Journey towards the Self and the Other: Vulnerability, Neuroplasticity and Interdisciplinary Care in the Context of Invisible Disabilities

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Abstract
Anxiety and depressive disorders may profoundly affect everyday functioning, relationships and participation in social and academic life, even when the associated distress remains largely invisible to others. Their limited visibility raises important questions about recognition, stigma and access to appropriate care. The article draws on a narrative review of selected literature, with emphasis on publications from 2018 to 2025 considered alongside earlier foundational works, and on reflections arising from the international workshop "(In)Visible but Invincible" (25-27 November 2025), to examine the relationship between psychological vulnerability, neuroplasticity and interdisciplinary mental healthcare. It develops a conceptual framework organised around three interconnected dimensions: the recognition of vulnerability as a potential starting point for therapeutic engagement; neuroplasticity as a biological process relevant to learning, adaptation and psychological change; and collaboration between psychologists and psychiatrists as a means of coordinating psychological and medical approaches to care. Particular attention is given to the academic environment, where expectations of continuous performance may discourage the disclosure of psychological difficulties and complicate access to support. Rather than treating all experiences of anxiety, depression or burnout as disabilities in themselves, the article considers the circumstances in which mental health conditions may become disabling through their interaction with individual, social and institutional barriers. It argues that effective responses require both appropriate clinical intervention and greater sensitivity to the ways psychological distress is experienced, interpreted and made visible within educational and healthcare settings.

Keywords: *invisible disabilities; anxiety and depression; psychological vulnerability; neuroplasticity; interdisciplinary mental healthcare; academic environments.*

1. Introduction
There are forms of suffering that remain difficult to recognise precisely because they do not necessarily leave visible traces. A person experiencing severe

anxiety may continue to work, a student living with depression may sit examinations, and an academic struggling with burnout may continue to teach. From the outside, their participation in everyday activities can be mistaken for evidence of psychological well-being. Yet the ability to fulfil professional or educational responsibilities does not in itself indicate the absence of distress. The discrepancy between outward functioning and lived experience raises the question of how psychological suffering becomes recognisable, credible and deserving of support.

Anxiety and depressive disorders constitute significant public health concerns worldwide (World Health Organization 2022). Their effects may extend beyond emotional distress to influence concentration, relationships, occupational performance and participation in education. However, epidemiological estimates require careful interpretation, particularly when comparing different populations, diagnostic categories and assessment methods. Prevalence figures derived from clinical diagnoses cannot be treated as interchangeable with rates of self-reported symptoms identified through screening instruments. This distinction is especially important when changes in psychological distress are discussed in post-pandemic contexts.

The present article developed from a presentation delivered at the International Workshop "*(In)Visible but Invincible: Tracing Silences, Breaking Frames-Disability, Representation, and the Power of the Unseen*", held on 25-27 November 2025. Bringing together perspectives on disability, representation and lived experience, the event provided an interdisciplinary setting in which psychological distress could be discussed beyond exclusively clinical frameworks. The presentation addressed the difficulties of recognising and communicating mental health concerns in academic environments, where expectations of competence, resilience and sustained performance may discourage individuals from acknowledging vulnerability or seeking support. The workshop serves here as a point of departure for conceptual reflection rather than as a source of systematically collected empirical data.

The concept of *invisible disability* offers a useful, although not unproblematic, framework for examining these experiences. It generally refers to disabling conditions or impairments that are not immediately apparent to others. Nevertheless, the distinction between a mental health condition and a disability must be maintained: not every experience of anxiety, depression or occupational burnout constitutes a disability, and the disabling effects of a condition depend on its severity, duration and interaction with environmental and institutional barriers. From this perspective, invisibility is not simply a property of the condition itself. It is also shaped by social expectations, cultural representations of psychological strength and the institutional practices through which distress is recognised, questioned or overlooked.

Such considerations are particularly relevant to academic settings, where the capacity to continue studying or working may conceal substantial

difficulties. Expectations of productivity and self-sufficiency can contribute to a culture in which psychological vulnerability is interpreted as personal inadequacy rather than as an experience requiring appropriate understanding and support. Recognising this tension does not diminish the importance of clinical diagnosis or treatment; it highlights the need to examine the relationship between individual experience, therapeutic intervention and the social conditions that influence access to care.

Against this background, the article examines three interconnected dimensions of psychological care: vulnerability as a potential starting point for therapeutic engagement, neuroplasticity as a biological process relevant to adaptation and psychological change, and collaboration between psychologists and psychiatrists as a model of interdisciplinary support. Rather than proposing a clinically validated treatment protocol, it develops a conceptual framework for understanding how these dimensions may contribute to more responsive approaches to mental health difficulties that are not readily visible to others. The journey towards the self and the other thus describes both the process of recognising one's own distress and the relational dimension of seeking, receiving and sustaining care. The phrase echoes the title of the first author's doctoral research, *Călătorie către S(T)INE…* which plays on the Romanian words *sine* (self) and *tine* (you). It reflects the patient's journey towards self-understanding and towards the other, particularly the psychologist and psychiatrist, whose coordinated involvement may support therapeutic engagement, continuity of care and psychological change.

2. Objectives

This article pursues five related objectives:

- ✓ To examine anxiety and depressive disorders in relation to the concept of invisible disability, drawing on selected clinical and conceptual literature while distinguishing between mental health conditions, functional impairment and disability.
- ✓ To conceptualise the journey towards the self and the other as a framework for understanding the relationship between self-recognition, therapeutic engagement and interdisciplinary care.
- ✓ To explore psychological vulnerability as a potential resource for therapeutic engagement, while critically considering cultural and institutional expectations of resilience, productivity and self-sufficiency.
- ✓ To discuss the relevance of neuroplasticity to psychological adaptation and therapeutic change, with particular attention to the limits of translating neuroscientific findings into clinical claims.
- ✓ To examine the potential contribution of psychologist-psychiatrist collaboration to the recognition and management of mental health difficulties, particularly within academic environments.

3. Methods

This article adopts a narrative, integrative approach, bringing together selected scholarship on anxiety, depression, psychological vulnerability, neuroplasticity and interdisciplinary mental healthcare. Its purpose is to develop a conceptual framework for understanding the recognition and management of mental health difficulties that may be experienced as invisible or disabling, particularly within academic environments.

The discussion draws on clinical and psychological literature, relevant theoretical contributions, professional guidelines and publicly available epidemiological evidence. The authors consulted PubMed, PsycINFO, Google Scholar and the Cochrane Library, using search terms related to invisible disabilities, anxiety, depression, neuroplasticity, psychologist-psychiatrist collaboration, academic burnout and psychological vulnerability. Recent publications are considered alongside earlier foundational works where these remain relevant to the conceptual argument.

The review is narrative rather than systematic. Accordingly, it does not claim exhaustive coverage of the literature, formal quality appraisal of all eligible studies or quantitative synthesis of findings. Epidemiological estimates are treated as secondary evidence and interpreted with attention to differences in populations, diagnostic definitions and measurement instruments. Particular care is taken to distinguish clinically diagnosed disorders from self-reported psychological symptoms and to avoid treating all mental health difficulties as disabilities.

The article also incorporates reflections arising from a presentation delivered at the international workshop "(In)Visible but Invincible" (25-27 November 2025). These reflections inform the discussion of psychological distress, disclosure and institutional expectations in academic settings. They are not presented as findings from a structured observational study, and no prevalence estimates or claims of therapeutic effectiveness are derived from workshop participation.

The resulting analysis is conceptual and interpretative. It brings clinical perspectives into dialogue with questions of social recognition, cultural representations of vulnerability and institutional access to support. The proposed framework, including the RESET self-regulation tool discussed below, is exploratory and has not been empirically validated within the present study.

4. Findings and Conceptual Discussion

4.1. The Scale and Visibility of Mental Health Difficulties

Anxiety and depressive disorders affect individuals across different age groups and social environments, but their significance cannot be understood through prevalence figures alone. Psychological distress may interfere with

concentration, emotional regulation, relationships, employment and educational participation, while remaining insufficiently recognised by colleagues, teachers, family members or institutional authorities.

Estimates of diagnosed anxiety and depressive disorders are not directly comparable with rates of psychological symptoms reported in population surveys or studies using screening questionnaires. The WHO World Mental Health International College Student project illustrates the point: nearly one third of first-year students surveyed in eight countries screened positive for at least one common mental disorder in the previous twelve months (Auerbach et al. 2018). Because these estimates derive from self-report screening scales, they indicate a substantial level of need rather than clinically confirmed prevalence. Similarly, findings obtained from university students, healthcare professionals or other occupational groups cannot automatically be generalised to the national population.

The invisibility of psychological distress is not simply a matter of symptoms being imperceptible to others. It also concerns the assumptions through which individuals and institutions interpret outward functioning. A student who continues to attend examinations may nevertheless experience substantial psychological difficulties. An academic who fulfils teaching responsibilities may simultaneously struggle with exhaustion or impaired well-being. Visible participation should not be confused with the absence of distress, just as psychological distress should not automatically be classified as disability.

From a disability-studies perspective, the central issue is the interaction between individual conditions and the social or institutional environments in which they are experienced. Expectations of uninterrupted productivity, reluctance to disclose mental health concerns and uncertainty about available accommodations may intensify the difficulties faced by those whose conditions are not immediately apparent. Understanding these processes requires attention both to clinical evidence and to the cultural conditions under which suffering becomes recognisable and support becomes accessible.

4.2. The University Environment: Academic Burnout, Psychological Distress and Invisible Barriers

The university environment provides a particularly relevant context for examining the relationship between psychological distress, institutional expectations and the visibility of mental health difficulties. Students and academic staff encounter different but sometimes overlapping pressures, including demanding workloads, performance assessment, professional uncertainty, competitive expectations and difficulties maintaining boundaries between academic responsibilities and personal life. Although these pressures do not necessarily result in mental health disorders, they may contribute to

psychological distress and complicate the recognition of difficulties that remain largely invisible to others.

Within academic culture, the capacity to maintain productivity may be interpreted as evidence of resilience and professional competence. Students who continue attending classes and examinations, and academics who fulfil their teaching and research responsibilities, may therefore find their psychological difficulties overlooked. Moreover, expectations of independence and achievement can discourage individuals from disclosing distress, particularly when they fear being perceived as incapable, unreliable or insufficiently committed to their work.

Evidence from academic populations points in the same direction, although it relies largely on screening measures. In a representative sample of 3,659 doctoral students in Flanders, one in three was at risk of a common psychiatric disorder according to the GHQ-12, and features of work organisation, including job demands, job control and the supervisor's leadership style, were associated with this risk (Levecque et al. 2017). A systematic review of research on university academics concluded that the academic environment is associated with high levels of stress and burnout and low levels of well-being among staff (Urbina-Garcia 2020). Brown (2020) describes the disclosure of disability or chronic illness in academia as a recurring dilemma, in which potential benefits must be weighed against possible personal and professional costs.

Burnout is an important part of this discussion, although it needs to be distinguished conceptually from anxiety, depression and disability. The World Health Organization (2019) identifies burnout in the International Classification of Diseases (ICD-11) as an occupational phenomenon associated with chronic workplace stress that has not been successfully managed, rather than as a medical condition. Its three principal dimensions are exhaustion, increased psychological distance from one's work or feelings of cynicism, and reduced professional efficacy (Maslach and Leiter 2016). Burnout should therefore not be treated as synonymous with a psychiatric disorder or automatically classified as an invisible disability.

Nevertheless, the experiences associated with burnout may be substantially impairing and may coexist with anxiety, depression or other mental health conditions. In academic settings, prolonged exhaustion, difficulties concentrating, emotional withdrawal and diminished professional confidence can affect both individual well-being and institutional participation. The significance of these experiences lies not only in their psychological consequences but also in the ways institutional cultures interpret, normalise or disregard them.

The international workshop "*(In)Visible but Invincible*", held in November 2025, offered a context for reflecting on these tensions. By bringing discussions of psychological vulnerability into an interdisciplinary conversation about

disability and representation, the event provided an opportunity to question the assumption that continued academic performance necessarily indicates well-being. It forms part of the intellectual context from which the present argument emerged.

From this perspective, the relationship between academic burnout and invisible disability is best understood through the broader question of recognition. The difficulty is not simply that psychological suffering may lack visible signs, but that institutional expectations can determine which forms of distress are considered legitimate and which remain unacknowledged. A more responsive academic environment therefore requires attention to psychological well-being, confidential access to appropriate support, reasonable adjustments where warranted, and institutional practices that do not make the disclosure of vulnerability a source of professional or educational disadvantage.

Recognising these barriers also shifts the discussion beyond individual coping strategies. Although psychological support and personal self-regulation may be beneficial, they cannot substitute for institutional responsibility in addressing excessive demands, fostering supportive relationships and creating conditions in which seeking help is compatible with academic participation and professional dignity.

4.3. Vulnerability as a Resource: From Cultural Stigma to Therapeutic Recognition

One of the central arguments of this article is that psychological vulnerability should not be understood exclusively as a sign of weakness or personal inadequacy. Although vulnerability may involve distress, uncertainty and a diminished sense of control, recognising and communicating these experiences can also create opportunities for self-understanding, interpersonal connection and therapeutic engagement. Its potential value lies not in suffering itself, but in the possibility of responding to suffering without shame or denial.

The cultural meanings attached to vulnerability carry particular weight in environments organised around achievement, competence and self-sufficiency. Within such contexts, the disclosure of psychological difficulties may be interpreted as a failure to meet expected standards of resilience. Individuals may consequently feel compelled to maintain an appearance of control, even when doing so requires considerable emotional effort. The distinction between outward performance and subjective experience becomes especially significant in academic settings, where professional identity and personal worth may become closely associated with productivity.

Brené Brown's (2012) discussion of vulnerability, shame and human connection offers a useful perspective on the cultural tendency to associate emotional openness with weakness. Her work encourages a reconsideration of vulnerability as an aspect of human relationships rather than an individual deficiency. However, this perspective should not be interpreted as evidence

that disclosing vulnerability necessarily improves mental health outcomes or that emotional openness constitutes a therapeutic intervention in itself. The significance of vulnerability depends on the circumstances in which it is expressed, including the availability of trust, appropriate support and psychological safety.

From a clinical perspective, acknowledging psychological distress may represent an important step towards seeking professional assistance and participating in treatment. This process is neither automatic nor straightforward. Individuals may experience shame, fear of judgement or uncertainty about whether their difficulties warrant clinical attention. Moreover, disclosure does not invariably produce understanding or support; in unsympathetic environments, it may expose individuals to misunderstanding, discrimination or further emotional distress. The therapeutic relevance of vulnerability must therefore be considered in relation to the quality of the interpersonal and institutional responses it receives.

The November 2025 workshop provided an opportunity to reflect on these issues through the question: "When did you last feel truly present and at peace with yourself?" Rather than functioning as a diagnostic instrument, the question invited participants to consider the relationship between their everyday responsibilities and their subjective experience of well-being. Within the present article, this moment is understood as an illustration of the reflective possibilities created by interdisciplinary dialogue, not as empirical evidence of a particular psychological response among participants.

Such reflection is particularly relevant to the journey towards the self and the other proposed in this article. Recognising one's own vulnerability may initiate a process of self-examination, while communicating that vulnerability to another person introduces a relational dimension shaped by trust, empathy and professional responsibility. In therapeutic contexts, this relationship may support the identification of psychological difficulties, the exploration of coping strategies and the development of more adaptive responses. Nevertheless, these possibilities depend on appropriate assessment and individually responsive care rather than on a universal sequence of emotional disclosure and recovery.

Reconsidering vulnerability also requires a critical examination of the cultural narratives that shape its interpretation. When exhaustion is equated with laziness, anxiety with personal weakness or depression with insufficient motivation, psychological suffering risks being moralised rather than understood. Challenging such representations can contribute to more supportive environments, but changes in discourse must be accompanied by accessible mental healthcare and institutional practices that recognise the complexity of individual experience.

Vulnerability, in this sense, is neither an illness to be eliminated nor a virtue to be celebrated unconditionally. It is a dimension of human experience

whose acknowledgement may facilitate therapeutic engagement when met with appropriate care. The journey towards psychological well-being begins with the possibility of recognising distress and receiving support, without being required to demonstrate strength or justify one's suffering through visible signs.

4.4. Neuroplasticity: Biological Adaptation and the Possibility of Therapeutic Change

The possibility of psychological change is central to the therapeutic understanding of anxiety and depressive disorders. Neuroplasticity, broadly defined as the nervous system's capacity to undergo structural and functional modifications in response to experience, learning and environmental influences, provides an important biological perspective on this process. Rather than representing a guarantee of recovery, neuroplasticity helps explain how patterns of cognition, emotion and behaviour may develop, persist and, under certain conditions, change over time.

The relationship between experience and neural adaptation has a long theoretical history. Hebb's (1949) account of learning contributed to the understanding of how repeated patterns of neural activity may strengthen connections between neurons. Although the principle commonly associated with his work offers a useful introduction to experience-dependent plasticity, it cannot, by itself, explain the complex mechanisms underlying anxiety, depression or their treatment. These conditions involve interactions among neural networks, psychological processes, individual histories and social environments that resist reduction to a single biological mechanism.

Research in affective neuroscience has identified associations between anxiety and depression and differences in the functioning of neural systems involved in threat processing, emotional regulation, memory and cognitive control. The amygdala, prefrontal cortex and hippocampus have received particular attention in this literature. Nevertheless, findings vary across individuals, diagnostic groups, research methods and clinical contexts. Large consortium analyses of structural neuroimaging data illustrate this point. The ENIGMA Major Depressive Disorder working group, pooling data from 1,728 patients and 7,199 controls, found smaller hippocampal volumes in depression, but the overall effect was small and was driven by the group with recurrent depression. Earlier onset was also associated with smaller hippocampal volumes, and no difference was detected between first-episode patients and controls (Schmaal et al. 2016). A pre-registered mega-analysis of generalised anxiety disorder found no effect of the disorder on brain structure in its main analysis (Harrewijn et al. 2021). It would therefore be misleading to suggest that anxiety disorders are invariably accompanied by consistent structural alterations in the amygdala, or that depression necessarily involves reduced hippocampal volume. Equally, the observation of neural differences does not

establish that these changes are uniformly reversible or that they can be directly translated into predictions about individual recovery.

Neuroplasticity is relevant to several approaches used in the management of anxiety and depressive disorders. Price and Duman (2020) have proposed treating it as a multilevel construct that links molecular, neural network, cognitive and clinical findings in depression, while noting that the clinical evidence is not entirely consistent. Psychological interventions, including cognitive-behavioural therapy, may support changes in habitual interpretations, emotional responses and patterns of behaviour. Physical activity, adequate sleep and other aspects of everyday functioning can contribute to psychological well-being. A meta-analysis of 65 randomised trials found that interventions improving sleep quality were associated with reductions in symptoms of depression, anxiety and stress, with larger improvements in sleep accompanied by larger improvements in mental health (Scott et al. 2021). These findings concern psychological outcomes and do not identify the neural mechanisms involved. Physical exercise and some other practices may involve biological processes associated with neural adaptation (Davidson and McEwen 2012). Pharmacological treatments may also influence neural signalling and processes implicated in plasticity. However, the mechanisms, strength of evidence and clinical outcomes differ considerably across interventions, and improvements in mental health cannot always be attributed to a specific neuroplastic process.

Mindfulness-based practices and expressive writing offer further examples of activities investigated in relation to emotional regulation and psychological well-being, although the evidence for each needs to be read on its own terms. Expressive writing has been studied particularly in relation to emotional processing and health (Pennebaker and Smyth 2016). For mindfulness-based interventions, the meta-analytic evidence is mixed: one review of 142 samples found them superior to no treatment and comparable to evidence-based treatments (Goldberg et al. 2018), whereas another, restricted to patients with common psychiatric disorders, judged their empirical support in the acute phase to be weak and found that methodological quality was negatively correlated with outcome (Hedman-Lagerlöf et al. 2018). The potential benefits of both practices should nevertheless be distinguished from claims about directly measurable changes in brain structure or guaranteed clinical improvement. The effects of such practices depend on factors including the population studied, intervention format, duration and outcomes assessed. They should not be presented as universally effective treatments or as substitutes for appropriate clinical assessment and evidence-based care.

These distinctions are particularly important when translating neuroscientific knowledge into psychoeducational recommendations. The language of neuroplasticity can encourage a sense of possibility, but it can also create unrealistic expectations if individuals are led to believe that recovery

depends primarily on sufficient effort, positive thinking or the repetition of prescribed daily activities. Such interpretations risk overlooking the severity of psychiatric conditions, differences in treatment response and the influence of social and institutional circumstances.

Within the conceptual framework proposed in this article, neuroplasticity is therefore understood as one dimension of psychological adaptation rather than as a complete explanation of therapeutic change. The significance of neuroplasticity lies in showing that neural functioning is dynamic and responsive to experience; at the same time, meaningful improvement may require psychological intervention, pharmacological treatment, social support or a combination of approaches, depending on individual needs.

For individuals experiencing psychological distress, this perspective offers a form of hope grounded in scientific possibility rather than therapeutic certainty. Change may occur, but its course is neither uniform nor entirely predictable. An interdisciplinary approach must therefore combine awareness of the brain's adaptive capacities with clinical judgement, realistic expectations and sensitivity to the lived experience of the person seeking care.

4.5. The Psychologist-Psychiatrist Partnership: Towards Coordinated and Person-Centred Care

The management of anxiety and depressive disorders requires an approach that takes account of the interaction between biological, psychological and social factors. Although psychological and pharmacological interventions have established roles in mental healthcare, their relative importance varies according to the nature and severity of the condition, individual circumstances, treatment preferences and previous responses to care. An interdisciplinary perspective does not imply that every patient requires both psychotherapy and medication. Rather, it recognises the potential value of coordinated professional expertise when an individual's needs extend beyond the scope of a single intervention.

Within this framework, collaboration between psychologists and psychiatrists may facilitate a more comprehensive understanding of psychological distress. Psychiatrists contribute expertise in psychiatric assessment, differential diagnosis, medication management and the evaluation of clinical risks. Clinical psychologists contribute psychological assessment, case formulation, psychotherapeutic interventions and strategies for emotional regulation and behavioural change, according to their professional training and scope of practice. These responsibilities are complementary but not entirely separate, and their coordination should be guided by the patient's needs rather than by a rigid division between biological and psychological dimensions of care.

Such collaboration is particularly relevant when mental health difficulties are persistent, complex or associated with substantial functional impairment.

In these circumstances, communication between professionals may support the development of coherent treatment plans, the monitoring of clinical progress and the timely adjustment of interventions. It may also reduce fragmentation of care, particularly when individuals move between medical, psychological and institutional support services. Effective collaboration nevertheless requires clear professional responsibilities, appropriate information-sharing procedures and respect for patient confidentiality and informed consent.

The relationship between psychological and pharmacological treatment should therefore be understood in terms of clinical appropriateness rather than universal necessity. Psychological interventions may be sufficient or preferred in some presentations, while medication may be indicated in others. Combined approaches can be appropriate for certain patients, particularly where symptoms are more severe, recurrent or insufficiently responsive to an initial intervention. Treatment decisions must remain individualised and informed by current clinical guidance, professional assessment and shared decision-making (National Institute for Health and Care Excellence 2011, 2022).

Evidence from depression illustrates this point. A network meta-analysis of randomised trials in adults found combined psychotherapy and pharmacotherapy more effective than either treatment alone in achieving response at the end of treatment, while the difference between psychotherapy alone and pharmacotherapy alone was not significant (Cuijpers et al. 2020). These findings concern depression and cannot be extended automatically to anxiety disorders.

The most extensive evidence on coordinated care comes from collaborative care models. A Cochrane review of 79 randomised trials involving 24,308 participants found that collaborative care was associated with greater improvement in depression and anxiety outcomes than usual care (Archer et al. 2012), and a more recent international review reported improvements in symptom outcomes across several settings, with results varying by study and outcome (Hernandez et al. 2024). These models, however, are usually organised around primary care physicians, care managers and consultant psychiatrists. The psychologist is not always a core member of the team, so the evidence cannot be transferred directly to partnerships between psychologists and psychiatrists who work in separate settings. Patient participation is a further weak point: a systematic review of 150 collaborative care programmes found that personalised care planning or shared decision-making was practised in fewer than half of them (Menear et al. 2022). Coordination between professionals does not, by itself, ensure that care is organised around the person.

These gaps are the starting point of the doctoral research to which this article is related. The project, conducted at the Faculty of Medicine and Pharmacy of "Dunărea de Jos" University of Galați, is designed as an observational, cross-sectional, mixed-methods study involving adults with

anxiety and/or depressive disorders, as well as psychologists, psychotherapists and psychiatrists. Its central methodological distinction is between access to both specialists and collaboration that patients perceive as functional. The two do not necessarily coincide, since a person may be seen by a psychologist and by a psychiatrist without experiencing their care as coordinated. The study therefore examines how perceived collaboration relates to patients' therapeutic experience and to continuity of care. The research is still in progress and the present article reports none of its results; it is mentioned here to show where the conceptual framework comes from and which questions it leaves open for empirical investigation.

Apart from coordinating clinical interventions, the psychologist-psychiatrist partnership has a relational dimension. Individuals experiencing anxiety or depression may encounter difficulties articulating their distress, acknowledging the need for assistance or negotiating the social stigma associated with psychiatric care. A coordinated approach can help create continuity between diagnostic understanding, therapeutic engagement and longer-term support. In this context, the journey towards the self is not an exclusively individual process: it is shaped by relationships through which psychological experiences can be recognised, communicated and addressed.

The university environment illustrates the potential importance of this approach. Students and academic staff may face practical and psychological barriers to seeking assistance, including concerns about confidentiality, professional reputation, academic performance and the consequences of disclosing mental health difficulties. Where appropriate, cooperation among mental health professionals and university support services may facilitate access to assessment, treatment and reasonable adjustments. Such cooperation must respect individual autonomy and should never make disclosure of a diagnosis a prerequisite for receiving general forms of institutional support.

An interdisciplinary model also requires attention to the limits of clinical intervention. Psychological distress may be intensified by excessive workloads, insecure professional conditions, social isolation or institutional practices that reward uninterrupted productivity. Although individual treatment can support coping and recovery, it cannot independently resolve these structural pressures. Effective care therefore involves recognising the distinction between difficulties requiring clinical attention and environmental barriers that call for institutional change.

The psychologist-psychiatrist partnership proposed here is best understood as a flexible model of coordinated, person-centred care rather than a standardised therapeutic pathway. Its value lies in the possibility of integrating complementary forms of expertise while preserving the individuality of the person seeking support. In the context of invisible mental health difficulties, such collaboration may contribute both to appropriate

treatment and to more consistent recognition of psychological suffering and its consequences for everyday participation.

4.6. RESET: A Proposed Psychoeducational Framework for Everyday Self-Regulation

Building on the preceding discussion of psychological vulnerability, neuroplasticity and interdisciplinary care, this article proposes RESET as a practical psychoeducational framework intended to encourage awareness of everyday self-regulation. The framework brings together five accessible dimensions of psychological well-being: regulated breathing, everyday movement, sleep and lifestyle awareness, emotional expression and time for oneself. It is conceived as a reflective and supportive tool rather than a clinically validated intervention or a substitute for psychological or psychiatric treatment.

The acronym RESET identifies five complementary practices:

R - Regulated Breathing. Brief periods of slow, comfortable breathing may provide opportunities to redirect attention towards bodily sensations and manage moments of heightened tension. Breathing exercises should be adapted to individual comfort and circumstances rather than prescribed as a universally effective technique. Their potential value lies in supporting awareness and self-regulation, not in guaranteeing a particular neurological or clinical response.

E - Everyday Movement. Gentle physical activity, such as walking, may contribute to psychological well-being and provide a manageable way of incorporating movement into daily routines. The type, intensity and duration of activity should reflect individual health, mobility, preferences and available resources. Movement is presented here as a potentially supportive practice; it does not replace indicated mental healthcare.

S - Sleep and Lifestyle Awareness. Attention to sleep routines and everyday habits may help individuals recognise relationships between rest, daily demands and psychological functioning. Maintaining a reasonably consistent sleep schedule and reducing avoidable disruptions can form part of a broader approach to well-being. However, sleep difficulties associated with mental health conditions may require professional assessment and should not be interpreted simply as failures of personal discipline.

E - Emotional Expression. Journalling, reflective writing and supportive conversation may offer opportunities to identify, articulate and explore emotional experiences. Such activities can contribute to self-reflection, although their effects vary across individuals and contexts. Emotional expression should not be treated as compulsory, nor should individuals be encouraged to disclose sensitive experiences in environments where confidentiality and psychological safety cannot be assured.

T - Time for Oneself. Creating opportunities for rest, reflection or personally meaningful activities may help individuals reconsider the relationship between their responsibilities and their own needs. The emphasis is not on prescribing a fixed daily duration but on recognising the legitimacy of personal time within routines often dominated by academic, professional or caregiving demands. Access to such time is also shaped by social and institutional circumstances and cannot be understood exclusively as a matter of individual choice.

These five dimensions are not intended to function as a sequential treatment programme. Individuals may find some practices more accessible or appropriate than others, and their usefulness will depend on personal circumstances, the nature of the difficulties experienced and the availability of professional support. The framework does not assume that psychological distress can be resolved through self-regulation alone.

In academic environments, RESET could serve as a starting point for psychoeducational activities that encourage reflection on well-being, help-seeking and the pressures associated with continuous performance. Its implementation would nevertheless require attention to accessibility, individual differences and the risk of transferring responsibility for institutionally generated stress entirely onto students or staff. Supportive institutional policies and appropriate referral pathways remain essential.

The proposed framework also illustrates the relationship between the three dimensions examined throughout this article. Recognising the need for support involves acknowledging vulnerability; engaging in sustainable everyday practices may contribute to processes of adaptation; and seeking professional assistance when necessary connects individual self-awareness with interdisciplinary care. Neuroplasticity provides a relevant biological context for understanding adaptation, but it should not be invoked as proof that RESET itself produces measurable neural changes.

RESET should therefore be regarded as a preliminary conceptual proposal requiring further development and evaluation. Future research could investigate its acceptability, feasibility and potential contribution to psychoeducational programmes, using clearly defined populations, outcome measures and appropriate research designs. Until such evidence becomes available, no claims can be made regarding its clinical effectiveness.

The value of RESET lies primarily in its invitation to reconsider psychological well-being as an ongoing process of attention, adjustment and support. Rather than imposing another standard of personal achievement, it is meant to help individuals recognise their own needs and acknowledge that seeking help, resting and setting limits are legitimate aspects of everyday life.

5. Discussion

The central contribution of this article is to relate clinical perspectives on anxiety and depression to broader questions of vulnerability, social recognition and institutional responsibility. Rather than treating psychological distress exclusively as an individual medical concern, the proposed framework considers how experiences of suffering are shaped by cultural expectations, interpersonal relationships and the environments in which individuals study, work and seek support. This perspective is particularly relevant to invisible disabilities, where the absence of readily recognisable signs may complicate the acknowledgement of functional difficulties and the provision of appropriate assistance.

The international workshop *"(In)Visible but Invincible"*, held in November 2025, provided an interdisciplinary context for exploring these questions beyond conventional clinical settings. For the present article, its main contribution was to highlight the relevance of discussing psychological vulnerability in educational and cultural spaces. Such conversations may challenge assumptions that mental health difficulties are exclusively private matters or that continued academic performance necessarily indicates psychological well-being. Nevertheless, awareness-raising activities should be understood as complementary to, rather than substitutes for, accessible mental healthcare and institutional support.

A central implication of the analysis concerns the relationship between vulnerability and therapeutic engagement. Cultural narratives that equate resilience with uninterrupted performance may discourage individuals from recognising distress or seeking assistance. Reconsidering vulnerability as a potential starting point for self-understanding can offer an alternative to such expectations. However, vulnerability should not be idealised, and emotional disclosure should not be presented as an obligation or a universally beneficial experience. Its constructive potential depends on the availability of trustworthy relationships, appropriate professional responses and environments in which acknowledging difficulties does not expose individuals to disadvantage.

The relationship between vulnerability and psychological adaptation also requires careful interpretation. Theoretical perspectives on attachment, emotional processing and human relationships, including those associated with Bowlby (1988), provide useful foundations for considering the interpersonal dimensions of psychological well-being. Similarly, work on emotional processes and neural functioning, such as that of LeDoux (2015), contributes to understanding the complexity of psychological responses. These perspectives should not, however, be treated as interchangeable forms of evidence or as direct demonstrations that acknowledging vulnerability produces particular clinical outcomes. Their value in the present discussion is

primarily conceptual, helping to situate psychological distress within interacting biological, relational and social processes.

Neuroplasticity offers a complementary perspective by highlighting the capacity of neural systems to adapt in response to experience and intervention. This understanding challenges overly deterministic representations of psychological suffering, but it does not imply that anxiety and depressive disorders are invariably reversible or that recovery follows a predictable trajectory. The clinical relevance of neuroplasticity must therefore be distinguished from its rhetorical appeal. Hope may be an important dimension of therapeutic engagement, but it should be grounded in realistic expectations, individualised treatment and recognition of the variability of clinical outcomes.

Within this context, the psychologist-psychiatrist partnership provides a model for considering how different forms of professional expertise may contribute to coordinated care. The proposed approach does not assume that all individuals require simultaneous psychological and pharmacological treatment. Instead, it emphasises the importance of appropriate assessment, shared decision-making, continuity of care and collaboration when clinically indicated. More broadly, the proposed approach challenges an artificial separation between biological processes, psychological experiences and the social conditions that influence access to treatment.

The RESET framework translates some of these considerations into a preliminary psychoeducational proposal. By bringing together regulated breathing, everyday movement, sleep and lifestyle awareness, emotional expression and time for oneself, it offers an accessible structure for reflecting on self-regulation and well-being. Its practical appeal, however, is not evidence of effectiveness: the framework has not been tested as an integrated intervention, and the existing evidence concerning individual practices cannot establish the clinical efficacy of RESET as a whole. Moreover, its potential use in academic settings must avoid reinforcing the assumption that individuals are solely responsible for managing distress generated or intensified by institutional conditions.

This distinction between individual and institutional responsibility is particularly important. Universities may encourage psychological well-being through educational initiatives and access to support services, but such measures are insufficient if accompanied by organisational practices that perpetuate excessive workloads, insecurity or barriers to disclosure. A more inclusive approach requires attention to confidentiality, reasonable adjustments where appropriate, accessible referral pathways and the recognition that psychological difficulties may affect participation even when they remain outwardly invisible. In this respect, the article's interdisciplinary orientation extends beyond clinical intervention towards questions of institutional culture and social participation.

Several limitations must be acknowledged. First, the article is based on a narrative and integrative discussion of selected literature rather than a systematic review; its conclusions are therefore interpretative and cannot claim exhaustive coverage of the available evidence. Second, no primary clinical or epidemiological data were collected for the present analysis, and the workshop reflections were not generated through a structured research protocol. Third, the available evidence does not permit direct conclusions about the prevalence of invisible disabilities in Romanian universities or the effectiveness of particular institutional responses. Finally, neither the proposed interdisciplinary framework nor RESET has undergone empirical validation within this study. The doctoral research mentioned in Section 4.5 is ongoing, and none of its data have been used in this article.

Future research could examine the experiences of students and academic staff living with mental health difficulties, with particular attention to disclosure, stigma, access to care and institutional accommodations. Qualitative investigations could help clarify how psychological vulnerability is understood and negotiated in academic environments, while feasibility and acceptability studies could inform the further development of RESET. If preliminary findings support its relevance and safety, subsequent controlled evaluations could assess specific outcomes using clearly defined populations, comparison conditions and appropriate measures. Research on interdisciplinary care could likewise investigate the circumstances in which coordinated psychological and psychiatric support improves patient experience, continuity of care or clinical outcomes. The ongoing doctoral study will address part of this question by examining whether collaboration perceived as functional, as distinct from simple access to both specialists, is associated with patients' therapeutic experience and continuity of care.

6. Conclusions

Invisible disabilities do not cease to exist simply because they remain unrecognised. Anxiety and depressive disorders may profoundly affect everyday functioning, relationships and participation in academic and professional life, even when their consequences are not immediately apparent to others. Recognising such experiences requires more than individual empathy: it calls for appropriate clinical assessment, accessible support and greater awareness of the social and institutional conditions that can intensify psychological distress.

This article has proposed a conceptual framework organised around three interconnected dimensions: psychological vulnerability as a potential starting point for therapeutic engagement, neuroplasticity as a biological process relevant to adaptation and change, and psychologist-psychiatrist collaboration as a model of coordinated, person-centred care. These dimensions do not

constitute a validated therapeutic sequence, nor do they imply that every individual requires the same combination of interventions. Rather, they offer complementary perspectives through which psychological suffering may be understood and addressed without reducing it either to individual weakness or to biological dysfunction.

The implications concern clinical practice but are not limited to it. For mental health professionals, the discussion highlights the importance of interdisciplinary communication, individualised assessment and continuity of care. For universities, it underscores the need for accessible psychological support, appropriate referral pathways and institutional practices sensitive to difficulties that may not be outwardly visible. For educators and academic leaders, it raises a broader question about the cultural expectations through which resilience, competence and vulnerability are defined. An inclusive academic environment should not require individuals to conceal their distress in order to demonstrate their professional or intellectual worth.

The RESET framework gives these concerns a preliminary psychoeducational form, inviting reflection on everyday practices of self-regulation while acknowledging the limits of individual coping strategies. Its value remains conceptual until its feasibility and effectiveness can be examined through appropriate research. More broadly, the framework developed in this article suggests that meaningful responses to psychological distress must combine individual support with attention to the relationships and environments in which suffering is experienced.

The journey towards the self and the other does not necessarily begin with a diagnosis, a protocol or a prescription. It may begin with the recognition that something is difficult, with the possibility of expressing that difficulty, or with encountering someone willing to listen without judgement. Nor does the journey follow a single path towards a predetermined destination. It unfolds through changing relationships with oneself, with others and with the conditions that shape everyday life. Vulnerability need not be transformed into extraordinary resilience before it becomes worthy of recognition. Sometimes, the possibility of being seen, heard and supported is where the journey towards the other begins.

Article Provenance

This article developed from a presentation delivered at the International Workshop *"(In)Visible but Invincible: Tracing Silences, Breaking Frames-Disability, Representation, and the Power of the Unseen"*, held on 25-27 November 2025. It is related to Mioara Grigoraș's ongoing doctoral research on psychologist-psychiatrist collaboration in anxiety and depressive disorders: *"Călătorie către S(T)INE. Parteneri pe termen lung în călătoria către TAD: psihologul și psihiatrul" ("Journey towards the Self… and You. Long-Term Partners on the Journey through Anxiety and Depressive Disorders: The Psychologist*

and the Psychiatrist"), undertaken at the Faculty of Medicine and Pharmacy, "Dunărea de Jos" University of Galați, under the supervision of Professor Anamaria Ciubară.

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