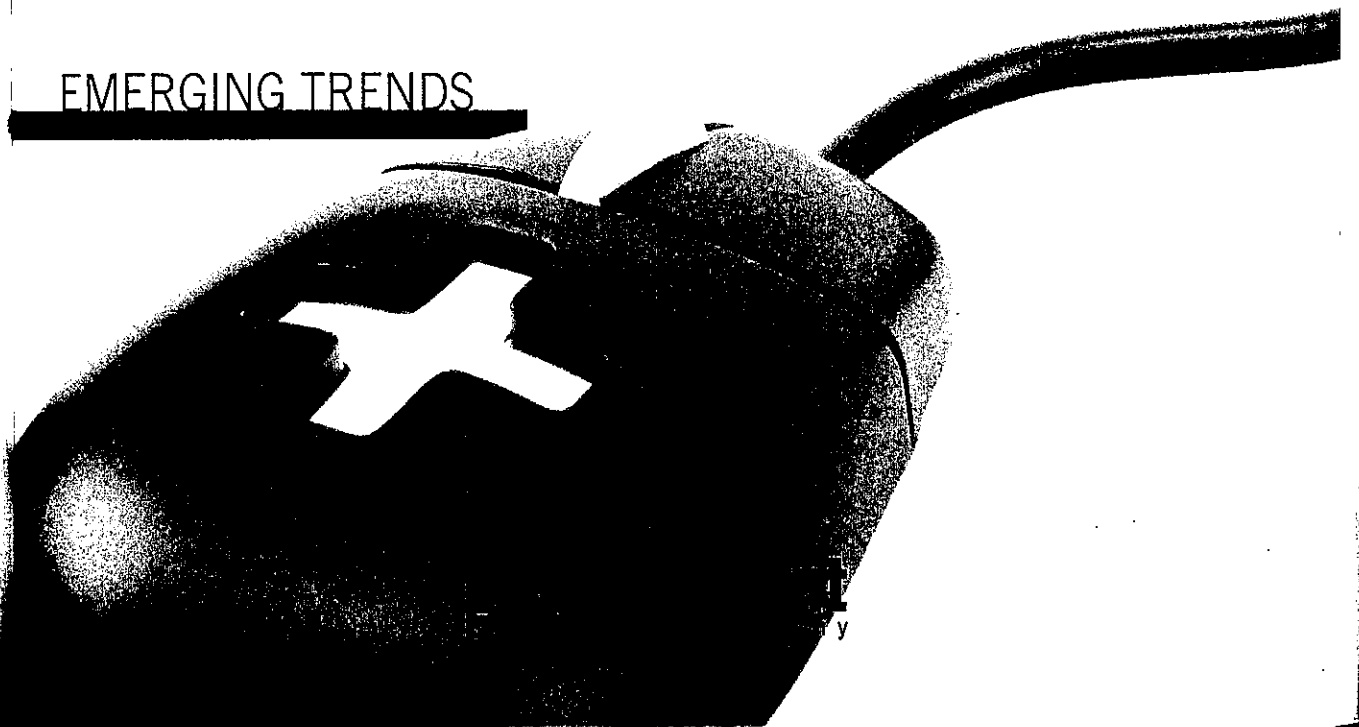


*Applications in*  
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■ Edited by Michael H. Eaves

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# Designing a disclosure-focused stigma intervention for mental health research

*Amanda Carpenter  
Rutgers University*

*Kathryn Greene  
Rutgers University*

## INTRODUCTION

Approximately 57.7 million Americans per year experience a mental health disorder including but not limited to schizophrenia, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, depression, and anxiety disorders (National Alliance on Mental Illness (NAMI), 2009; Watson & Corrigan, 2005; Yamaguchi, Mino, & Uddin, 2011). Several misconceptions about mental illness contribute to stigma, including ideas that mental illnesses are a result of abusive parenting or poor upbringing (NAMI, 2009). Several efforts have targeted reduction of stigma associated with mental health disorders (e.g., Corrigan & Gelb, 2006; Heijnders & Van Der Meij, 2006; Stuart, 2008; Watson & Corrigan, 2005). Unfortunately, these initiatives have not experienced the desired effects over time (Heijnders & Van Der Meij, 2006; Link & Phelan, 2001; Watson & Corrigan, 2005). Few mental illness interventions are grounded in communication theory, thus designing such an intervention has the potential to advance the field of health communication and contribute to public health.

There is evidence that campaigns or interventions that focus on encouraging people with mental illness to disclose their illness is an effective approach to reducing stigma and increasing interpersonal outcomes (Davidson et al., 1999; King et al., 2007). This chapter presents a disclosure-focused mental health stigma intervention centered on decisions to share mental health diagnoses to create social support and decrease stigma for people living with mental health issues. This intervention utilizes the disclosure decision-making model (DD-MM, Greene, 2009) as the theoretical framework and extends an existing brief disclosure intervention to this new context (Greene, Carpenter, Catona, & Magsamen-Conrad, 2013). Applying theory to an intervention addressing a significant health topic further advances the field and study of health communication.

In this chapter we first highlight the importance of mental illness as a health condition in the United States. Next, we discuss various definitions of stigma and how stigma relates specifically to mental illness. The chapter continues with a review and critique of existing interventions targeting mental illness and stigma. In the later portion of this chapter we discuss the importance of disclosing mental illness and present a disclosure-focused mental illness intervention to reduce stigma. We begin by describing mental illness.

## *Mental Illness*

Mental illness is a serious problem that can emerge throughout the lifespan and it primarily affects individuals initially during adolescence and young adulthood (NAMI, 2009). Mental illnesses are defined as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others, and daily functioning” (NAMI, 2009). The *Healthy People 2020* objectives include a focus on mental health and mental disorders as an area of health that needs to be further addressed in the next decade (United States Department of Health and Human Services [USDHHS], 2011). About 6% of Americans live with a serious mental illness such as schizophrenia or bipolar disorder (NAMI, 2009). These illnesses can be difficult to treat because “stigma often prompts people to hide their symptoms and avoid psychiatric treatment” (NAMI, 2010). NAMI (2010) estimates that “only one in two people with a serious mental illness seeks psychiatric treatment” and many patients discontinue recommended treatment plans. Untreated mental illnesses can lead to “unnecessary disability, unemployment, substance abuse, suicide and wasted lives; the economic cost of untreated mental illness is more than 100 billion dollars each year in the United States” (NAMI, 2009). Four of the top ten causes of disability in the United States are mental health disorders (NAMI, 2009).

Because of the many gaps in both care and coverage in the United States healthcare system, people living with mental illness are overrepresented in homeless and incarcerated populations (NAMI, 2009). Mental illnesses also affect physical health as several chronic health conditions such as obesity and diabetes are likely to co-occur (Centers for Disease Control and Prevention [CDC], 2011). It is also estimated that mental illnesses shorten the lifespan as significantly as illnesses such as cancer or heart disease (NAMI, 2010). This review of mental illness emphasizes the importance of mental health disorders and why developing an effective intervention would be beneficial. The prevalence of mental illness combined with its implications for overall health and the consequences of not treating it contribute to the importance of addressing mental health issues. Stigma is central to addressing such issues, as discussed next.

## *Conceptualizing Stigma*

Stigma affects the lives of people living with mental disorders in a number of ways. First, stigma affects the way people living with mental illness are perceived, approached, and treated. Second, stigma affects the way people with mental illness perceive themselves. Third, the shame associated with stigma discourages people living with mental illness from seeking psychiatric treatment,

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which results in hiding symptoms and avoiding treatment (NAMI, 2009). Finally, negative stereotypes about mental illness interferes with people living with mental illness achieving life goals (e.g., obtaining employment, living in a safe home, and having satisfying relationships with friends, family, and romantic partners).

There are several competing conceptualizations of stigma that can apply to mental health, and each perspective emphasizes a different component. Goffman (1963) is credited with early theorizing related to stigma and defined stigma as "an attribute that is deeply discrediting" (p. 3). Goffman (1963) suggested that the stigmatized deviated from "normality," providing a broad lens through which to consider stigma. Goffman's framework is the most widely utilized to conceptualize stigma, but it was not adapted specifically for health but can loosely apply to public perceptions of people with mental illness as "abnormal." More relevant to health communication research specifically, Leary and Schreindorfer (1998) suggested that stigma consisted of identifying traits or characteristics that led to avoidance or rejection from others. They identified four characteristics of stigma relevant to health research: perception that individuals a) threaten others' health and/or safety, b) diverge from group standards, c) fail to contribute to society, and d) create negative emotional reactions in others. Although all four components of Leary and Schreindorfer's framework can be applied to mental illness, perhaps the threat to others' health and safety is most prominent in public perceptions of people with mental illness.

Corrigan and Watson (2002) added multiple levels to their conceptualization of stigma including defining stigma from a public perspective and a self-perspective. Both public and self perspectives incorporate stereotype, prejudice, and discrimination. Public stigma stereotypes include believing that group members are "dangerous, incompetent, or have character weakness" (Corrigan & Watson, 2002, p. 16). Prejudice associated with public stigma includes the negative reaction toward a particular group. Discriminatory behavior associated with public stigma includes "avoidance and withholding employment, housing opportunities, and help" (Corrigan & Watson, 2002, p. 16). Self-stigma stereotypes include views about the self, more specifically people perceiving themselves as "incompetent and having character flaws" (Corrigan & Watson, 2002, p. 16). Negative emotional reactions associated with self-stigma include low self-worth. Discrimination associated with self-stigma includes "a behavioral response to prejudice" (Corrigan & Watson, 2002, p. 16), which includes the failure to pursue employment or housing. Corrigan and Watson's framework can be applied to mental illness as well and adds focus on how people living with mental illness perceive themselves, in addition to the more widely described public perceptions that are central in stigma.

Link and Phelan (2001) identified two unresolved challenges to the conceptualization of stigma, the people studying stigmatized conditions and an individualistic focus, which Leary and Schreindorfer (1998) also identified. Link and Phelan (2001) suggested that researchers studying stigmatized conditions did not always belong to the stigmatized group, therefore potentially misunderstanding the illness experience. Link and Phelan (2001) also added power to their definition to address the individual: "stigma exists when elements of labeling, stereotyping, separation,

status loss, and discrimination occur together in a power situation that allows them" (p. 377). Link and Phelan's framework can also be applied to mental illness and highlights the interpersonal experience of the person living with mental illness.

All of these conceptualizations apply to mental illness, either broadly or more specific to health. Each of these definitions focuses on a different component, either from the public's perception or the interpersonal experience of the person living with mental illness. These definitions of stigma highlight a core feature where people living with mental illness struggle with many aspects of stigma.

### *Mental Illness and Stigma*

Mental illness is one of the most stigmatized health conditions (NAMI, 2009; Stuart, 2008; Watson & Corrigan, 2005; Yamaguchi et al., 2011). West, Yanos, Smith, Roe, and Lysaker (2011) found that people living with severe mental illness experienced an elevated level of self-stigma, which is particularly troubling considering the implications for self-esteem, support, and treatment. Several misconceptions about mental illness contribute to stigma including ideas that "mental illnesses are a result of personal weakness, lack of character, or poor upbringing" (NAMI, 2009). These perceptions highlight the personal responsibility (Corrigan et al., 2002) or blame that people living with mental illness confront. Cases of untreated mental illness also contribute to the misconception that all people living with mental illness are dangerous and violent, and this "fear leads to avoidance" (Corrigan & Watson, 2002, p. 16).

Media content perpetuates and propagates beliefs that mental illness is associated with violence (Philo, 1994). Media, including news, movies, and television, often present an exaggerated depiction of people living with mental illness, portraying them as unstable, erratic, and unsafe, and these representations influence and shape our perceptions of mental illness (Thorncroft, 2006). Further, the preponderance of media depictions of mental illness is negative (Wahl, 1992). Media may also sensationalize negative events and emphasize the mental health components associated with violent behaviors, for example in national school tragedies, yet underrepresent success stories, such as people coping well with their condition.

*Stigma and outcomes.* Stigma affects the lives of people living with mental disorders in a number of ways. Stigma affects how people living with mental illness are perceived, approached, and treated (Link & Phelan, 2001). A study conducted by the CDC (2010) reported discrepancies between perceptions of the general public and people living with mental illness where 57% of the general population believed that people are caring toward people living with mental illness, while only 25% of people living with mental illness perceived people to be sympathetic toward people living with mental health disorders. Taylor and Dear (1981) specifically identified three stigmatizing attitudes people held toward mental illness: a) people with serious mental illness are to be feared and therefore do not deserve acceptance in communities with non-mentally ill people; b) people with serious mental illness are unable to make their own decisions; and c) people with serious mental illness lack maturity and require constant care. Additionally, the historic treatment

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of mental illness that included segregating mentally ill people and thus implicitly labeled them as "dangerous," and this pattern of separation may also contribute to the perception that people living with mental illness are unsafe. These negative attitudes and perceptions affect the way we behave toward and respond to people living with mental illness, additionally affecting the way this population perceives themselves.

Stigma affects the way people with mental illness perceive themselves. Public attitudes and beliefs about mental illness create negative beliefs about the self (Corrigan & Watson, 2002). These stigmatizing attitudes are internalized, creating negative self-worth and self-esteem, and eroding self-efficacy to live a productive life (Corrigan & Watson, 2002). With low self-esteem and self-worth, people living with mental illness have little confidence to engage in society, resulting in increased social isolation and decreased access to social support. These outcomes may further exacerbate the symptoms of mental illness, for example, leading to a spiral of depression.

Stigma prevents people living with mental illness from seeking psychiatric treatment by encouraging people to hide their symptoms and avoid treatment (NAMI, 2009). Contributing to this barrier are public beliefs that coercive treatment and segregated institutions are the best methods for treating mental illness (Corrigan & Watson, 2002). Stigma "erodes confidence that mental disorders are real, treatable health conditions" (NAMI, 2009). The World Health Organization (2010) reported that "between 35 and 50% of people with severe mental health conditions did not receive the necessary treatment for their condition" (p. 16). Mental health has high documented treatment effectiveness rates, with between 70 and 90% of those seeking treatment seeing improvements in symptoms and quality of life (NAMI, 2009). Without treatment, people living with mental illness have a greater chance of relapsing during the recovery process (NAMI, 2010).

Additionally, stigma often hinders people living with mental illness from achieving life goals. People living with mental illness have desires to live productive and fulfilling lives that include obtaining employment, living in a safe home, and having satisfying relationships with friends, family, and romantic partners. However, obtaining these goals is complicated by stigma. Stigmatizing behaviors include withholding help (e.g., refusing to lease safe housing) and social avoidance. Even people intending to help mental illness patients may smother, overwhelm, or be perceived as "taking over" (see unhelpful social support for people living with HIV/AIDS, Barbee, Derlega, Sherburne, & Grimshaw, 1998). Martin, Pescosolido, and Tuch (2000) reported that more than half of their survey respondents were opposed to a range of interactions with people living with mental illness including: a) socializing with a person living with mental illness, b) working with a person living with mental illness, and c) having a family member romantically involved with a person living with mental illness. Thus, people would rather avoid than interact with people living with mental illness.

This review highlights the barriers that stigma creates for people living with mental illness. Stigma affects how people living with mental illness perceive and value themselves, how the public perceives and approaches people living with mental illness, people living with mental illnesses' willingness to seek treatment, and how people living with mental illness are able to achieve life goals.

## Existing Interventions Addressing Mental Illness

With all of the negative outcomes of mental illness stigma, it is not surprising that several initiatives to reduce mental illness stigma already exist. Each of these initiatives relies on different strategies to deliver the intervention. However, most of these anti-stigma initiatives have shortcomings that prevent long-term sustained effects and changing attitudes and behaviors (Heijnders & Van Der Meij, 2006; Link & Phelan, 2001; Stuart, 2008; Watson & Corrigan, 2005). Watson and Corrigan (2005) identified three different types of anti-stigma efforts: protest, education, and contact.

**Protest.** Protest, the first category of anti-stigma initiatives, relies on a moral demand to the public to stop stigmatizing people living with mental illness (Watson & Corrigan, 2005). Protest involves a “punishing consequence” (Watson & Corrigan, 2005, p. 283) such as shaming the public for its bad behavior or negative attitudes. An example of a protest initiative is the program StigmaBusters, launched by NAMI in 2000. StigmaBusters is a system run by mental illness advocates that alerts members when national media portrays people with mental illness in a stigmatizing manner (NAMI, n.d.). Members are then expected to report the negative representation to the offending organization and create pressure (NAMI, n.d.). This particular initiative has experienced some success, contributing to the cancellation of a television program (ABC’s *Wonderland*, 2000) that depicted people living with mental illness as dangerous and violent (Watson & Corrigan, 2005).

Protest sends a strong message to combat stigma, and this strong message could be a benefit or a risk. This approach was effective in canceling *Wonderland* and shaming the major network and its sponsors (Watson & Corrigan, 2005). This may be an effective way to approach media to reduce stigmatizing portrayals of people living with mental illness. However, this approach has several inadequacies. Because protest sends such a strong message, psychological reactance may occur as “freedom of behavior is a pervasive and important aspect of human life” (Brehm, 1966, p. 7). Specifically the protest could backfire and increase negative attitudes toward mental illness and stereotyping. StigmaBusters has also had limited success, canceling only the one television show. This approach also does not take power into consideration, part of the stigma definition provided by Link and Phelan (2001). Media organizations could find ways to ignore advocacy groups’ complaints. The protest approach may work best at a higher level, such as public policy, where organizations would face the risk of lost revenue should they continue perpetuating stigmatizing representations.

**Education.** The second anti-stigma initiative category was education. Education attempts to “replace stereotypes with factual information” (Watson & Corrigan, 2005, p. 283). This approach relies on several ways to disseminate information such as through public service announcements, flyers, or videos. A well-known effort utilizing this approach was the Elimination of Barriers initiative launched by the Substance Abuse and Mental Health Service Administration [SAMHSA] in 2004. Created using social marketing principles, Elimination of Barriers sought to educate the public and reward positive portrayals of people living with mental illness (Bell, Colangelo, & Pillen, 2005).

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Education is useful for targeting and reaching large audiences (Corrigan & Gelb, 2006). This mass marketing approach requires fewer resources (unless the intervention requires purchased advertising time or space) and less planning time than the protest and contact processes. Previous research also suggests that education can create changes in attitudes (Corrigan & Gelb, 2006). However, this attitudinal change is often short-term and it is unclear how to best sustain change in attitudes and behaviors (Corrigan & Gelb, 2006). A specific problem with the Elimination of Barriers initiative is the broad scope of the project, and social marketing calls for more specific goals (Lee & Kotler, 2011). The mass approach may not be the most effective way to reduce stigma, in fact, targeting more specific audiences and tailoring messages to these audiences may be a more efficacious strategy (Heijnders & Van Der Meij, 2006).

*Contact.* Contact was the third anti-stigma intervention category, where people living with mental illness engage in interpersonal interaction with small groups of the public. For a contact initiative to work, four elements must be present: a) equal status between the groups, b) common goals, c) no competition, and d) sponsorship by an organization (Watson & Corrigan, 2005). Developed by NAMI, In Our Own Voice is an example of a contact initiative aimed at reducing stigma (Corrigan & Gelb, 2006). In Our Own Voice is a 90-minute program directed by people living with mental illness about their mental illness experience. The program utilizes peer discussion with small groups (e.g., a class of college students, police officers, or teachers) about mental illness (Corrigan & Gelb, 2006). The presenters must complete training before they can lead the program; as leaders, people with mental illness are seen as credible sources because they have undergone treatment for their mental illness and can discuss information pertinent to their illness (Corrigan & Gelb, 2006). This is similar to other intervention strategies where a cancer patient or person living with HIV/AIDS credibly speaks about prevention or screening.

*Comparing intervention categories.* This discussion of anti-stigma interventions reviews several existing initiatives and approaches, including the advantages and disadvantages of these types of interventions. There are no direct comparisons across these categories of mental illness stigma interventions. We first compare the interventions and then in the following section we outline an interpersonal disclosure intervention that falls into the contact category.

Previous research has indicated the best results for contact initiatives out of the three intervention categories (Corrigan & Gelb, 2006; Watson & Corrigan, 2005). Intergroup contact reduces prejudice and increases positive attitudes toward mental illness (Corrigan & Gelb, 2006). Contact initiatives are unable to address mass audiences, and these smaller and more interpersonal approaches may be better strategies for reducing stigma. There are also more resources required for contact initiatives (e.g., personnel, planning, time) than the protest or education initiatives. Although most of these anti-stigma efforts have not sustained long-term effects (Heijnders, & Van Der Meij, 2006; Link & Phelan, 2001; Watson & Corrigan, 2005; Yamaguchi et al., 2011), important insights from these efforts can be used to improve future interventions and campaigns.

Several features of existing initiatives are worth noting. First, the literature suggests that the most successful feature of earlier anti-stigma initiatives was interpersonal interaction with a person living with mental illness (Corrigan & Gelb, 2006; Read, Haslam, Sayce, & Davies, 2006; Watson

& Corrigan, 2005; Yamaguchi et al., 2011). Hearing firsthand from a person living with mental illness increased positive attitudes toward mental illness and reduced negative stereotypes about mental illness (Watson & Corrigan, 2005; Yamaguchi et al., 2011). This “mere exposure” could reduce uncertainty and increase positive attitudes toward mental illness. Positive expectancy violation is another explanation for the effect, where the audience was expecting a negative or strange interaction but ended up enjoying the experience of learning about mental illness (Yamaguchi et al., 2011). Regardless of the reason why positive attitudes are increased through interpersonal interaction with people with mental illness, future initiatives should continue to include people living with mental illness because this personal interaction appears to resonate with the public. This inclusion of people living with mental illness in these initiatives also reduces the separation of people with mental illness from the general public. In the following section we outline the importance of disclosing a mental illness as one mechanism for increasing interpersonal interaction.

### *Disclosure and Mental Illness*

Disclosure is a component of contact interventions and is defined as “an interaction between at least two individuals where one intends to deliberately divulge something personal to another” (Greene, Derlega, & Mathews, 2006, p. 411; also see Derlega, Metts, Petronio, & Margulis, 1993). Disclosure has been studied with many health issues such as HIV/AIDS, cancer, nonvisible illness, sexual abuse, heart conditions, and infertility. Some research on disclosure and health examines how patients share their diagnoses (when and with whom), for example, a patient with a heart condition may be selective about who knows the diagnosis particularly early in treatment. Other emerging research focuses on how patients share updates regarding their health condition, for example, a breast cancer patient may be selective about what is shared regarding treatment, recurrence, or side effects. Disclosure of both diagnosis and ongoing updates is relevant in the context of mental health issues.

Studying disclosure of a mental illness specifically is important for several reasons. First, disclosing a mental illness is associated with potential increased social support (Davidson et al., 1999) because people must be aware of the condition to be able to provide appropriate social support. This social support can be received from several sources including family, friends, peer support groups, and from healthcare providers (Davidson et al., 1999). Increasing social support may lead to important outcomes such as symptom improvement, social network enhancement, and increased quality of life (Davidson et al., 1999). Second, disclosing mental illness can reduce stigma by reducing negative stereotypes (King et al., 2007; SAMHSA, 2008). Third, disclosing a mental illness is often necessary to receive certain accommodations, for example, from work or school. For example, it is common for college students in the United States to receive testing accommodations such as additional time and a quieter setting if they document a disabling medical or mental health condition. Fourth, nondisclosure can negatively affect life satisfaction because secrecy and avoidance can lead to social ostracism (Rosenfield, 1997). Fifth, disclosing is a necessary step for contact interventions to be successful and reduce stigma (SAMHSA, 2008). Finally, more openness and disclosure is related to overcoming discrimination by creating a sense of self-empowerment and self-worth (SAMHSA, 2008).

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People living with mental illness who are considering disclosing their diagnosis must weigh the risks and rewards of sharing this information. Because disclosure involves risks, people carefully calculate whether to reveal or conceal a diagnosis and whether to later share ongoing updates. Benefits of disclosing a mental illness include more openness and less secrecy and reducing the burden of nondisclosure or "holding it in." Disclosure can lead to identifying similar others and finding people who can provide assistance. Disclosure can also educate others, impact stigma, and allow people to "promote a personal sense of power and act as a living testimony against stigma and discrimination" (SAMHSA, 2008, p. 11). Risks of disclosing a mental illness include social rejection, discrimination, anxiety, and stress (SAMHSA, 2008). Further, people who share also lose control of the information because the recipient may further share the information (Venetis et al., 2012). Because the risks are high, people with mental illness may choose to be cautious in how they weigh decisions to share, opting for less openness to protect themselves.

SAMHSA (2008) identified several strategies that people used to disclose their mental illness including selecting a safe place in which to disclose, planning what to disclose, selective disclosure, and trusting the disclosure target. These strategies are similar to research on disclosing other stigmatized health conditions (e.g., Greene et al., 2013). These disclosure strategies often require a training or intervention to fully develop the skills necessary to disclose a mental illness. The following section outlines a mental illness disclosure intervention designed to reduce stigma and improve outcomes for patients.

### *Proposed Disclosure Intervention*

This chapter presents a revision of an existing disclosure intervention to increase the disclosure efficacy of people living with mental illness. Focusing more on an interpersonal perspective, this intervention suggests that selectively disclosing a mental illness can yield positive outcomes such as increased social support and reduced stigma. This intervention uses the DD-MM (Greene, 2009) as the theoretical framework, described next.

*DD-MM.* The DD-MM suggests that several variables predict whether a person will disclose a health issue such as a mental health disorder (Greene, 2009). These variables include information assessment, receiver assessment, and disclosure efficacy. Information assessment includes stigma, prognosis, symptoms, preparation, and relevance to others and addresses *what* a person is considering disclosing. Receiver assessment includes relational quality and anticipated response, incorporating *who* is the potential disclosure recipient and how this person might respond to the information. Disclosure efficacy is the belief that sharing information will result in a positive outcome or *how*, encompassing confidence related to disclosure skills and message enactment. If information and receiver assessments are positive and disclosure efficacy is high, it is likely that people will choose to disclose. The DD-MM specifically identifies factors that people weigh in a disclosure decision that can be applied to sharing a mental health diagnosis.

The DD-MM has been applied to several health conditions including HIV/AIDS (Greene et al., 2013), heart disease (Checton & Greene, 2012), nonvisible illness (Checton, Greene,

Magsamen-Conrad, & Venetis, 2012), cancer (Venetis, Greene, Checton, & Magsamen-Conrad, under review; Venetis, Magsamen-Conrad, Checton, & Greene, in press), and infertility (Steuber & Solomon, 2011). Greene et al. (2013) used the DD-MM as the framework for a disclosure intervention to increase disclosure efficacy for people living with HIV/AIDS. Checton and Greene (2012) considered how illness uncertainty affected ongoing disclosure about the patient's heart condition to partner and focused on two sources of uncertainty, prognosis and symptom. Checton et al. (2012) examined different sources of uncertainty and illness interference, and how uncertainty and interference affected communication efficacy and health condition management. Two studies relating to cancer examined how cancer patients made decisions to engage in topic avoidance with their partners (Venetis et al., under review; Venetis et al., in press). Steuber and Solomon (2011) considered how disclosure of infertility to social network members related to perceived stigma and disclosure efficacy. These studies highlight the different contexts to which the DD-MM has been applied. The DD-MM serves as the theoretical framework for a brief disclosure intervention, described next.

**Brief disclosure intervention (BDI).** The Brief Disclosure Intervention (BDI) is guided by the DD-MM, and this intervention focuses on evaluating options for disclosing by increasing efficacy in ability to share a difficult piece of information. The original version of the BDI was developed and utilized with another highly stigmatized population, people living with HIV/AIDS (Greene et al., 2013). Results of the BDI implemented with people living with HIV/AIDS indicated, from pretest to posttest, that the intervention increased disclosure efficacy, and decreased anxiety and worry about disclosure (Greene et al., 2013). Thus, preliminary evidence indicates that the BDI is effective.

The BDI is grounded in brief motivational interviewing. Brief motivational interviews consist of engaging motivational discussion (Miller & Rollnick, 1991). Brief motivational interviewing affords a shortened version of an intervention where participants are encouraged to reflect on specific behaviors or decisions through a brief tailored conversation with an interviewer. The BDI asks participants to assess the risks and benefits of disclosure and incorporates the three main DD-MM assessments of information, receiver (relationship quality and anticipated response), and efficacy. The focus of the BDI is on options and methods for sharing sensitive information.

A trained interviewer delivers the intervention to participants in three phases. The first phase asks participants, "If you were telling someone else about how to share their HIV status, what would you recommend? What would you say works well?" The first question in this section asks participants to identify recommendations for sharing their HIV status and is less threatening than asking participants about sharing their own HIV status. In this phase, participants are also asked about specific disclosure strategies including planning, location, non-face-to-face, practice, gradual disclosure, and hinting. The second phase asks participants to identify additional strategies they would use to disclose their own HIV status. These disclosure strategies include third party disclosure, taking another person when disclosing, and testing reactions. The interviewer also asks participants to assess the risks and benefits of using each strategy. The third phase asks participants to think about several people who do not know about their HIV status but they might tell in the

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*BDI applied to mental health.* This present mental illness application of the BDI is derived from the intervention tailored for HIV/AIDS. HIV/AIDS and mental illness are both highly stigmatized health issues, nonvisible (i.e., diagnoses must be shared), and share the misperception that the illness is not treatable. We propose that the BDI can also apply to mental illness and label this applied version the Brief Disclosure Intervention-Mental Illness (BDI-MI). This BDI-MI intervention is intended for participants living with a mental illness. This intervention is designed for people diagnosed with a mental illness who have undergone treatment rather than focusing on people in crisis or undiagnosed patients. For people who are in treatment, increasing social support through disclosure is also one way to maintain adherence to treatment, an added benefit.

The three phases in the original BDI are adapted for the BDI-MI. The goal of the BDI-MI is not necessarily for people to disclose but for patients to better anticipate outcomes, maximize productive social support, and decrease stigmatizing responses. In the first phase, participants are asked, "If you were telling someone else about how to share their mental illness, what would you recommend? What would you say works well?" In this phase participants are asked about the strategies identified in the original BDI: planning (e.g., having a script to follow), location (planning a specific place to disclose), non-face-to-face (writing a letter or email disclosing mental illness), practice (imagining the disclosure situation and possibly rehearsing dialogue), gradual disclosure (incremental disclosure where symptoms or medication are initially shared), and hinting (asking indirect questions about mental illness or saying you are not feeling well). The participants are asked to complete the risk/benefit assessment where they describe the risks and benefits of using each strategy for disclosure. For example, what is the upside of utilizing gradual disclosure? What is the downside of non-face-to-face disclosure? Follow-up questions and prompts ask about the benefits and costs or pros and cons of each specific strategy.

The second BDI-MI phase asks participants to identify any additional strategies they would use for disclosing their own mental illness. These strategies are in addition to the six aforementioned strategies in Phase I. These additional strategies include third party disclosure, for example, asking an immediate family member to tell a relative. Another additional strategy is taking another person when disclosing, for example, bringing a parent or sibling along when telling a friend about mental illness. The risk/benefit analysis continues in this phase when participants identify the benefits and drawbacks of using each of these additional strategies to disclose their own mental health issues.

The final BDI-MI phase asks participants to think about the people in their social network who do not know about the mental illness. The prompts ask how they would disclose this information to these people. Participants use the previous two phases to assist in developing this plan and weigh the risks and benefits of sharing the diagnosis. If participants disclose to someone in the near future, they should be better prepared for a productive interaction based on these strategies. Even if they choose not to share, participants should feel better equipped to disclose when they feel it is beneficial.

This modified BDI-MI intervention follows a very similar pattern to the original BDI because HIV/AIDS and mental illness have several similarities. It is likely that the BDI-MI will yield similar outcomes to the original BDI. HIV/AIDS and mental illness are similar, in part, because of the high levels of stigma associated with the disease. Results from the original BDI included increased disclosure efficacy, decreased anxiety about disclosure, and decreased worry about disclosure, which are also expected outcomes of the BDI-MI. The BDI-MI has the potential to decrease the stigma associated with mental illness by increasing social support, empowering people living with mental illness to share their story, and decreasing prejudice. By emphasizing the risk/benefit evaluation process, participants are better equipped to evaluate and likely avoid the most stigmatizing responses.

## CONCLUSION

Anti-stigma interventions have not experienced the sustained effects that were expected (see Heijnders, & Van Der Meij, 2006; Link & Phelan, 2001; Stuart, 2008; Watson & Corrigan, 2005). The prevalence of mental illness makes the illness and the problems associated with it far too significant to ignore. Stigma is a central feature that contributes to the challenges of people living with mental illness, including low self-worth and self-esteem in people living with mental illness, avoidance of medical treatment of mental illness, and as a barrier to achieving life goals. Disclosure is one way to decrease stigma and increase social support for people living with mental illness. The present BDI-MI intervention takes a step to prepare participants to engage in one form of contact interventions. The intervention is theoretically grounded, incorporates prior disclosure research, and has been previously tested with a stigmatized group. The adaptation to mental illness is a significant step forward.

Any future interventions should include a contact or interpersonal component; these positive effects are promising for stigma reduction (Corrigan & Gelb, 2006; Read et al., 2006; Watson & Corrigan, 2005; Yamaguchi et al., 2011). The scope of the effort is another consideration, and a model such as the BDI-MI for reducing stigma could empower people with mental illness to share their story. These suggestions for future anti-stigma initiatives and research could increase the chances of sustained attitude change toward mental illness. Anti-stigma efforts should include the narratives disclosed from people living with mental illness as those strategies have yielded positive effects (Corrigan & Gelb, 2006; Read et al., 2006; Watson & Corrigan, 2005; Yamaguchi et al., 2011). Finally, empowering people with mental illness to be proactive in disclosing and reducing stigma is something else that future initiatives should focus on such as current contact interventions.

In this chapter we propose a disclosure intervention tailored for people diagnosed with mental illness. The BDI-MI tailors an existing intervention designed for people disclosing their HIV status. The goal of the BDI-MI is for people with mental illness to increase efficacy by anticipating the outcomes of disclosure and increasing the amount of received social support. The BDI-MI follows three phases and utilizes several strategies to increase participants' efficacy and anticipate the

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response of the disclosure target. This intervention provides a valuable tool for increasing options for sharing. It also increases the range of potential strategies for participants to disclose their mental illness. The BDI-MI intervention can also apply to updates in mental illness treatment, not just diagnosis. This chapter outlines an intervention that can be implemented with people diagnosed with mental illness. Future research should test this BDI-MI intervention and track participants' progress over time. Communication-focused interventions are significant approaches to public health issues, and we need additional theory-grounded, effective interpersonal communication interventions to improve health.

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