Coming out proud to erase the stigma of mental illness

Stigma may harm people with mental illness as much as the symptoms and disabilities of their disorders. This experience is often divided into public stigma (the prejudice and discrimination experienced by people with mental illness when members of the general population endorse stereotypes about them) and self-stigma (the sense of shame that emerges when people with mental illness internalize these stereotypes).

Substantial research has examined stigma reduction strategies by contrasting the effects of education (countering the myths of mental illness with facts) versus those of contact (facilitating interactions between people in recovery and the general population). Findings fairly consistently suggest that contact has a deeper and broader impact on public stigma than education. In fact, education programs that seek to decrease stigma by framing mental illness as a brain disorder actually seem to worsen stigma[1].

Stigmas are marks that signal a "spoiled" identity, with these marks described as obvious (such as skin color leading to racism or body features leading to sexism) or hidden. Stigma related to mental illness falls into the latter category, and in some ways is similar to the kind of stigma experienced by the lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) community. There are no patently observable marks that unequivocally signal a person as LGBTQ or with mental illness. Hence, people must decide to disclose their experiences if they seek to be an effective contact that is meant to diminish the stigma related to their condition. The LGBTQ community realized this over the past 50+ years by bravely coming out to tell their stories and demand solidarity. I want to explicitly state that comparing the LGBTQ experience to mental illness is not a reiteration of previous harmful ideas that LGBTQ is a mental illness, a particularly troubling part of psychiatry's lore. In terms of the goals of this paper, what I mean is that people may need to disclose their mental illness in order to be effective anti-stigma contacts.

This kind of strategic disclosure not only tears down the public stigma that robs people of rightful opportunities, but also diminishes the sense of shame that describes self-stigma. Being in the closet, hiding one's mental illness, has been repeatedly shown to exacerbate the shame of self-stigma, undermining one's sense of self-esteem and self-efficacy[2]. Strategic approaches to disclosure may provide one way to help people overcome the harmful effects of closetedness.

This might seem counterintuitive, especially when considering impression management strategies which suggest that people should reframe or avoid altogether describing troubling experiences in their past – e.g., poor school performance, dishonorable military discharge – in order to avoid the public stigma that accompanies this knowledge. Proponents of impression management seem to suggest that people should at least distance, if not deny, mental illness-related identities that will be disparaged by the public.

This assertion, however, is contrary to fundamental social psychological research about stigma in general[3], which has shown that people from stigmatized groups (e.g., people of color, women, those from the LGBTQ community) report less stress and more self-esteem when identifying with their group. But does this apply to a group that is defined by illness and disability? In fact, yes: research has shown that people who identify with their mental illness and deny the stigma demonstrate more hope and better self-esteem[4]. Even more, people who then decide to disclose some aspect of their "mental illness" identity report less self-stigma, more personal empowerment, and enhanced well-being[5].

A group of us with lived experience of mental illness developed the Honest, Open, Proud (HOP) program as a way to promote strategic disclosure meant to diminish self-stigma (www.HOPprogram.org). HOP is a group-based program for people dealing with the shame of mental illness, typically led by two trained facilitators with lived experience.

The program consists of four lessons. The first lesson is to consider the pros and cons of disclosing one's mental health experiences. These, by the way, vary by situation: the pros and cons of coming out at work differ from those of coming out with one's faith-based community or among one's extended family. The second lesson is to learn ways to safely disclose one's identity. One way, for example, is to "test" a possible person one might disclose to by asking him/her about general attitudes regarding people who have disclosed: "Hey, did you see Mariah Carey came out with her bipolar disorder? What do you think?". If that person responds negatively ("I hate when people talk about things that should be kept a secret!"), then he/she is probably not a good person to disclose to. The third lesson is how to craft disclosure in ways that are most effective for the individual. The fourth lesson is to use one month follow-up: ask people if they disclosed and how it went.

Let me be clear on the goals of HOP. It is not to convince people with mental illness to disclose their story. Such disclosure has risks, and only the individual, over time, can know whether and where it might benefit him/her. Anecdotally, only about one-third of people at the Lesson 4 follow-up will report having actually disclosed their story to someone. Nevertheless, research has shown that completing HOP has beneficial effects on self-stigma, stigma stress, self-esteem, and recovery, if one actually discloses mental illness[6-8]. As one person put it, "I never knew I had the option of coming out. I thought I was supposed to keep it a secret".

Honest, Open, Proud. What is there to be proud of? After all, isn't mental illness fundamentally some mark of failing – albeit biological failing – which the person wants to overcome and move away from? Pride is a common human response based on accomplishment and essence[9]. In terms of accomplishment, people feel proud in meeting personal goals such as students earning diplomas or runners meeting a faster time. People with mental illness have similar aspirations, which sometimes are even more pride-filled when achieved despite disabilities. But, perhaps even more

so, pride is related to sharing one's essence. People do this ethnically; for example, when I tout being an Irish American. Mental health experiences are part of many persons' perceived essence. Being an authentic person means having the choice on when and what to share from these experiences. Coming out tears down the fabric of societal stigma so that people have the space to be authentic and whole.

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Meaning in life is a fundamental protective factor in the context of psychopathology

In the midst of profound upheavals to the world, the question of what life means feels urgent and acute. Decades ago, the inspiring advocate for the human need for meaning, the psychiatrist V. Frankl, argued that the 20th century was marked by a widespread affliction in which people complained of "the feeling of the total and ultimate meaninglessness of their lives. They lack the awareness of a meaning worth living for. They are haunted by the experience of their inner emptiness, a void within themselves"[1, p.128].

Such words could have been uttered last week. In contemporary life, the haunting inner emptiness that Frankl spoke of seems increasingly accompanied by a haunting outer emptiness, as the world whirs through accelerating technological, social and ecological convulsions. Fortunately, a wealth of empirical research has emerged to provide guidance on how meaning in life may buttress us against such pressures.

Meaning in life has been defined as people's subjective judgments that their lives are marked by coherence, purpose and significance, which emerge from "the web of connections, interpretations, aspirations and evaluations that a) make our experiences comprehensible, b) direct our efforts toward desired futures, and c) provide a sense that our lives matter and are worthwhile"[2]. Thus, coherence is our cognitive capacity to make sense of our lives and perceive predictability and consistency. Purpose is our motivational capacity to strive for long-term aspirations that are personally important. Significance is our evaluative capacity to see inherent value and worth in being alive and recognize that we matter.

Despite this tridimensional conceptualization, the vast bulk of research has been conducted using general "meaning and purpose" measures, such as the Meaning in Life Questionnaire (MLQ)[3]. The MLQ is brief, psychometrically robust, has been used globally, and seems to have helped facilitate an explosion in research on meaning in life. It is no exaggeration that thousands of empirical studies have been published demonstrating that meaning in life is a foundational component of well-being. Meaning in life is thought to support well-being by integrating cognitive and motivational aspects of functional relevance to people, such as identity and self-worth, attachment and belonging, and self-concordant goal-setting and goal pursuit[1-3]. Meaning in life gives people a reason to live and a basis to make sense of their life experiences – past, present and future.

It is encouraging to see considerable research aiming to document how meaning in life relates to and interacts with psychopathology and treatment for mental disorders, particularly psychotherapies. Unsurprisingly, most research shows that people with diagnosed disorders or with elevated symptoms of psychopathology report lower levels of meaning in life and are more likely to score in the "my life is meaningless" range on measures.

Research often finds that meaning in life has especially strong inverse relations with the presence and severity of depression symptoms[4], although studies have also focused on schizophrenia, eating disorders, substance use disorders, anxiety disorders, and post-traumatic stress disorder, with multiple papers published on each of these disorders.

Beyond diagnosis- and symptom-focused studies, research has indicated that meaning in life appears to play a protective role against suicidal ideation, suicide attempts, and non-suicidal self-harm. Among 199 patients surveyed in a psychiatric emergency department in Switzerland, lower scores on the presence of meaning in life scale of the MLQ were related to higher levels of suicidal ideation and suicide attempts over and above sociodemographic variables[5].

This protective role of meaning in life also holds for an array of stressors and mental health challenges, including the psychological strain of the COVID-19 pandemic. Meaning in life scores collected among a sample of university students in China were positively related to prosocial behavior and negatively related to severity of depression, stress, anxiety, and negative emotionality in a survey conducted in February-March 2020, when the initial tumult of the pandemic was mounting fearsomely in China[6].

People need not be left to their own devices in seeking the benefits of greater meaning in their lives. Evidence is abundant that psychotherapies and other treatments are reflected in increased meaning in life[4]. A meta-analysis of 33 randomized controlled trials found significant effects in increasing meaning in life for several psychotherapies, narrative methods (i.e., individuals reviewing and writing about their lives), mindfulness techniques, and psychoeducational approaches[7]. An earlier meta-analysis reinforces these conclusions in a larger body of 60 interventions