disclosures serve as a powerful tool for relationship-building, role modelling, and destigmatization of mental illness in teacher education.

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Dr. Bergen and Dr. Jaunzems-Fernuk were responsible for study design, data collection and analysis, primary manuscript drafting and editing. Terri Croteau and Kerry Marshall were responsible for data analysis support and manuscript editing.

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Obtained.

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Data sharing statement

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