

Beyond Shame and Stigma: The Disclosure of Mental Illness

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Abstract

This paper, written in journalistic style, discusses the disclosure of mental illness and its relation to stigma and discrimination. It consists of two magazine length articles. The first article, or chapter, is about the personal disclosure of mental illness by mental health professionals—psychiatrists, psychologists, social workers, and others—who have experienced mental illness themselves. The article discusses the extent of mental illness among professionals, the reasons professionals often remain silent, the risks and benefits of disclosing, and the complexity involved in revealing mental illness. The second article discusses disclosure as it pertains to all people who have mental illness. The article discusses disclosure and its relationship to stigma and discrimination, why stigma exists and persists, the disclosure of mental illness on the job, and the role of work in stigma reduction and recovery.

As a journalistic account, the paper is based on original reportage. Close to 100 people were contacted and over thirty interviews conducted. Those interviewed were people with mental illness, consumer advocates in mental health, clinicians and researchers in the field, attorneys specializing in aspects of mental health law, and professionals in related fields. Additionally, for background information and in some instances direct citation, a half dozen lectures were viewed, seven books referenced, close to 50 articles, reports, and fact sheets were read, and just over 20 research articles and studies consulted.

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Chapter I

For Some Mental Health Professionals, the Disclosure of Mental Illness Is Personal

Fred Frese is balding and gray and wears glasses, but don't let his age throw you, he's as tough and wise as an old willow. When he speaks to his audience, it's with assuredness. His phrases come in short bursts, sounding like the declarations of the retired United States Marine soldier he is. At the podium, his voice rises and falls. Even his pauses command attention.

"I got a message for all psychologists, all my fellow marines, all my fellow..." he bellows. His voice softens, "all my fellow travelers." Frese is addressing the United States Psychiatric Rehabilitation Association's 34th Annual Conference in the summer of 2009. A psychologist, he has given over 2000 of these talks all around the country.

"Yeah, I'm schizophrenic," he says, matter-of-factly. Then drawing out each word, he says, "I absolutely refuse to be ashamed." His voice soars and his fist comes down. "I absolutely refuse to be ashamed of any serious mental illness."

Frese is one of a small but growing number of licensed mental health professionals—psychiatrists, psychologists, nurses, and social workers—who are acknowledging their mental illnesses and attempting to shrug off historic stigma and fear that has kept many in the shadows. Disclosure helps people forge a new, more complete identity. If done carefully and wisely, it can be affirming and empowering, some experts say.

However, few licensed professionals disclose mental illness at all—despite the medical belief and growing evidence that mental illnesses are diseases of the brain, often activated in part by genetic vulnerability, not personal failure, and should be viewed and treated as such.

The willingness by professionals to hide mental illness is lessening, but the change is slow. More mental health professionals are disclosing their illnesses these days, says Frese. “Fifteen years ago—almost no one in the professions was being open,” he says.

However, many more may still be in the closet. In recent years, some, but not many, clinicians have publicly revealed their mental illnesses and recovery stories. A few of the better known ones have either written about their illnesses or have been active in the mental health consumer movement, or both. They include psychiatrists Carol North, Dan Fisher, Suzanne Vogel-Scibilia, and Elizabeth Baxter, as well as psychologists Kay Redfield Jamison, Patricia Deegan, Ron Bassman, and Al Siebert. But we don’t know exactly how many other mental health professionals have serious mental illness nor how many have disclosed their illnesses. There’s “no good data on this,” says Steve Hinshaw, PhD, chair of the Department of Psychology at the University of California, Berkeley. Hinshaw, an expert on stigma, says, “Nobody really knows because it’s a taboo subject.” The disclosure by professionals is a “slow growing movement,” he says.

Zlatka Russinova, PhD, senior research associate, Center for Psychiatric Rehabilitation at Boston University, concurs with Hinshaw. “We don’t know to the best of my knowledge,” she says when asked about the disclosure rate among professionals. There’s “no such study.”

As a Marine and as a person with schizophrenia—a serious brain illness affecting about 2.4 million people in the United States, according to estimates by the National Institute of Mental Health—Frese delivers an empowering message about the dignity and rights of people with serious mental illness. His message, however, packs added power because of his status as a professionally licensed clinical psychologist. He received his doctorate in psychology from Ohio University. For fifteen years, he was the director of psychology at Western Reserve Psychiatric Hospital in Ohio before retiring in 1995 and is now the coordinator for the Summit County Recovery Project in Akron, Ohio.

Standing in a dark suit, white shirt, and tie, Frese gazes over the audience, as though getting ready to call forth a flock. “Now I want to know something, is there anybody else in this room who refuses to be ashamed, who is not afraid to stand up right now and announce to everybody in this room, ‘yes, I have a mental illness and I’m not going to be ashamed.’ Is there anybody?”

“One, two, three, four, five, yes, yes, yes, yes, yes,” he says, counting and recognizing those who raise their hands. “Thank goodness. Thank goodness brothers and sisters,” he says. “We can no longer hide in the shadows. We can no longer be excluded.” During speeches, Frese often asks audience members to raise their hands or stand up if they have mental illness or have been treated for mental illness. The first time was in Alabama 15 years ago. He’s been doing it ever since.

People with serious mental illness have long lived their lives on the hidden edges of society. Shunned, locked up, experimented upon, sometimes even beaten or killed. The historical facts about the treatment of people with mental illness are not pretty, though there’s been some light along the way. For instance for those with family wealth during

the 19th and 20th centuries, private American and European asylums offered long-term protected residence and some measure of humanity, even if effective medicines or other treatments were non-existent. And during the past half century, especially the past quarter century—as more effective medicines have been developed, treatment has improved. But the stigma of mental illness has endured. Discrimination is pervasive. And with it, a deep-seated culturally reinforced propensity, a necessity some would say, to keep silent about mental illness.

No longer are diseases such as schizophrenia considered by the medical establishment to be the product of bad parenting. Not that environment and stress don't have their role to play in mental illness. Childhood neglect and abuse certainly wreaks havoc on the brain. And no longer are these illnesses considered character flaws or caused by demons or sin, as once was thought just a few centuries ago. And yet, our beliefs about mental illness and our attitudes towards those with these complex illnesses have not progressed as far as our biological understanding, limited as it may currently be. This is no more apparent than when it comes to people's reluctance and outright refusal to disclose their mental illnesses. And, ironically, especially when that reluctance and refusal comes from licensed mental health professionals who live with mental illness themselves.

Those at work who knew about Frese's illness were supportive, he says, but they also cautioned him about disclosing his illness. He recalls a conversation early in his career with a psychologist who had hired him for a position within what was then called the Ohio Department of Mental Hygiene and Corrections. "He pulled me in one day and told me, 'Do not tell anyone you have this condition.'"

“I am sure he felt he was being very kind with his warning,” Frese says. In 1976, the top administrator at Western Reserve Psychiatric Habilitation Center gave him a similar warning when he began working there. “He did not give me specific reasons [to be quiet], and I did not ask,” says Frese.

In April 2007, at a talk at the University of Akron (at the Psychology Archives Colloquium Series organized by the Archives of the History of American Psychology), Frese asked the main speaker, an authority on racial inclusion in the psychology profession, how many of the 150,000 psychologists in the American Psychological Association had schizophrenia, he says. The answer he heard was worse than zero. “Schizophrenia, that’s a shameful condition,” said the speaker, according to Frese. He wouldn’t acknowledge that the American Psychological Association included any members with schizophrenia, Frese says, despite his award for advocacy from the American Psychological Association. Frese received the Hildreth Award, the American Psychological Association’s highest honor from its Psychologists in Public Service Division in 1999, according to Lauren Schussler, governance officer at the professional association. When asked for a comment about Frese’s recollections, the speaker replied in an e-mail that he didn’t recall making the comment.

When it comes to supporting its own members with mental illness, the American Psychological Association as an organization appears to be gaining enlightenment. The professional association has an Advisory Committee on Colleague Assistance that works with state psychological association affiliates to develop programming for impaired psychologists, according to Dan Abrahamson, assistant executive director for state advocacy at the American Psychological Association.

There is also a Task Force on Serious Mental Illness and Severe Emotional Disturbance. Several psychologists with serious mental illness have served on the task force, Schussler says. The task force has strived to include at least one psychologist who is also a consumer. As of August 2010, she says, three of the fifteen task force members are self-identified consumers and several have family members who are consumers.

The Extent of Mental Illness Among Licensed Professionals

Though we don't know how prevalent serious mental illness may be among the ranks of licensed mental health professionals, circumstantial evidence suggests that depression, substance use disorders, and other psychiatric conditions are not uncommon. The extent to which professionals experience psychiatric and behavioral health problems may be far greater than they want the public to know, perhaps even more common than they themselves want to know.

One key indicator, for instance, may be the suicide rate among physicians and psychiatrists in particular. Each day on average, a physician somewhere in the United States commits suicide. Each year, 300 to 400 physicians in the U.S. die by suicide, reports the American Foundation for Suicide Prevention. Death by suicide among male physicians is 70 percent higher than men in other professions. Among female physicians, the rate is an astounding 250 to 400 percent higher than women in other professions. The Foundation's report, however, doesn't detail the suicide rate of psychiatrists or any other medical specialty. Some research puts the psychiatrist suicide rate as the same for all other medical specialties, but the British-based *Psychiatric Times* asserted that roughly 25

percent of British psychiatrists have psychiatric morbidity and that psychiatrists have the highest rate of suicidal tendencies among male physicians, according to the 2006 article.

Though results of individual studies of physician suicide are not consistent, the overall evidence supports the notion that physicians have higher rates than average, according to a 1995 survey of research in the field. Rates may be higher for other health professionals as well. A higher rate of suicide goes hand in hand with a higher rate of depression and alcoholism, the authors say.

A one-hour public television documentary, *Struggling in Silence: Physician Depression and Suicide*, produced in association with the American Foundation for Suicide Prevention, makes known what the group says is a “hidden and perplexing phenomenon.” Michael F. Myers, MD, a specialist in physician health and vice-chair of medical education and director of training for the Department of Psychiatry and Behavioral Sciences at the State University of New York Downstate Medical Center, says he was once asked to address a health care community in which three psychiatrists had killed themselves in 18 months. When he arrived, he was told the title of his talk had been changed. The word “suicide” was taken out and he was asked to talk more generally about physician health and wellness. Those in charge thought the topic might “frighten” people, he says. “I was shocked,” says Myers. During his talk, it became apparent that many audience members had come to grieve and to talk about these deaths. He shifted the focus when it felt safe to do so.

Reports of depression are also another indicator. “Depression is as common in physicians as in the general population,” states a 2003 article in the *Journal of the American Medical Association*. Debra Grossbaum, attorney and legal counsel to

Physician Health Services in Massachusetts says the number of physicians seeking treatment is up during the past six years. We've "absolutely seen a significant increase," she says. Physician Health Services, Inc., a non-profit organization founded by the Massachusetts Medical Society, provides confidential consultation and support to physicians, residents and medical students battling alcoholism, substance abuse, and behavioral and mental health problems.

Grossbaum cites major depression, bipolar disorder, learning challenges such as attention deficit disorder (ADD) and attention deficit and hyperactivity disorder (ADHD), and personality disorders as problems physicians have experienced. Though she's not sure the reason for the increase, it doesn't necessarily mean mental health problems are on the rise, she says. It may be due to more awareness. Grossbaum said Physician Health Services does a lot more outreach than it used to.

The number of physicians monitored each year by the Massachusetts Board of Registration for substance use, mental health issues, and other issues during the years 2007 through 2009 ranged from 93 to 116, according to the Board's spokesperson. This represents roughly about one-half percent of all physicians. In 2007, there were 20,740 licensed medical and osteopathic physicians in Massachusetts, according to a published report from the Massachusetts Office of Consumer Affairs and Business Regulation.

An estimate of mental illness among the ranks of mental health professionals can be ascertained from data collected by the American Psychological Association's Center for Workforce Studies. In 2008, the Center surveyed psychology health service providers. According to preliminary results published in 2009, about .05 percent of the 6,364 respondents reported a psychiatric disability (excluding learning and cognitive

disabilities). If the .05 percentage were applied to the 92,317 non-student 2008 membership level, there would be 461 psychologists with a psychiatric disability, or more if the .05 percent represents an underreported figure.

Licensed Professionals—Why They Stay Silent

Licensed professionals don't disclose mental illness for varied reasons. On licensing applications, professionals are asked questions about impairment, and in some states they are asked about psychiatric history. At best, this causes inconvenience. At worst, a person may not be allowed to practice.

Mental illness in licensed professionals is something to watch out for and be aware of, but it doesn't disqualify people from practicing, says Otto Wahl, professor of psychology and director of the University of Hartford's Graduate Institute of Professional Psychology.

Though a history of mental illness doesn't automatically disqualify someone from holding a professional license, some say that professionals are wary about receiving treatment at all because it can cause career difficulty. Physicians are fearful about going for help, Myers said. There are professional repercussions: higher malpractice insurance rates, discrimination in medical licensure and residency training, and restrictions on hospital privileges. The fear is less than it was ten or fifteen years ago, but it still exists. Some physicians "suffer in silence." Others "self medicate," he says.

State medical and other professional licensing boards exist to protect the public and ensure safe practice by qualified people. When a mental illness or substance abuse is involved, immediate issues of competence and safety, response to treatment, and long-

term reliability of any improvement must be considered, according to William Reid, a forensic psychiatry consultant and former medical director of the Texas Department of Mental Health and Mental Retardation. These are “highly individualized situations that involve, first, patient safety, and, second, fairness to the clinician whose career and life are on the line,” Reid says in an email. “Acute impairment is usually an easy call. Chronic, waxing and waning illness with improvement or "recovery" can be difficult to judge.”

Impaired clinicians can often return to effective practice with appropriate treatment and monitoring, Reid says. “While some clinicians should or must lose their licenses in the name of public safety, many more can salvage useful careers and provide care for future patients who need that care,” he writes. That is, if they recognize their impairment and can be treated successfully.

Linda Worley, a physician at the Department of Psychiatry at the University of Arkansas for Medical Sciences, also notes the public safety role of licensing boards. “There is an important balance—medical board responsibilities are to protect patients,” she writes in an e-mail. “When physicians have conditions that they lack insight about and choose to treat patients anyway—potentially giving suboptimal care or harming patients—the boards need to have the power to know about these illnesses and see that physicians are getting adequate treatment or quit practice (e.g., addiction, dementia). There are many other conditions that physicians could have that don’t impair their treatment of patients – getting help for them confidentially actually helps physicians be better doctors and have more empathy for their own patients.

“In the past, some medical licensure questions didn’t make sense,” she writes, “requiring disclosure for seeking private counseling of any kind, be it for divorce or anything. They served as a deterrent to physicians reaching out for help and had nothing to do with impairment. Some conditions (e.g., depression) without treatment worsen and potentially leave a physician functioning less than optimally.” New questions “serve to protect patients by having medical boards aware of what they need to be aware of while encouraging physicians to take good care of themselves on the front end and not worry about having to disclose things that are no one else’s business.”

In states like Massachusetts, updated licensing applications for physicians, psychiatrists, psychologists, and social workers require applicants only to disclose a current impairment that affects their ability to practice their profession, but this is not true of every state. Some states ask specifically about the history of mental illness or treatment. “Quite a few states haven’t actually changed their questions,” says mental health lawyer Susan Stefan.

Even if treated successfully, licensed professionals have other reasons to keep mental illness quiet. Stigma is high on that list. They may worry about how disclosure might affect how colleagues perceive their professional competence. “I think there is substantial stigma within the [mental health] profession,” Wahl says.

When Frese was in graduate school, he twice had to take time away from his studies to manage his illness. Rumor spread that he had an alcohol problem, he says, but he didn’t do anything to dispel that rumor. At the time, he says, it was more acceptable for a person to be recovering from alcoholism than from schizophrenia.

Mental health professionals “fear a loss of respect, loss of clients, position,” Wahl says. There’s a sentiment among professionals that people with mental illness shouldn’t be treating others with mental illness, he says. And there’s concern about whether those with mental illness have the necessary professional objectivity when treating patients. When psychologist and author Kay Redfield Jamison disclosed her bipolar illness, she received a great deal of criticism, says Wahl. Some responded: “How dare you reveal that.”

Psychiatrists have a special problem regarding mental health treatment, says Myers. “They feel they should be immune,” he says. “They say, ‘Oh my God, I feel fraudulent,’” because they’re prescribing antidepressant medications to patients and now a doctor is asking them to take medication. Myers uses a medical analogy when recommending medication to a psychiatrist. He likens depression among psychiatrists to cardiologists who have heart attacks, endocrinologists who have diabetes, and obstetricians who have babies. He wants to make the point: “Depression is an illness...We’re human too.”

Hinshaw says many people become mental health professionals because of their own personal and family experiences with mental illness. He cites himself as an example. His father had bipolar illness. But mental health professionals don’t talk about these experiences, he says. They don’t reveal their histories. They don’t want to appear weak. And they don’t want to become “one of them.” When this is the case, it might be helpful if clinicians talked about why and how they became mental health professionals, he says.

Jennifer Boyd, a psychologist with the University of California and the Veterans Affairs Medical Center in San Francisco, thinks professionals are prone to what others

have termed “clinicians illusion.” She says professionals can develop a “distorted picture of mental illness” because they spend a great deal of time with people who are acutely and chronically ill, rather than those who have recovered. This can produce a “pessimistic view” of mental illness. We also all grow up in the same culture with the same stereotypes as everyone else, she says. “If you get diagnosed with mental illness, it’s ‘Oh, I’m one of those kinds of people.’”

From talking with experts and reading journal articles, it becomes apparent that professionals aren’t given a special exemption or pass from stigma. To some degree, we’re all at risk of both internal and external stigma. It can affect anyone because it’s so embedded in our culture. So why should it matter if mental health professionals keep their mental illnesses to themselves? After all, health is a private matter. And disclosure of any illness, especially mental illness, can have profound affects on a person’s life, especially with regard to employment. And aren’t professionals due the same rights and privacy everyone else?

While privacy is extremely important, stigma is a huge barrier to recovery, say experts. It saps confidence. And a culture of non-disclosure increases that stigma. There’s a “veil of secrecy around these conditions,” says Ron Honberg, director of Policy and Legal Affairs for the National Alliance on Mental Illness. “The more people are reluctant to disclose, the more mental illness will be in the dark ages,” he says. Ultimately, the way to deal with stigma is through disclosure. “Through more and more people willing to speak out.”

When people with mental illness are in recovery and functioning in society, they lessen that stigma. They serve as powerful examples of potential and hope. And the effect

can be even more powerful when it is licensed professionals who are in recovery, disclosing their mental illnesses.

Walking the Walk: The Clinical Upside

In the 1980's, when Pamela S. Hyde, now the administrator of the Substance Abuse and Mental Health Services Administration, a federal agency, served as the director of the Ohio Department of Mental Health, she ushered in a new law in Ohio that required mental health consumer representation on each of the state's 50 regional county mental health boards. Hyde invited Frese to be the first consumer to serve on the Akron Board. He accepted.

Though everyone knew the 16-member board now included a person with mental illness, no one knew who it was. The information wasn't made public. This irony didn't escape Frese. Though his illness was known among family, some friends, and close colleagues, Frese had never gone completely public. At the time, doing so could endanger his career. But he figured that as long as Hyde was the top mental health administrator in Ohio, his job would be safe. She was supportive of people like him, says Frese. Plus he was not far from retirement. So, after making a careful political calculation, he began looking for an opportunity.

One day in the late 1980's while teaching a course in psychiatric rehabilitation at Kent State University, he asked the three-dozen graduate students in his class to stand up if they had been treated for mental illness. "No one stood up," he says. Then Frese looked at his students and said, "I guess I'm the only one standing." His declaration that day was

unplanned. “I just blurted it out,” he says. “The audience was in shock. But I was in more shock.” He says he thought to himself: “What did I just say.”

Career repercussions aside, that day Frese gave his students a positive image of someone with mental illness, an image of someone doing well in life—married, children, and professionally employed. It was so unlike many of the images people have of mental illness. Often, when it comes to mental illness, we don’t hear about the hopeful stories. There’s a lack of positive images, according to psychologist Boyd. “People who are doing well blend in,” she says. We don’t see them. They’re not in the newspapers.

As well as providing hope for others, the personal experience of living and struggling with mental illness can help licensed professionals identify with and understand those that come to them for help. Personal experience fosters compassion and empathy. “When you get better, it teaches you compassion,” says Max Parker, a Massachusetts social worker who recently moved back to his home state of Oklahoma. Parker himself is in recovery from mental illness. He was hospitalized twice as a very young adult for psychosis and placed on the medication Clozaril, but his condition stabilized in 1993. He later earned his graduate degree in social work. Parker has created meaning from his illness. He poses the age-old question “why do good people suffer” and then answers for himself: “To learn compassion, to help,” he says.

Before attending graduate school, Parker participated in a recovery model of care that has been gaining steam for several years: the use of peer counselors. He worked for a community-based mental health program in which people in recovery with mental illness are trained as peer counselors to help others who are also in recovery. He says that he’s always been open about his illness, but he began disclosing more readily when he started

working as a peer counselor. “That’s what peer counselors do,” he says. They call it “mutual recovery.” Being upfront and open helped others and himself, he says.

In some ways, the use of peer counselors in recovery seems to be the antithesis of the traditional clinician-patient relationship whereby licensed professionals are assumed to be exemplary models of mental well-being and reveal little of themselves. However, in some treatment and recovery circles, hiring employees with firsthand experience of mental illness is considered critical. At the Veterans Health Administration, according to psychologist Boyd, there’s been a switch from a medical model of care for veterans with mental illness to a recovery-oriented model of care. Recovery coordinators and peer support technicians have been hired by Veterans Health Administration Medical Centers throughout the country to implement this policy change. Peer support technicians, a role first proposed in 2005, are people who are comfortable self-identifying as individuals in recovery, Boyd says.

As of April 2010, the Veterans Health Administration had filled 191 of 219 peer support technician positions, according to psychologist Patricia Sweeney, Education Director for the New England Mental Illness Research, Education and Clinical Center at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Mass. Royal Riddick, a Vietnam veteran and former United States Marine, is one of those peer support technicians. He has been employed in the position for 16 months and was a patient at the same hospital in which he now works: the Baltimore Veteran’s Administration Hospital. A trainer for 12 years with the National Alliance on Mental Illness and a current board member at the Maryland branch, Riddick is now a member of a treatment team that

includes two nurses, a nurse practitioner, occupational therapist, psychiatrist, psychologist, vocational rehabilitation specialist, and consulting primary care physician.

At the Baltimore hospital, “They look at peer support technicians as another discipline,” Riddick says. Peer support technicians “bring something to the table that other clinicians don’t.” They bring the experience of having mental illness. That’s important to veterans. It means support from someone who has “walked where you have walked,” he says.

“Peer support is taking off,” says Karen Wilson, the recovery coordinator at the same hospital where Riddick works. A nurse with more than 30 years experience in the mental health field, she’s been in this position for three years. The mandate given to her: “Create a new culture from a medical model to a person-centered model” of care.

The Benefits of Disclosure to Recovery

When working on the grant and start-up of the Metro Boston Recovery Learning Community, Anne Whitman, co-executive director of the consumer run initiative says she suggested that the team working on the project disclose their psychiatric status. Whitman has bipolar disorder and is the co-founder and president of the Cole Resource Center in Belmont, Mass. She says she was running around disclosing all over the place and thought why shouldn’t everyone else do so as well. At first, there was hesitation. People were concerned about trivializing serious mental illness if they revealed less severe problems. She recollects one person saying, “Does it count if I get my antidepressants from my primary care physician.” The head physician disclosed, she says. And so did everyone else.

Though not a clinician herself, Whitman says that over time it became clear that working in an environment where secrets had to be kept was not going to work well for her. Earlier in her career, she was let go from a management position when the dean of the business school in which she worked found out she had bipolar disorder. “I’d rather find a place I didn’t have to hide,” she says. Whitman cites the “the energy it takes not to be authentic.” Ironically, Whitman is more employable now in her present line of work than she was when hiding her illness, she says.

Others also report the pressure and stress associated with keeping their illness hidden. And many experts and consumers of mental health care believe that disclosure is empowering. The Substance Abuse and Mental Health Services Administration quotes psychiatrist Dan Fisher about the benefits of disclosure. According to Fisher, disclosure promotes recovery because it allows people to form or join self-help groups and to reconstruct their self-images in a more positive light.

When Max Parker applied for admission to the Simmons Graduate School of Social Work, he was concerned that his grade point average might not be high enough. It was a little lower than what was required, he says. So he wrote a letter to the school explaining his circumstances—the illness that affected him at times during his undergraduate years. The school not only admitted him into its Master’s in Social Work program, but he was also awarded a \$6,000 per year scholarship, he says. While in graduate school, he didn’t discuss his illness and recovery with other students and generally didn’t talk about it with his professors. “I didn’t want special treatment. I wanted to get through it on my own,” he says. He did, however, write a few papers in which he discussed his own mental health experiences. There was never any negative

reaction from his professors. Overall, he says, Simmons College was “incredibly supportive.”

The Who, When, Where, and How of Disclosure

If disclosure of mental illness is necessary for broadening public understanding about who has mental illness, fostering empathy towards those with these complex illnesses, changing beliefs and attitudes, and ultimately decreasing stigma, then how should licensed professionals with mental illness handle their own revelations, given the complexity of this landscape? And where can they go for support?

Frese says many of the well-known mental health professionals who are open about their illness are over 50. He thinks older, established professionals should come forward, but cautions younger people. In June, he spoke to a group of 200 medical and pharmacy students. One woman asked for his advice. “You’re really too young, too early in your career,” he told her. There are “significant consequences.”

Dan Fisher also advises prudence. “A person’s freedom to disclose is also contingent upon the individual’s power, status, and position,” he writes in an article called “A Psychiatrist’s Gradual Disclosure,” according to 2008 report titled *Self-Disclosure and Its Impact on Individuals Who Receive Mental Health Services* by the Substance Abuse and Mental Health Services Administration.

People established in their careers are better positioned to withstand stigma and discrimination. They can fall back on experience, credibility, contacts, and other social and political capital. For everyone, not just licensed professionals, disclosure is a very

complex, very personal matter. The decision is not black and white. (See Appendix, “Reasons for Choosing to Disclose or Not Disclose.”)

Additionally, experts say there is no cookie cutter answer or approach, though there are important guidelines. Revealing a mental illness is not like flipping a switch. Unless you come out on the front page of the newspaper, there’s no ‘reveal’ switch that gets turned on and everyone knows everything. People often disclose in stages. As Steve Hinshaw says, “Timing is everything.”

What information people reveal, to whom, when, where, and how—these all vary. What’s best for one individual may not be best for another. Type of illness, reason for disclosing, trust in the person you’re telling and quality of the relationship are all factors that go into a decision, say experts on disclosure. Just as we don’t tell just anyone we meet our cholesterol level or blood pressure, we don’t need to tell others our mental health status, either, unless there’s good reason. The important point is that privacy should be a choice, not a default requirement due to discrimination and fear.

Though research shows that stigma and discrimination are a significant problem for those who suffer from mental illness, perhaps the cracks are widening just a little bit in the negative attitudes and beliefs about these kinds of brain disorders, particularly when it comes to mental health professionals.

Frese reveals a telling story about why and when he and his wife Penny told their children about his mental illness. When the children were young, Frese was featured in a newspaper story, and soon after a person from New York approached him about a movie contract. The “kids were excited” about their father getting all this attention, he says.

They thought the interest was because their father was a great psychologist. His wife told them: your father may be a great psychologist, but that's not why he's getting all this attention. "The attention is because he has mental illness."

They didn't believe it at first, Frese says. "No, it can't be," they said to their mother. "Our father never killed anybody." That's when Frese had to explain mental illness to his children.

Chapter II

Stigma and Discrimination—The Second Front in the Battle Against Mental Illness

Twenty years after Congress passed the Americans with Disabilities Act, many people are still afraid of revealing a mental illness to an employer or to others. The sweeping 1990 law set up protections in employment, housing, and other areas for people with disabilities. Two decades later and ten years into the 21st century, the quest to eliminate stigma and discrimination towards people with psychiatric disability still goes on, despite the millions of Americans who are affected by mental illness.

The estimated figures for mental illness are staggering. According to figures from the National Institute of Mental Health, almost 21 million people, 9.5 percent of American adults, are affected by a mood disorder each year. This includes almost 15 million with major depressive disorder and over 5 million with bipolar disorder. Schizophrenia affects 2.4 million adults, or 1.1 percent of adults. Anxiety disorders affect upwards of 40 million, just over 18 percent of adults. In this broad category are illnesses such as panic disorder, post-traumatic stress disorders, phobias, and generalized anxiety disorder. Add in those with alcohol and substance use disorders, personality disorders, and the myriad of other illnesses that affect the brain and behavior, and the burden becomes quite large. Comprising these numbers are the individuals trying to dodge stigma and discrimination in their lives.

One such person is Dan O’Connell (a pseudonym) from Franklin. On a Saturday morning in May, O’Connell sits across from me in a coffee shop in southeastern

Massachusetts. He's built like a basketball player or cross-country runner—tall and thin. He's smart, well mannered, professionally employed, and the kind of guy you'd want to invite to your neighborhood cookout or to a ballgame. O'Connell is also a careful guy, wary in fact. He has bipolar disorder and he doesn't want too many people to know it.

“No friggin' way,” he says, when asked whether he'd disclose to an employer. “I could lose my livelihood.” At one job, to ensure privacy, he didn't use his health insurance to purchase his medication. The generic formulation of the drug made it affordable for him to pay out of pocket.

O'Connell certainly isn't alone with his privacy concerns. Many people with mental illness don't feel they can be open about it. And when they do reveal something about their illness, they believe they must be very careful and cautious about what they disclose and to whom. Often with good reason.

“They were right on top of me,” Katherine Masley from Melrose says about her last job in a 30-year career as a nurse. “Nursing is notorious for being intolerant to mental illness. I've seen it before,” she says. Masley has suffered from bouts of depression since she was 16 years old. She needed to take days off because of her illness. She “felt pressured” about calling in sick, though discrimination didn't legally occur because she didn't ask for accommodation and her employer didn't know about her disability. “I didn't feel I could work and call in sick occasionally,” she says. “People said I should've fought it,” Masley says. “But I didn't have the strength.”

For American's with psychiatric disability, the Americans with Disabilities Act has helped in employment discrimination in one enormous way: it outlaws questions about past history of treatment and medications before a job offer, according to mental

health attorney Susan Stefan. And, after a job offer, it's permissible for employers to require employees to undergo physical exams and submit health information only if it's required of all employees, she says.

“The ADA attacks discrimination in three ways,” according to the Bazelon Center for Mental Health Law in Washington. “It prohibits governments and business from treating people differently simply because they have a disability.” Second, it requires governments and business to provide “reasonable accommodations” to people with disabilities. Third, it requires state and local governments to deliver services, including mental health services, in settings that maximize independence and participation in community life.

For many years, according to the Center's website, employers avoided ADA requirements by arguing that persons capable of working don't have a “disability” and are not protected. Congress amended the law to fix this problem. Now, employers can't discriminate against people with mental conditions that “substantially limit” major life activity, including working.

It's the requirement that allows for reasonable accommodation that many think of when it comes to the law. Reasonable accommodations are those that enable employees to perform essential job functions. They may include: “changing rules or procedures, environmental changes, a modified or part-time schedule, job restructuring, reassignment, altering policies on conduct or attendance, and working from home,” according to the Bazelon Center. However, employers don't have to provide accommodations that cause what's termed “undue hardship,” which means “significant difficulty or expense.”

Though accommodation is a tremendous gain, employees must ask for it and employers must be notified of the psychiatric disability. The only way to protect the legal right to accommodation is by disclosing mental illness. Though employers are obliged to keep this information private, revealing any disability leaves a person open to subtle forms of discrimination and stigma that can limit opportunity for advancement.

Kevin Burke from Revere works at the Cole Resource Center in Belmont, Mass., helping people with mental illness find employment. He says employers are generally supportive when someone gets ill at work, but he's also known people to lose their jobs after taking a leave of absence. He cites a schoolteacher with bipolar illness who experienced a major depressive episode. They filled his position because he was out so long. He's been searching for two years for a new permanent job. Fortunately, the "school gave him a glowing reference," and he's working as a substitute teacher. He hasn't missed a day of work for six months, says Burke.

Another woman he counseled hasn't had even that small amount of luck. As a nurse in an intensive care post-surgical unit at a Boston hospital, she asked for a transfer to another position after an episode of severe depression. She was told there were "no openings." If she couldn't perform in that job, there'd be no other options. She left and is still looking for employment.

"It comes down to employers expecting a repeat performance" and "liability of behavior on the job," Burke says, when discussing the reticence about hiring people with mental illness. There's also people's discomfort with mental illness, he adds. People walk in with a cancer diagnosis and get the full support of their department. Not so with mental illness, Burke says. "People feel awkward around mental illness. They don't know how to

respond to it.” Disclosure, however, can have its advantages. On the job it’s helpful for others to know because it “breaks down the walls.” If you’re having an off day, you can let people know.

Based on surveys that Stefan and others have done, people who disclose psychiatric disability to get accommodations don’t do as well as those who just ask for the accommodations, she says. “To some extent, this is a result of stigma associated with psychiatric disability, but I think it also reflects employers’ aversion to being told by an employee that anything is a right in the workplace setting,” she says. “I interviewed one CEO of a fairly large company who said they make all sorts of arrangements and allowances for employees, but whenever anyone asks for something by saying they have a right to it under federal law, ‘we know that they are troublemakers.’”

Ron Honberg, director of policy and legal affairs for the National Alliance on Mental Illness, says disclosure is “a terrible dilemma for folks.” Earlier in his career, he was a vocational rehabilitation counselor and advised clients about what they should and shouldn’t tell. Honberg says disclosure in the workplace can have its advantages, though; it provides legal protection under Title I of the Americans with Disabilities Act. But there are onerous requirements in advocating for oneself, even in a lawsuit, he adds. “The burden is on the individual to make the case,” Honberg says. “I don’t see the playing field as exactly level.”

The Roots of Stigma and Discriminations Go Deep

Stigma and discrimination lurk not just in the workplace, but elsewhere as well—in housing, social relationships, and insurance, says Honberg. Stigma is so problematical

that some say even the term itself has negative connotations. The use of the word "stigma" is stigmatizing, according to Nancy Ayers of the Substance Abuse and Mental Health Services Administration's Office of Communications. She suggests using other terminology such as "social exclusion."

So why are we human beings exclusionary? One perspective is that stigmatizing behavior is innate, says Steve Hinshaw, PhD, chair of the Department of Psychology at the University of California, Berkeley, and author of *The Mark of Shame*. "There are reasonable people who would say that as we evolved, 150,000 years ago, we couldn't have made it on our own on the savannah's of Africa without being cooperative and helpful to children," he says. We learned to be social to survive. But at the same time, we learned that if we were too social, we could be taken advantage of, he adds. This makes us careful.

A related evolutionary psychology theory postulates that we pick up signals, perhaps hardwired in us, Hinshaw says, that make us wary if others look ill—"contagious," or if others are different in some way, for instance if they're from a different tribe or have a different color skin. We're alert to others that we think might pose a threat. In a similar vein, this theory hypothesizes that not only are we sensitive to threat, but also to those we think aren't of much value to us. When we perceive others as having what social scientists term "low social capital," then we don't bother interacting with them. It's not the threat, but the lack of perceived benefit that may cause us to ignore others. When people with serious mental illness are not valued, then they can become marginalized and ostracized.

Hinshaw points out, however, that though stigma may be basic and essential to whom we are as human beings, it does not mean people are doomed to behave or react this way. We can overcome apprehension and prejudice.

Another perspective on stigma, Hinshaw says, points to the media—news, movies, cartoons, and advertising that portray mental illness “disfavorably” with images that are “ridiculing,” that emphasize violence and incompetence. “That’s the one-two punch,” he says. Evolution and media. The media barrage reinforces our nature. “No wonder those with mental illness don’t have a fighting chance.”

Recent research found that people are more willing and prone to reject others who they perceive as dangerous, as responsible for their illness, and whose illnesses seem rare or unfamiliar to them, contend the authors of a research study published in 2007 in the *Journal of Social and Clinical Psychology*. The researchers studied “social distancing,” the social scientific term for avoiding or shunning others, as a stand-in for stigma. They isolated the aspects of mental illness associated with “people’s willingness to avoid individuals with mental illness.” Earlier research had already shown that this kind of “avoidance is damaging, distressing, and disruptive to people’s lives.”

With regard to perceived peril, an important factor leading to avoidance, the authors point to a 1998 study showing that from “1950 to 1996, Americans increasingly perceived mentally ill persons as violent.”

“Studies have shown over and over that people with mental illness are no more violent” than others, says Reva Stein, Executive Director of the Massachusetts Clubhouse Coalition, an organization working to expand employment, housing, education and other rehabilitation opportunities for people with psychiatric disabilities.

Media portrayals give us a different idea of things, however. One only has to pick up a newspaper or go to the movies to see why the public believes that people with mental illness are violent. It was only a few years ago that Heath Ledger's Joker in the Batman movie *The Dark Knight* portrayed schizophrenia as dangerous.

With regard to attributing responsibility for illness, mental health professionals commonly believed that stigma could be reduced if the biological causes for mental illness were emphasized, say the authors of the previously cited 2007 study. They call this belief a "somewhat fading notion." Based on knowledge from other research, the issue is probably more complex, they say. Stigma may not simply be tied to whether an illness is believed to be biologically based or not, but whether people believe those with mental illness have control over the onset of the disease. Additionally, their research showed that the more people think that medication (rather than psychotherapy) is the prescribed treatment, the more they're willing to be close to others with mental illness.

As cited, the researchers also found "perceived rarity" of an illness to be a major factor in whether people avoid those with mental illness. Given that so many people keep their illnesses private, it's no wonder that these illnesses are thought to be much more rare than they actually are. It's another example of where the public's beliefs about mental illness are at odds with reality. A further interesting note—the authors contend that most mental health providers receive little, if any, training on mental illness stigma. When they searched for information on addressing stigma in psychotherapy, they found little written about this topic.

The Challenges to Lessening Stigma

The effort to reduce stigma has centered mainly on educating people about mental illness, while laws have been used to prevent discriminatory behavior. In England, a massive multifaceted campaign to combat stigma and discrimination called Time to Change is being undertaken with funding from the lottery and the organization called Comic Relief. It includes media campaigning, education, training for student doctors and teachers, grassroots organizing, community projects, and other programs designed to change not just beliefs and attitudes, but discriminatory behavior as well. The program is being evaluated by the Institute of Psychiatry at King's College, London.

A related trend is for famous individuals to speak out on the issue. Actress Glenn Close, who has two family members with mental illness, has put her considerable celebrity weight into her own anti-stigma campaign. And so has actor Joey “Pants” Pantoliano, who played the character Ralph Cifaretto on the television series *The Sopranos*. Pantoliano has experienced clinical depression. Close’s campaign is called Bring Change 2 Mind; Pantoliano’s is called No Kidding, Me Too (NKM2). Another well-known person speaking out is astronaut Buzz Aldrin, who suffered from depression and alcohol use. These campaigns put a human face on mental illness. However, some question how much these kinds of efforts can ultimately impact stigma and discrimination.

Anti-stigma campaigns have not been effective in the past, said Harvard professor Arthur Kleinman, who specializes in cross-cultural psychiatry and medical anthropology, this past spring at a Grand Rounds lecture at a hospital on the outskirts of Boston. Kleinman prefers the term “social death,” rather than the commonly used term of

“stigma.” The seriously mentally ill—those with psychosis—are often turned into non-persons, ending up socially displaced and unprotected. The abuse of those with mental illness, he says, is worldwide and particularly egregious in developing countries. Only by dealing with stigma and discrimination as a moral and human rights issue will we be able to address the problem.

Though the two campaigns—Bring Change 2 Mind and No Kidding, Me Too—highlight people with mental illness, some public service campaigns provide only education and information.

“Education alone is not enough,” according to Hinshaw. Providing facts alone “doesn’t fundamentally change attitudes.” Any effect “doesn’t last very long,” and it “might actually increase stigma.” Research by psychologist Patrick Corrigan from the Illinois Institute of Technology, says Hinshaw, shows that education works better when accompanied by personal contact—that is, when knowledge is obtained directly from seeing and knowing someone with a mental illness. Facts without the human element may in fact be counterproductive and education should emphasize people’s resilience.

Similarly, psychologist Otto Wahl from the University of Hartford says research has shown that the best way to change attitudes and dispel stereotypes about mental illness is through contact with people who have these illnesses. This is one reason that mental health consumer groups say disclosure is needed to visibly contradict stereotypes.

Another important aspect of stigma is what is termed “self-stigma”—the negative attitudes and beliefs held by those with mental illness. Self-stigma is a particularly insidious internalized state caused by absorbing the dominant culture in which one lives. The greatest difficulty is the “shame and self loathing, not the illness,” says Steve Lappen

from West Medford, who runs the speakers bureau for the Depression and Bipolar Support Alliance of Greater Boston. “We blame ourselves,” he says.

People with mental illness must work at identity and self-image. They wrestle with questions such as: How do I feel about having a mental illness? What does it mean to have mental illness? Lappen says over time he changed his thinking from “I am bipolar” to “I have bipolar disorder.” He became the “author of his own recovery” and “developed his own voice” through his involvement with the Depression and Bipolar Support Alliance of Greater Boston, he says. The organization helped him to feel less alone in his illness. If you have mental illness, people see you “as other” or “as alien.” So it’s helpful to find people who “get it,” he says. Finding supportive people is particularly helpful if you’re disclosing your illness. The irony is that “you may be closed off by opening up,” he says. When you reveal your illness, that’s when you “find out who your friends are. Friends won’t abandon you.”

The Importance of Work

Employment and vocational education may play a key role in fighting stigma. Work raises social value, hence acceptance, particularly in places like the United States, where status is tied to achievement, employment status, education level, wealth, and similar attainments. It also raises esteem. And it enables those without mental illness to come into contact with those that do.

To aid recovery, more effort is being placed on work issues. A critical devastating effect of mental illness is impairment and dysfunction related to work, according to a fact sheet published by Boston University’s Center for Psychiatric Rehabilitation.

Additionally, costs of reduced and lost productivity, health care, and other related matters are estimated to be \$150 billion, states the Center's fact sheet. In the mid-2000's, employment was set as a high priority by the President's New Freedom Commission on Mental Health, which came out of the Bush Administration, as well as by the Substance Abuse and Mental Health Services Administration and the National Institute on Disability and Rehabilitation Research. Whether this recent emphasis on employment is motivated by saving money or helping people recover, the goal looks to be the same: helping people find work.

The Massachusetts Clubhouse Coalition has always emphasized employment. "One of the best stigma busters is employing someone," says Reva Stein, executive director of the Massachusetts Clubhouse Coalition. People realize, "Hey, you're just like me." Stein says: "People can work. It's an essential part of recovery. Sitting around all day is not good for a person's mental health."

Clubhouses are run like businesses with consumers participating like employees. Members have responsibilities, and they receive training to prepare them for public and private employment. At the clubhouse, they do real work: answering phones, writing newsletters, working in coffee shops, entering statistics, and more. There's also a great deal of peer support. Clubhouses help people from various walks of life, says Stein. One member designed airplanes before becoming ill. He was a Massachusetts Institute of Technology graduate. Others have been professors or teachers who later in their careers became clinically depressed.

In Massachusetts, there are 32 clubhouses that serve 8300 people, says Stein. They work with more than 70 employers throughout the state, including the University of

Massachusetts Medical School and the TJX Company. Nevertheless, “there’s a serious unemployment problem” among people with serious mental illness, Stein says. She estimates the employment rate at about ten to fifteen percent. In 2006, the Substance Abuse and Mental Health Services Administration reported that only 22 to 25 percent of adult mental health consumers are employed, according to figures published by the Center for Psychiatric Rehabilitation. An accurate number is not really known, nor is it easy to determine.

The research on employment figures can be misleading, Stefan says, because it often focuses on people receiving benefits such as social security and disability, whereas “quite a few people with serious psychiatric diagnoses have not disclosed and have serious jobs.” Additionally, “most of the research concentrates on people who receive public vocational services, which often treat people with serious psychiatric disabilities as though they have educational and intellectual deficits. They end up working as janitors or in McDonalds, which, as Elyn Saks and others have persuasively written, is the worst possible kind of employment for people with problems of sensory overload who need flexibility in employment.”

One employment bright spot is the National Employment Expansion Project. Six years ago, according to Stein, the project began nationally with \$1 million in funding. In Massachusetts, at that time, clubhouse members were earning \$8.9 million a year. Three years, later in 2009, that increased to \$13.2 million. That’s an almost 50 percent increase in the earning power of people with psychiatric disability. Despite this kind of valiant effort, despite the Americans with Disability Act, and despite treatment improvements,

significant impact seemingly has not been made on employment rates in the country as a whole.

“I don’t see any improvement in employment rates,” says Honberg. He sees no evidence that in the last 10 to 20 years that employment has improved for people with serious mental illness.

Part of the problem, he says, is that there are not enough supported employment programs available and that there are disincentives for working built into the social security and Medicaid systems. People are afraid of losing critical benefits.

Transitional employment is very important in helping people get back to work, concurs Stein. It allows people to work part-time, 15 to 20 hours a week, and begin a gradual transition back into employment. The “mental health system across the country is under extreme stress,” says Stein, and there aren’t enough funds to pay for this kind of recovery assistance. About one-third or more of club houses in the country are funded by Medicaid programs, which won’t pay for employment support. Additionally, we have “a health care benefit system that is a scary disincentive,” she says. The “nervousness about losing benefits can be enough to stop people” from working. Many legislators don’t know enough about mental illness or what kinds of programs help most, she says.

Caregivers and mental health providers also sometimes discourage people from working, Stein says. If someone is out of the hospital for a time and recovering well, therapists may not want to “rock the boat.” Sometimes family members discourage working. They’re worried about the effect of work stress on the illness. “Fear of stress” is a big factor in causing people to shy away from working.

It seems that fear all-around works against people with serious mental illness. According to Kevin Burke, the economy is tough enough; the self-doubts that people with mental illness can have worsens the situation. And there's also the caution by employers wanting to know if a person has recovered. But there's "no crystal ball saying I will or won't relapse," he says. Then again: "I myself have been stable for seven years, almost eight years," he adds.

Appendix

Reasons for Choosing to Disclose or Not Disclose¹

Reasons to Disclose:

- To gain the protections of the ADA
- To request accommodations, access technology
- To explain gaps in work history, past accommodations received
- To address or explain symptoms, sudden hospitalization, or crisis issues in the workplace
- To explain problems in work performance
- To enlist the support of the employer
- To increase understanding of supervisors and coworkers
- To have someone to turn to if problems arise
- To reduce fear or anxiety of coworkers
- To make sure coworkers have accurate information instead of speculating
- To allow the involvement of a VR professional or advocate to access or maintain employment
- To become employed in targeted positions in the Mental Health system for “consumers” or “peers”
- To serve as a role model, combat stigma, to educate others
- To relieve the stress of keeping secrets, remembering explanations or cover stories
- To continue the process of recovery, acceptance of disability

- To enhance self-esteem because of choosing not to hide what others may see as a negative fact about oneself
- To improve psychological well-being
- To be honest, to myself and others
- To reduce isolation, connect with others, share personal information
- To confirm health insurance coverage prior to accepting job

Reasons to Not Disclose:

- To protect my privacy
- To be ‘normal’, to fit in
- To preserve self-esteem by not identifying as ‘disabled’
- Because I do not see myself as disabled, or my condition is manageable, not disabling
- Because there is no need for accommodation
- Because my job is naturally accommodating, a good job match
- Do not feel I should ask, deserve it, am eligible for accommodations – if part-time, I should not ask for accommodations
- Do not want to be seen as asking for special treatment
- Did not know I could ask for accommodations
- Fear of negative employer attitudes
- Fear of a change in supervision
- Fear that disclosure would lead to biased work evaluations
- Because it is the cultural norm not to complain

- Fears of isolation from coworkers
- Because of past negative experiences with disclosure in the workplace or personally
- To avoid emotionally hurtful responses
- To avoid being more closely monitored by supervisor
- To avoid rejection/negative attitudes/being treated differently by coworkers or supervisors
- To avoid harassment, gossip, social disapproval
- To avoid all my behavior being interpreted as due to mental illness
- To avoid discrimination, to reduce chances of not being hired, promoted, or terminated because of disability
- To avoid being thought of as less competent
- Because you need to work harder to prove your worth if they know you have a mental illness

¹. With permission, Appendix material excerpted from MacDonald-Wilson, Kim L., Shengli Dong, Terri Ferguson, Chia Huei Lin, Megan Kash MacDonald, Sally E. Rogers, and Zlatka Russinova. "Disclosure of Mental Health Disabilities in the Workplace." In *Handbook of Job Accommodation in Mental Health*, ed. I. Z. Schultz and E. S. Rogers. Springer, (Forthcoming).

Bibliography

In keeping with the style of newspapers and magazines, notes are not included in the text. (The Appendix is the exception.) As an alternative, a full bibliography is provided here with citations separated by Works Cited and Works Consulted. Because interviewing sources is the key reporting tool of a journalist, citations for all interviews and personal correspondence with sources are listed first and titled Original Interviews.

Original Interviews

Anju Khubchandani (disability issues officer, American Psychological Association), phone interviews by author, August 5 and September 23, 2010.

Anne Whitman, MEd, MBA, PhD (president, Cole Resource Center), in-person interview by author, May 18, 2010.

Jane Briant (member, DBSA-Boston), in-person interview by author (conducted in confidentiality; name withheld and pseudonym used by mutual agreement), June 11, 2010.

Dan Abrahamson, PhD (assistant executive director for state advocacy, American Psychological Association), phone interview by author, September 23, 2010.

Dan O'Connell (member, DBSA), in-person interview by author (conducted in confidentiality; name withheld and pseudonym used by mutual agreement), May 8, 2010.

Debra Grossbaum (attorney, Physicians Health Service), phone interview by author, June 14, 2010.

Fred Frese, PhD (coordinator, Summit County Recovery Project), phone interview by author, June 7, 2010, and email interviews by author, August 20, 23, and 24, 2010.

Jennifer Boyd, PhD (psychologist, University of California and Veterans Affairs Medical Center, San Francisco), phone interview by author, June 16, 2010.

Karen K. Wilson, BSN, MHA (recovery coordinator, Baltimore VA Medical Center), phone interview by author, September 3, 2010.

Katherine Masley (member, DBSA-Boston), in-person interview by author, June 16, 2010.

Kathy Petkauskos (senior program director, University of Massachusetts Medical School), phone interview by author, June 21, 2010.

Linda Worley, MD (professor of psychiatry, Department of Psychiatry, University of Arkansas for Medical Sciences, Little Rock), e-mail interview by author, June 15, 2010.

Max Parker, MSW, phone interview by author, July 8, 2010.

Michael F Myers, MD (vice-chair of medical education and director of training, Department of Psychiatry and Behavioral Sciences, Downstate Medical Center, State University of New York), phone interview by author, spring 2009.

Patricia M. Breslin, MSW, LCSW (associate executive director, Office of Consumer Affairs and Business Regulation, Division of Professional Licensure, Commonwealth of Massachusetts), phone interview by author, June 14, 2010.

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- William H. Reid, MD, MPH (forensic psychiatry consultant; Psychiatry and Law Updates), e-mail interview by author, August 30, 2010.
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