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Reducing Self-Stigma by Coming Out Proud

Self-stigma has a pernicious effect on the lives of people with mental illness. Although a medical perspective might discourage patients from identifying with their illness, public disclosure may promote empowerment and reduce self-stigma.

We reviewed the extensive research that supports this assertion and assessed a program that might diminish stigma's effect by helping some people to disclose to colleagues, neighbors, and others their experiences with mental illness, treatment, and recovery.

The program encompasses weighing the costs and benefits of disclosure in deciding whether to come out, considering different strategies for coming out, and obtaining peer support through the disclosure process. This type of program may also pose challenges for public health research. (*Am J Public Health.* 2013; 103:794–800. doi:10.2105/AJPH.2012.301037)

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PEOPLE WITH MENTAL ILLNESS who internalize stigma (self-stigma) often experience significant loss of self-esteem and self-efficacy,[1,2] which may interfere with the course of their illness,[3] achievement of personal goals,[3–5] and participation in evidence-based services.[5,6] An interesting empirical question is the role of identity and disclosure on self-stigma. A medical perspective, which attempts to eliminate disease, might recommend that people distance themselves from a mental illness identity and might see disclosure as harmful to self-esteem and self-efficacy. However, research shows that sharing one's experiences with mental illness and corresponding treatments can be empowering and may actually enhance self-esteem for some people.[7,8]

We sought to make sense of these seemingly contrary circumstances and to discover theoretical ground for the essential public health goal of informing the advocacy community about how it might develop an effective approach to self-stigma change. The gay, lesbian, bisexual, transgender, and questioning (GLBTQ) community calls this coming out: announcing to the world one's sexual orientation proudly to assert control over one's life. Although the experiences of GLBTQ individuals and people with mental illness are not precisely equivalent, they have sufficient parallels to render research and theory from the coming-out literature useful to the self-stigma reduction goals of people with mental illness.

THE PROBLEM OF SELF-STIGMA

Sociologists since Mead and Morris have framed deviance and stigma as social constructions[9]; rather than being inherent, the meaning of behavior is subject to interpretation and definition bounded by the constraints of language and symbol.[10] This has been further described in terms of identity[11]—the conceptualization of self meant to foster a sense of personal esteem and efficacy—and identity threat, the harm that occurs when one's sense of self is challenged by association with a stigmatized group.[12,13] Identity threat appraisals have pernicious effects on emotional well-being (increased anxiety and vigilance) and corresponding health.[13] Social psychologists have further described stigma in terms of cognitive structures, perspectives that are especially useful for making sense of identity threat and self-stigma in people with mental illness: stereotypes (usually negative beliefs about a group, e.g., people with mental illness are dangerous), prejudice (endorsement of these

beliefs leading to negative emotional evaluation, e.g., that's right; they're dangerous, and I'm afraid of them), and discrimination (the behavioral response to prejudice, e.g., because I am afraid of them, I am not going to hire them).[14–16]

Some people with mental illness who internalize these stereotypes suffer significant blows to self-esteem and self-efficacy, which may undermine pursuit of goals related to independent living, such as employment.[17–22] This has been called the "why try" effect, exemplified by such sentiments as "Why try seek out a job? I am not worthy of it." and "Why attempt to live on my own? I do not have the skills to manage my own home."[5] Why try is a variant of what Link et al. call modified labeling theory[23,24]; when people perceive devaluation, they avoid situations where public disrespect is anticipated. Finally, self-stigma can undermine participation in services that might ameliorate a mental illness and its corresponding challenges.[25–28]

Programs have been developed to reduce the pernicious and insidious effects of the self-stigma of mental illness. A recent comprehensive review of the literature yielded 14 studies that have tested such programs.[29] Most common are psychoeducational approaches, in which participants are taught facts that dispute stereotypes of mental illness.[30–32] The educational experience is often augmented by participants sharing their own experience with the prejudice of others and its internalization.

A second approach to self-stigma reduction incorporates cognitive–behavioral therapy, framing self-stigma as irrational self-statements that the person seeks to strategically challenge by collecting feedback from others.[33,34] These challenges lead to counters—pithy statements people might use next time they catch themselves self-stigmatizing. More recently, a variant of this approach, acceptance and commitment therapy, has been used to address self-stigma.[35,36] This approach incorporates mindfulness strategies to promote self-esteem among group participants. Another intervention augments cognitive–behavioral therapy with narrative enhancement, the sharing of personal stories with themes of hope that contrast with stigmatizing views.[37,38] Narrative enhancement diminishes stigmatizing effects by helping people experience themselves as entitled and able to create meaning through constructing a personally meaningful story in which they are protagonists.

IDENTITY AND DISCLOSURE

In summarizing social psychological theory about ways to challenge the identity threat that results from stigma, Major and O'Brien point to an additional approach to resolving self-stigma.[13] Individuals who identify with their stigmatized group may report less stress arising from prejudice and better self-esteem, a result found in African Americans,[39] older adults,[40] women,[41] and gay men and lesbians.[42] The latter group, more broadly construed as GLBTQ, is especially relevant for understanding the experiences of identity and mental illness because GLBTQ orientation and mental illness are conditions Goffman considered marked by discreditable stigma.[43] Indication of group membership is not readily obvious to the public (compared, for example, to skin color for ethnicity or body type for gender). Hence, effects of group identification are influenced by public disclosure of membership in the stigmatized group. Keeping secret and suppressing such important aspects of identity as sexual orientation have egregious effects—what Smart and Wegner call private hell[44]—with harmful effects on mental and physical health, relationships, employment, and well-being.[44,45] Strategic disclosure of closet secrets not only diminishes these hurtful effects but often leads to a sense of personal empowerment and improved self-esteem.[46–48]

The GLBTQ experience is a useful metaphor for discussion of mental illness identity and disclosure,[49] but the error of framing GLBTQ as mental illness, as the psychiatric profession did for many years, should be avoided. How are the 2 experiences similar? The public cannot easily tell that people are gay or mentally ill just by looking at them. Naive psychological notions might suggest that homosexuality (or mental illness) distinguishes a unique category from the rest of the population, a duality that accentuates the we-versus-they qualities that augment stigma.[50] This can be false. Although many people characterize themselves as either gay or straight, others self-identify as heterosexuals and have had gay or lesbian experiences, and still others are bisexual.[51,52] Similarly, the boundary between mental illness and what is considered normal is gray. Many symptoms of mental illness, including depression and anxiety, are quite common.

Finally, both groups have been stigmatized because of society-wide misperceptions. In earlier times, homosexuality and mental illness were viewed in moral terms. Homosexuality represented a volitional decision to opt for a sinful lifestyle.[53] Mental illness embodied the demon-possessed individual who did not have sufficient moral backbone to hold off Satan.[54] The 19th and 20th centuries replaced religious models by medicalizing these conditions.[55,56] The *Diagnostic and Statistical Manual of Mental Disorders, First Edition*, for example, lists homosexuality among the sociopathic personality disturbances.[57] Similarly, most of what we consider to be major mental illnesses—schizophrenia, bipolar disorder, major depression—have been defined as medical conditions.[57–59]

Although it can serve as a useful metaphor, the coming-out experience of GLBTQ persons differs from that of people with serious mental illness. People with mental illness are challenged by symptoms and disabilities that interfere with life opportunities. Hence, they must sort out barriers to life goals by evaluating stigma versus disabilities; current symptoms will likely affect coming-out decisions and activity.

To escape the opprobrium of prejudice and discrimination, people might seek to deny self-perceptions consistent with a stigmatized role. For example, people with sexual orientations that differ from the majority might distance themselves from thoughts and behaviors consistent with their orientation to control pejorative self-statements (e.g., I am morally weak because I am attracted to people of the same gender).[60] This is analogous to advocacy of color blindness in the 1960s: people of color should ignore their ethnic differences in preference for a world without color boundaries.[61,62] The Black Power movement that emerged in that decade was in reaction to this naive view; it promoted proudly embracing African heritage.[62] Similarly, research fairly consistently shows that GLBTQ persons who accept

and hold close their sexual orientation, often publicly, experience not only less self-stigma,[63] but also greater self-esteem,[64] health and wellness,[64] relationship satisfaction,[65] and personal achievement.[66]

Identity and Mental Illness

An intriguing contradiction may seem to challenge facile extrapolation of this view of identity development to the experiences of people with mental illness. Some research supports the health value of avoiding a mental illness identity. Studies have found correlations between assuming a sick patient role and worse prognosis and greater pessimism.[67–69] A further concern is that in persons with serious mental illnesses such as schizophrenia, a cogent sense of self may be disrupted by cognitive dysfunctions, including poor insight into the illness.[70–72] This would seem to imply that identity as a person with mental illness is to be avoided. A final consideration is the impact of identity threat on people with mental illness. Research has validated Major and O'Brien's model for people with mental illness,[13] showing that higher perception of identity threat corresponds with lower self-esteem.[73–75]

The relationship between identity and self-stigma is complex, however. An important study by Lysaker et al. showed that the effects of illness identity are influenced by perceived legitimacy of mental illness stigma.[76] Those who identified with mental illness but also embraced the stigma of their disorder reported less hope and diminished self-esteem. Conversely, persons whose sense of self prominently included their mental illness and who rejected the stigma of mental illness showed not only more hope and better self-esteem, but enhanced social functioning as well. Hence, identifying with mental illness does not automatically lead to more stress; it is the perceived legitimacy of the stigma that threatens identity and harms emotional health.[75,77] Qualitative research by Davidson et al. explains this in terms of the transformative process of constructing a new sense of self.[78–80] Roe describes the evolution from patienthood to personhood as not necessarily a rejection of mental illness but rather an integration of its central experiences into a total self-image.[81] The ever-emerging conversation about recovery[82,83] and capabilities[84–86] seeks to move beyond a medical perspective of recovery as an end-state remission of symptoms and overcoming of disabilities.[87] Research has shown that the definition of recovery should include a sense of hope, goal attainment, and community.[88–91]

Pride and Mental Illness Identity

Pride and identity have been understood in multifactorial models that, among other things, distinguish accomplishment from being. On one hand, people experience pride in achieving a standard recognized by their culture (e.g., a medal for the long-distance runner or a college degree for the person challenged by psychiatric disabilities) or set by themselves (e.g., a personal-best running time or meeting a course deadline when experiencing a recurrence of depression). These examples present overcoming the challenges of mental illness as leading to identity pride, an experience not to be minimized. This view may have a downside, however, because it recapitulates the medical view of recovery: pride is only achieved when symptoms abate and disabilities are resolved. An alternative perspective recognizes that a sense of agency (i.e., self-determination) in addition to the symptoms and disabilities of mental illness fosters self-esteem and self-worth as part of an identity about which a person might be proud.[92]

In this light, pride emerges from a sense of self. Ethnic pride is a clear example[93–95]: the statement, I am African American, does not suggest any accomplishment per se, but rather satisfaction with heritage, an additional answer to the question, Who am I? This phenomenon explains mental illness as an identity in which a person might be proud. For some people, being a person with mental illness defines much of their daily experience. This kind of identity promotes authenticity, a recognition of internal conceptualizations in the face of an imposing world. Although authenticity and agency are concepts that emerged from existential philosophy[96,97] and psychology,[98,99] social scientists have applied it to empirical models of sexual orientation,[100,101] organizations,[102] and ethnicity,[103–105] operationalizing authenticity, for example, in a tripartite model that encompasses self-alienation, authentic living, and accepting external influence.[106] A scale measuring this factor model was shown to predict self-esteem and aspects of well-being.[106] Authentic people are proud of their authenticity.

Group identification, defined as feelings of strong ties to a socially defined collection of people,[107] has been shown to diminish the effects of stigma on people with mental illness. One study found that people with mental illness who identified more with the group were less likely to experience harm to self-esteem or self-efficacy as a result of internalized stigma.[20] Another study showed that strong group identification was associated both with viewing stigma as potentially more harmful and with more perceived resources to cope with this threat. This means that identifying with the group of people with mental illness can both expose the individual to the risk of being discriminated against as a member of that group (the downside of disclosure) and offer sources of support to cope with discrimination.[75]

Disclosure of Mental Illness Identity

If some kind of mental illness identity has a potentially positive impact, then—as for members of the GLBTQ community—disclosure of that identity might yield health and other life benefits. In a previous study, Corrigan et al. conducted qualitative interviews with gay men and lesbians to identify specific attitudes and behaviors that exemplify the costs and benefits of staying in the closet or coming out.[108]

In another study, Corrigan et al. transposed those findings into a quantitative assessment of coming out with mental illness.[7] An exploratory factor analysis of responses provided by 85 people with serious mental illnesses yielded a 2-factor structure: the benefits of being out versus the reasons for staying in. Being out proved to be a protective factor against self-stigma's effects on quality of life and to augment a sense of personal empowerment that enhanced well-being. If these findings are substantiated in

other research, coming out proud could have positive effects on the mental and physical health and well-being of people with mental illness.

COMING OUT PROUD AS A PUBLIC HEALTH PROGRAM

How do public health advocates promote coming out? Morrow developed and tested a group intervention meant to promote coming out among lesbians.[109] It was an ambitious program with 10 sessions that addressed such issues as costs and benefits of living openly, homophobia communication skills, sexism assertiveness training, and workplace issues. Results of a nonexperimental study showed higher disclosure rates in the intervention than in the control group. Increased disclosure corresponded with lesbian identity development and enhanced personal empowerment. We developed Coming Out Proud, derived from this model and the literature, for public health advocates to help people with mental illness address disclosure and identity. It is a 3-part program that addresses key issues related to disclosure: (1) the costs and benefits of coming out, (2) the range of strategic approaches to disclosure, and (3) the augmenting effects of peer support.

Costs and Benefits of Disclosing

Disclosure offers many benefits, such as enhanced self-esteem and self-efficacy, which promote emotional and mental health that in turn may improve physical health and well-being.[109] The box on the next page shows examples related to coming out at work. Disclosing can improve relationships and expectations at work and in many social settings. Still, disclosure has potential costs as well, including physical and emotional harm (hate crimes), discrimination, disapproval from others, and self-consciousness (see the Box on this page).[110]

The balance of costs and benefits depends on the individual and the setting (coming out at work probably has a different pattern of costs and benefits than coming out in a faith community). Hence, people must decide for themselves. Guiding principles of motivational interviewing may be useful to facilitate the decision process: a facilitator expresses empathy with both costs and benefits of the disclosure decision, avoids disputing interviewee responses, and supports self-efficacy that moves the person to positive change.[111,112]

Strategic Approaches to Disclosure

Research shows that disclosure is not a simple or solitary process but might be described by a hierarchy of approaches. In an ethnographic study of 146 people with mental illness, Herman identified 5 specific ways that people might disclose; these are summarized in the box on this page, along with their costs and benefits.[113] At the most extreme level, people may stay in the closet—not come out at all—through social avoidance. People who are victimized by stigma may choose to not socialize with, live near, or work alongside persons without disabilities. They may opt to live in a therapeutic community, work in a sheltered environment, or interact with friends in a social club developed for mental illness. We suspect social avoidance can lead to as many negative as positive effects.

People do not generally need to avoid work or community situations to keep their experiences with mental illness private. Many people choose to enter these worlds but not share their experiences with others. Secrecy provides a means to do this. An alternative is selective disclosure. Some people take a chance and disclose their mental illness to selected coworkers or neighbors. These people risk being shunned by those they confide in. However, with this risk comes opportunity. Persons who disclose may find support. Certain strategies can be used to test whether a potential confidant will react positively.

Another option is indiscriminant disclosure: people abandon secrecy altogether by making no active efforts to conceal their mental health history and experiences. Abandoning concealment is not the same as telling everyone one's story. Broadcasting personal experiences can educate people about mental illness and involves much more than rejecting secrecy. The goal is to seek out people with whom to share past history and current experiences with mental illness. People who broadcast foster their sense of power over the experience of mental illness and stigma.

Disclosing With a Community of Peers

GLBTQ persons often report that affiliating with a community of peers augments a proud identity and eases disclosure.[114] Similarly, peer support may positively facilitate identity and disclosure of mental illness. Research has shown that people with serious mental illness who identify with the mental illness group are more likely to attend a peer support program; participants in peer support programs report a better quality of life.[115] Peer support programs provide a range of services: encouragement for those who are just coming out; shared experiences, which foster a sense of community within a surrounding hostile culture; and advocacy efforts to further promote group pride.[75,116–118] Unfortunately, research on the effects of peer programs is limited. In qualitative evaluations, participants reported improvements in self-reliance and independence, coping skills and knowledge, and feelings of

Some Costs and Benefits of Coming Out With Mental Illness at Work

Benefit	Cost
No need to worry about hiding mental illness from supervisor or coworkers.	May face disapproval of mental illness or disclosure.
Can be more open about day-to-day affairs.	May face gossip.
Can be honest with supervisor when requesting time off for appointments with mental health providers.	May be excluded from work events or cooperative work projects.
May receive approval for disclosure.	May worry more about other people's perceptions.
May learn of others with similar experiences.	May worry about being pitied or having competence questioned.

Hierarchy of Approaches to Disclosure of Mental Illness

Approach	Benefit	Cost
Social avoidance: tell no one; avoid situations where illness might be revealed.	Avoid people who might be harmful.	Lose opportunity to meet supportive people.
Secrecy: keep illness a secret, but frequent environments with persons with and without mental illnesses.	No need to avoid important settings such as work or the community.	Possible guilt about keeping secrets.
Selective disclosure: disclose illness to selected individuals (e.g., coworkers, neighbors).	Find a small group of understanding and supportive people.	Some people may misuse disclosed information; may be difficult to keep track of who knows and who doesn't.
Indiscriminant disclosure: do not actively conceal illness from anyone.	No need to worry about who knows; may find supportive people.	Some people may misuse disclosed information.
Broadcast experience: actively seek to educate others through sharing personal experience of illness.	No need to worry about who knows; feel empowered and fight stigma.	Some people may misuse disclosed information or disapprove of political statement against stigma.

empowerment.[116,117] Similar findings are emerging from a multisite experimental study of peer support programs.[119,120]

The Wellness and Recovery Action Plan is another peer support program that has garnered research support. In one study, participants showed significant improvements in self-reported symptoms, recovery, hopefulness, self-advocacy, and physical health.[121] Another found that the program led to significant changes in attitudes regarding hope, recovery, and symptom management skills.[122] More research is needed to determine whether the beneficial effects of peer support on self-stigma and disclosure continue over time.

Additional Public Health Approaches

Coming Out Proud focuses on what the person with psychiatric illness might do about self-stigma. Coming out is facilitated in a community that disdains stigma and endorses affirming attitudes such as recovery and empowerment. Governments and large advocacy organizations have therefore made tackling the stigma of mental illness a public health priority.[123] These efforts have been differentiated by researchers into education programs (contrasting the myths of mental illness with the facts) and contact (facilitating interactions between people with lived experience and the community).[124]

A recent meta-analysis found that both forms of public stigma change lead to significant improvements but that effect sizes for contact programs are significantly larger and often 3 times greater.[124] This finding reveals an intriguing irony. Public health efforts that promote contact will diminish stigma—providing the community welcomes disclosure. To achieve this, however, people with lived experience must come out. Resources to support coming out and contact programs are therefore essential. ■

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