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Star Shots: Stigma, Self-Disclosure and Celebrity in Bipolar Disorder

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1. Introduction

Recent public disclosure by Catherine Zeta Jones of her treatment for Bipolar 2 disorder and the list of other celebrities past and present who have also experienced mental health problems prompted us to explore the phenomenon of the self-disclosure of mental illness by such well known public figures given the risk of such disclosure. We asked these questions:

What does this mean for deepening understanding?

What does this mean for reducing stigma?

What is the role of self-disclosure?

2. Bipolar disorder

What a creature of strange moods [Winston Churchill] is – always at the top of the wheel of confidence or at the bottom of an intense depression. (Lord Beaverbrook (1879-1964), quoted in Manchester, 1984:24)

The above reference to Sir Winston Churchill's periods of fluctuating mood from elevation to depression sums up the most common presentation of the mood disorder generally known in Western society as Bipolar Disorder. The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (Text Revision), DSM-IV-TR, divides mood disorders into two basic categories: Depressive Disorders (also known as Unipolar Depression) and Bipolar Disorders (previously referred to as Manic Depression). These disorders are characterized by experiences of elevated or depressed mood. Whilst all people experience fluctuations in mood, people with mood disorders experience a sense of a loss of control of their moods and high degrees of subjective distress (Sadock et al., 2003).

The depressive episodes that accompany all mood disorders are not merely episodes of sadness. They are severe, distressing and prolonged episodes of depressed mood or loss of interest or pleasure that represent a change in previous functioning and significantly interfere with the person's ability to function socially, interpersonally or occupationally (American Psychiatric Association [APA], 2000). In addition to depressed mood and/or loss

of interest or pleasure, people with depressive episodes may complain of weight loss or gain, fatigue, restlessness, problems thinking or concentrating and may have recurring thoughts of death or suicide (indeed it has been estimated that up to 24% of Bipolar Disorder suffers will attempt suicide (Rihmer & Kiss, 2002)).

Manic episodes are not just periods of subjective wellbeing but are intense and prolonged episodes of elevated, expansive or irritable mood which, as with depressive episodes, are severe enough to cause impairments to occupational, relational and social functioning. In addition to the elevated or irritable mood, people may also experience grandiosity or inflated self-esteem, decreased need for sleep, racing thoughts and excessive involvement in pleasurable pursuits such as buying sprees and sexual activity (APA, 2000).

People who experience depressive episodes alone are said to have a Depressive Disorder and those who experience both elevated mood (manic episodes) and depressive episodes are said to have Bipolar Disorder (APA, 2000).

Whilst the above descriptions represent the broad parameters generally accepted as defining mood disorders (both depressive and bipolar), it needs to be acknowledged that each individual experiences mood disorders in different ways. In Bipolar Disorder, some people will experience more depressive than manic episodes whilst for others it will be the opposite. Some may have severe manic episodes whilst for others it may be the depressive symptoms that predominate. Episodes may occur following a psychosocial stressor whilst for other people they may appear out to the blue and can last from weeks to months, often with long periods in between where the person can be symptom free.

Falret first characterized Bipolar Disorder as a distinct illness in 1851. He termed the cycle of manic and depressive episodes with intervening symptom free periods "folie circulaire" or circular madness. Later Kraepelin (1899) coined the term "Manic Depressive Insanity" (Angst & Sellaro, 2000). However, descriptions of Bipolar Disorder date back to ancient times. Mood disorders describing melancholia and mania are mentioned by Homer and by Hippocrates (Marneros, 2008).

Bipolar Disorder today (whilst not common), is still a significant burden on the individual and society (Das Gupta & Guest, 2002). Some studies have shown a lifetime prevalence of between 1% and 5% for Bipolar 1 Disorder (Emilien et al., 2007; Marneros, 2008). A large national survey in Australia reported a 12 month prevalence of 0.5% for Bipolar Disorder with a more equal gender ratio when compared to major depression (Mitchell et al., 2004). An earlier study by Bebbington and Ramana (1995) based on first admission rates, concluded that the incidence of Bipolar Disorder was around 8–10 per 100 000 (a morbid risk of the order of 0.5%).

Given that the mean age at onset for a first Manic Episode is the early 20s, with some cases starting in childhood and adolescence, and given the high suicide risk, cost to the community is consequently high. Indeed Das Gupta and Guest (2002) estimated the annual direct and indirect costs of Bipolar Disorder in the UK to be around £2 billion. Of this, only 10% was attributed to the direct cost of treatment. However, this may only be the tip of the iceberg. There is evidence to suggest a high degree of misdiagnosis of BD with some studies showing an average gap of 8–10 years between the onset of symptoms and the correct diagnosis (Emilien et al., 2007; Firipis, 2010).

2.1 Treatment and care

Typically the treatment of BD falls into two categories: medication and psychological treatments. As has been noted, people with BD always have some degree of depressive symptoms. However, treatment with antidepressants alone can precipitate the onset of hypomania or mania. Consequently, treatment with a mood stabilizer (with or without an antidepressant) is usually the first line of treatment (Emilien et al., 2007). Lithium and Valproate are the most common mood stabilizers in use today. Antidepressants are also commonly used in some cases of BD although they may, as mentioned earlier, precipitate switching from depression to mania in some people. Atypical antipsychotics have also proved to be effective but these can have unpleasant or dangerous side effects as can the mood stabilizers such as Lithium.

In cases where people with severe Bipolar Disorder do not respond to pharmacotherapy, there is evidence that Electro Convulsive Therapy (ECT) can be an effective treatment for acute mania and bipolar depression. However, whilst it is still considered safe and effective, it is usually used as a last treatment option (Loo et al., 2011; Taylor, 2007).

Psychological treatments such as cognitive therapy, family focused therapy and psycho-education can reduce the risk of relapse and are an important adjunct to pharmacotherapy (Emilien et al., 2007; Sorensen et al., 2006).

There would appear to be a need to find more efficacious drug treatments that have fewer side effects and work across the range of symptoms and phases of the disorder. As well, more research is needed into non-pharmacological treatments that could reduce the use of medications and assist in avoiding hospitalization.

2.2 Experience

The lived experience of Bipolar Disorder is in stark contrast to the measured words of the diagnostic criteria that cannot convey the pain the sufferer experiences, nor the disruption the illness causes to their life and those around them.

I was terrified that I could feel so wrecked inside, terrified that something was horribly wrong with me and terrified that I didn't know how to tell anyone that I was slipping into a dark place. I felt tortured by my mind and I thought I could not contain myself or be contained by those I loved. (Anonymous, quoted in Licinio, 2005:828)

As has been discussed, BD can run a fluctuating course. It is not surprising that the illness can be misdiagnosed or the diagnosis delayed, sometimes for years. All people experience fluctuations of mood, often in response to external stressors. However, with people who suffer from BD, the stressors can coincide with the cyclic nature of the illness and be exacerbated by the illness. Also, the behaviours associated with the illness may in turn precipitate the external stressor making a feedback loop which further exacerbates the episode of illness.

I have this belief that stress sometimes brings out an illness. Maybe you have a predisposition just like you have a predisposition to diabetes or varicose veins, and you if don't get those variable things that cause, that would impact on them, you won't get the disease. (Anonymous, quoted in Sajatovic et al., 2008:721)

The wit, humour, creativity and energy that often accompany the elevated mood states of BD can spiral into grandiosity, insomnia, irritability and poor decision-making. The depressed mood can spiral down into deep depression and thoughts of suicide and suicide attempts. All of this has a negative effect on personal relationships, work, finances and physical and psychological well-being.

Diagnosis, especially after years of suffering, often comes as a relief. Whilst the accompanying self-disclosure to family, friends and work colleagues can be beneficial, it may also be accompanied by stigmatisation that adds further stress to an already stressful situation.

2.3 Diagnosis

As mentioned, many people experience a delay in diagnosis or misdiagnosis. After several episodes of elevated or depressed mood of varying severity, the person or their family come to a realisation that something is wrong. The individual may feel guilty for their behavioural excesses whilst in a manic state or be tormented by depression. When they finally do seek help they may be misdiagnosed with Unipolar Depression when presenting in a depressed state, or misdiagnosed with a psychotic disorder or anxiety when presenting in a manic or hypomanic state (Delmas et al., 2011).

When the diagnosis is finally made it may be accompanied by a sense of relief, as expressed here by Neil Cole, a former politician:

I must say I was then, as I am today, grateful for his diagnosis. He had done for me what no-one had done for me over the previous 15 years of trying; namely to establish what on earth was wrong with me! (Cole, 2004:671)

2.4 Treatment

Once the illness has been diagnosed, treatment can commence. As mentioned earlier, the first line of treatment will generally be pharmacological, usually a mood stabiliser and/or antidepressants. In some cases atypical antipsychotics will also be used. In most cases people with BD will experience initial relief from their symptoms.

The anger that used to overcome me, and the irritability, had done much damage to a lot of people. Worse still was a perception that my temper was very bad, which meant it was best not to get near me. It upset me when I lost my temper. Since my treatment with lithium it is hardly like what it was; in fact it's nothing like it was at all. (Cole, 2004:671)

Unfortunately treatment, like the illness, can also run a fluctuating course. After the initial relief drug treatment usually brings, there are often relapses and sometimes these are precipitated by the medications themselves. As has been discussed, antidepressants may precipitate a manic or hypomania episode.

My new antidepressants were good in stopping depression, but I couldn't sleep. Then as often happens when I don't sleep or I am on an antidepressant that over-stimulates me, I went high. I bought a house I couldn't afford, gave away money, became extremely anxious… (Cole, 2004:673)

It may be some time (perhaps years) before the right combination of medications can be tailored to the needs of the individual. Many people with Bipolar Disorder will need to grapple with an acceptance of the diagnosis and the possibility that they will be on medication for the rest of their lives.

Every night my husband and I embark on the ritual of laying out the pills just so, arranged by color. This is a constant reminder that I am bipolar and that I will be taking these meds for the rest of my life. I lay out the next morning's dose in a silver heart-shaped pillbox that has my initial on one side and 'Love Always, J' on the other. This pillbox is all about my husband's wholehearted acceptance of me as a bipolar woman. (Anonymous, quoted in Licinio, 2005:827)

Whilst medication and medication adherence is still the mainstay of treatment, factors effecting social supports and coping strategies also have an impact on rates of relapse. This realisation has seen a greater acceptance in the medical community of psychosocial approaches to treatment, including Cognitive Behaviour Therapy and Psycho-education amongst others (Sorensen et al., 2006). A strong therapeutic alliance with a trusted professional and strong family supports can assist treatment adherence and build resilience and other constructive changes in people with Bipolar Disorder (Lazarus & Lazarus, 1991; McEnany, 2005).

2.5 Coming out

However, the path to diagnosis, acceptance of the illness and treatment is not an easy one. Not least because it entails some form of self-disclosure to a health professional, family member or friend.

Self disclosure (SD) is an important part of building identity and relationships. It is a means by which we express thoughts and feelings, build intimacy within personal relationships and develop a sense of self (Chaudoir & Fisher, 2010). However, for people with a stigmatising mental illness such as Bipolar Disorder, it is of potential benefit and also a great risk as it may invoke the prejudice of others as following quotes illustrate.

He was admitted to the Psychiatric Department. It was hurtful to experience the gossip. Behind shop shelves, at Sunday parties: 'He's crazy'! Our friends just vanished. When important people abandon you, it really gets to you and undermines your identity, and I feel as if I'm the one being abandoned by them. And then; just silence. I was left sitting alone with the children, who were terrified. (Anonymous, quoted in Tranvåg & Kristoffersen, 2008:9)

The social impact of the illness as a general rule, it can either make or break friendships. It can make people encourage you and be supportive or they can totally leave you alone. (Anonymous, quoted in Sajatovic et al., 2008:721)

With this very real risk in mind, it is not surprising that people may try to hide their illness.

You close up and isolate yourself, you hide the disease so you try to look presentable when you're out, talk presentably, seem interested, you don't want to go to social things because you don't know if you can hide it anymore. (Anonymous, quoted in Sajatovic et al., 2008:721)

The fear and experience of stigma for people with a mental illness can be profound and have far reaching consequences.

3. Stigma and mental illness

The term "stigma" has its origins in Greece (Ng, 1997). It meant to mark the body with a burn or cut to signify that the person is shameful. With time, this meaning evolved to refer to a mark of disgrace with a negative connotation invoking rejection, stereotyping and discrimination (Ng, 1997). Goffman (1974) comprehensively discusses the interpersonal and intrapersonal forces of stigma resulting in a damaged sense of self and identity that is profoundly compromised. The stigmatised person is undesirably different and prone to be segregated and discriminated against. Indeed they are more likely to experience social exclusion across a number of domains (Sayce, 1998). In a qualitative study of self-disclosure and mental illness (Cross, 2009) one person with mental illness stated:

When I first found out I actually got more depressed because I didn't want to be mentally ill. I didn't want to think that there was something mentally wrong with me. It was just abhorrent to me the feeling; and I either was going to be depressed about it forever or had to come to terms with it. (Cross, 2009:133)

And another:

How I felt about my mental illness? I hated having it, I felt like I wasn't a full citizen, that my rights were taken away from me, that I had to take medication for the rest of my life. I didn't want to take drugs because it might have side-effects. (Cross, 2009:134)

Stigma is common for people with a mental illness with three out of four people reporting it. The labelling of people according to their illness stereotypes them and creates prejudice and discrimination (Corrigan et al., 2009). Stigmatised people with mental illness experience humiliation, guilt, despondency, despair, media misrepresentation and sensationalism and impaired help-seeking. Their families are also touched by stigma, giving rise to embarrassment, which in turn leads to avoidance and isolation (ARAFMI NSW, 2005; Corrigan et al., 2006; Hayes et al., 2008).

[N]ot many people understood mental illness and I think my family were embarrassed in a sense. Like my Mum had manic depression and … nobody understood her… None of her children understood, my grandfather didn't understand and people just kind of kept her away from society because she was different. That wasn't my experience but I still was afraid that people were embarrassed about my illness. (Cross, 2002:203)

Highet et al. (2006) showed that while 90% of respondents in their survey believe mental health is a significant issue in Australia, Australians do not have a clear understanding of mental illness. Another Australian study found that:

- almost 25% of people thought that depression was a sign of personal weakness and would not employ a person with depression
- 30% would not vote for a politician with depression
- 42% thought people with depression were unpredictable
- 20% said that if they had depression they would not tell anyone
- almost 66% thought people with schizophrenia were unpredictable and a 25% considered them dangerous (SANE Australia, 2009)

Francis et al. (2001) stated that surveys of the general population as well as consumers of mental health services indicate that a significant percentage believe that media representations (in both news and entertainment) of mental illness are mainly negative, biased and unbalanced. Further, this negativity contributes to less tolerant attitudes and for consumers had detrimental impact on their mental health (Ferriman, 2000; Granello et al., 1999; National Mental Health Association, 2000). Positive portrayals had little influence on attitudes (Domino, 1983; Thornton & Wahl, 1996; Wahl & Lefkowits, 1989).

3.1 Self-stigma

Self-stigma occurs when people internalise the negative messages and this leads to low self esteem, poor self-efficacy, despair, vulnerability and self loathing (Corrigan et al., 2009). Self-stigma results in avoidance of contact with others. In particular, the avoidance of mental health and social services, the consequences of which are further social isolation and loss of support networks. In the end, the person experiences a deterioration in mental health status and possibly an increased risk of suicide (Commonwealth of Australia, 2009).

Well … I'm sort of knocking myself all the time. I'm beginning to look beyond that, bit by bit. I'm the one that's stopping myself stigmatising myself, no-one else. I'm a very beautiful person people love. So I have nothing to be afraid of in that regard. (Cross, 2002:204).

So, given all this negativity around mental illness why do people like Catherine Zeta Jones disclose their Bipolar Disorder? Surely this is a great risk?

According to SANE Australia (2009), we all have a role in creating a mentally healthy community that supports recovery and social inclusion and reduces discrimination. The more sharing the facts about mental health and illness and talking openly about personal experiences of mental illness the better because when mental illness remains out of sight, the community continues to believe that it is shameful and needs to be hidden.

Stephen Fry, another celebrity with Bipolar Disorder, has gone to great lengths to promote understanding of the illness. He uses his fame, in his words, "to fight the stigma and to give a clearer picture of a mental illness most people know little about" (The Independent, 2006). He has taken this further with the BBC2 documentary, *The Secret Life of the Manic Depressive.* In this documentary he seeks advice from experts and connects with other celebrities with Bipolar Disorder, including comedian Tony Slattery, singer Robbie Williams and actors Richard Dreyfuss and Carrie Fisher as well as ordinary people to shed light on this life-long debilitating disorder.

We feel as if we "know" these people because of their celebrity and that we invite them into our lives and homes through a variety of media. Our intimacy with them enables a relationship that embraces self-disclosures that would normally remain private. That they experience mental illness and can still look stunning, land starring roles, have robust relationships and beautiful children can have a very positive effect on the stigma that is associated with mental illness. The media portrays them far more positively than many other people with mental illness.

Indeed, research has shown that people with mental illness tend to be depicted in the media (both news and entertainment media) as objects of mockery, violent, unpredictable,

bungling and inept (Thornicroft, 2006). This is confirmed by Australian studies (Hazelton, 1997) though recent Australian research suggests reporting may be improving (Francis et al., 2001).

Francis et al. (2001) reviewed the literature regarding media portrayal of mental health and illness, how it influences community attitudes towards mental illness, and the impact of mental health promotion in the media. They found that community attitudes are influenced by the negative coverage of mental illness (both fictional and non-fictional) and where the media is a major source of information, people are more likely to have disapproving attitudes towards people with a mental illness. Importantly, there appears to be an imbalance between the reporting of positive and negative mental health issues. Mental health promotional campaigns are thought to influence community attitudes more optimistically.

High profile celebrities break the stereotype and as a consequence are treated with respect and dignity. They speak on behalf of others to create an enabling environment that promotes support, decreases labelling and discrimination and challenges our assumptions. Of course there are exceptions to this where some celebrities have had to not only face the problem of mental illness but the unrelenting public scrutiny and ridicule from some sections of the media (Britney Spears [singer], Robert Downey Jr. [actor]); all of which exacerbates the stigma and shame surrounding mental illness. They would probably not welcome the exposure.

I actually think it depends on the personality. It really depends on whether you care about what other people think and whether you trust the [person] you are talking to. I know I've made some terrible mistakes. I haven't been the best person in the world. I wouldn't like to be a politician or a movie star, because they are under scrutiny of journalists all the time. Like I was reading about [a singer] who committed suicide. I thought well every part of his life is scrutinised and [judged]. I don't think I'd pass either if someone were to judge me, I wouldn't pass the moral test. (Cross, 2002:197)

It is important therefore to understand the role of self-disclosure.

4. Self-disclosure

Self-disclosure is defined as the process of sharing personal information, thoughts and feelings with others. Although Heidegger and Laing (Rosenfeld, 2000) both considered self-disclosure within their philosophical views it was Sydney Jourard (1964) who was the first to examine the conceptual basis of self-disclosure. Jourard claimed that in order to be healthy (or to have a healthy personality) a person must be courageous enough to be themselves with others. That is, through word and behaviour, to self-disclose.

Self-disclosure follows in the phenomenological traditions of Husserl (1859–1938) and Heidegger (1889–1976) where the concept of self-disclosure is closely related to the existentialist tenet of sharing "here and now" feelings and the humanistic tenet of authenticity. The authentic being acknowledges the truth of their feelings, needs and drives and communicates this with others. It involves being "genuine" and "real" which indicates openness with the world and an acceptance of that world *as it is*. This is the truth of self-disclosure (Chelune, 1979).

Spontaneity in self-disclosure relates to the here and now element and reflects a self-confluence to which an authentic being is attuned. There is an element of risk-taking in the act of self-disclosure. In a strong healthy interpersonal relationship the message should be accepted and this should encourage greater self-disclosure in both amount and level of intimacy (Jourard, 1964).

Mental health is distinguished by two common attributes. They are the individual's psychological end states and his/her ability to cope with and respond to stressful situations (Toukmanian & Brouwers, 1998). As previously stated, Jourard (1971:32) claimed that self-disclosure is "a means of ultimately achieving a healthy personality". However, early research only weakly supported Jourard's assertion. Cozby (1973) reviewed 11 of these early studies and could find positive associations in only three, whereas five actually demonstrated a negative association.

Other writers have agreed with Jourard's belief. Moreover, they have made connections between Jourard's position and physical health. In an infrequently reported essay, Jourard (1959:503-504) suggested that an individual's lack of self-disclosure could lead to physical ill health:

In the effort to avoid becoming known a person provides for himself a cancerous kind of stress which is subtle and unrecognised but nonetheless effective in producing … [a] wide array of physical ills.

Tardy (2000) revisited Jourard's hypothesis and concluded that several studies have demonstrated the link between self-disclosure (as either trait or behaviour), with health. Kowalski (1999) also identified many positive consequences of self-disclosure. These positive outcomes relate to physical and psychological well being, acquiring new insights into old problems, securing confirmation for thoughts and feelings and the satisfaction of engaging in meaningful relationships (Kowalski, 1999).

Self-disclosure is purposeful. The aim of disclosing may be to establish or strengthen a relationship, to confess, to inform or to reciprocate. An individual might disclose for catharsis, for self-clarification, self-validation, reciprocity, impression formation, relationship maintenance and enhancement, social influence, manipulation and possibly to remedy injustices or address stereotypes as occurs in celebrity disclosure (Rosenfeld, 2000).

The goal of the interaction influences self-disclosure and thus it is important to examine the goals that lead to self-disclosure. Goals differ when the target is a friend than when the target is a stranger. Are disclosure patterns different when the goal is different? Given specific goals, are there differences in beliefs, resources and strategies in self-disclosure?

According to Archer (1987) the goals of self-disclosure are both intrapersonal and interpersonal. As an intrapersonal goal it is a form of self-expression whereby the individual may reveal his/her innermost feelings. It may also be used to clarify the individuals thoughts, beliefs and for social validation. As an interpersonal goal, self-disclosure functions as a mechanism for social control where the individual may self-disclose in order to please others or to avoid reprisals from others. It is also used interpersonally to elicit self-disclosure from others and for the development of the relationship.

There are a number of other factors that moderate self-disclosure and a particularly important one in this context is that of the valence of the disclosure.

The valence of the disclosure relates to the value placed on the content by the speaker or the listener. Positive or negative values may be ascribed depending on whether the information perceived as "good" or "bad" and is judged on the perceived reaction of the listener.

Kowalski (1999) states that negative thoughts and feelings are more likely to remain concealed because they lead to embarrassment or humiliation or have serious implications. For example, some individuals will avoid unpleasant disclosures in an effort to prevent being a burden to the listener or upsetting them by negative disclosures. This conclusion was drawn in interviews with Holocaust survivors (Pennebaker et al., 1989). The researchers concluded that survivors typically did not disclose their experiences because they were attempting to protect the listener from physical and psychological distress. An alternate conclusion to be drawn from these studies, however, is that the survivors have experienced such trauma themselves and avoid disclosure to prevent reliving the trauma and exposing themselves to psychological distress. This is particularly evident in sufferers of Post Traumatic Stress Disorder (PTSD).

According to Dindia (1997), disclosure of stigmatising (negative valence) content such as information related to mental illness follows a dialectical process rather than a single act. That is, the information is revealed in pieces and built upon to create the whole story rather than being divulged in its entirety in the first instance. There appears to be an "unlayering" of information as the person reveals then conceals then reveals a bit more (Gard, 1990; Limandri, 1989; Marks et al., 1992). Limandri (1989:69) describes the nature of disclosure of stigmatising topics:

To perceive her/his condition as stigmatising, an individual experiences an underlying feeling of shame. The notion of hiding or concealment is intrinsic to and inseparable from the concept of shame. To avoid shame, the individual must avoid disclosure of the condition … This, however, cannot always be avoided. In fact, the individual may need to disclose her/his stigmatising condition in order to receive necessary health care.

Interpersonal control will also moderate self-disclosure. Anderson and Randlet (1994) found that high self-monitoring and self-control was significantly related to satisfaction with disclosure. They concluded that high self-monitors experienced increased satisfaction because they had a greater sense of interpersonal control and self-disclosed in a situation-specific strategic way. That is, the high self-monitor judged the interpersonal situation and disclosed as they perceived the listener's responsiveness. Bryan, Dodson and Cullari (1997) found an inverse relationship between self-monitoring and self-disclosure. They found that males had significantly higher self-monitoring scores than females. This sense of interpersonal control is important in that the disclosure of areas of privacy potentially gives the listener power over the discloser and renders him/her susceptible to rejection and other negative consequences.

Limandri (1989:70) argues:

The circumstances for voluntary disclosure must yield sufficient anticipated reward to counterbalance the disesteem and rejection that may result. The stigmatised person struggles with the conflict of the need to reveal due to a concomitant stressor versus the need to conceal due to further stigmatisation.

Petronio, Ellemers, Giles and Gallois (1998) examine self-disclosure in light of privacy and argue that communication boundary management explains why people want to control who knows private information about them. Boundaries relate to groups, families, organizations and communities. Rules govern the opening up of the boundaries that allow others to gain access to personal/private information. Some rules are tightly controlled and others loosely. Moreover, disclosure routines apply for some sorts of information. For example, some rules for disclosure may have been utilised for so long that they are invoked as a matter of routine: *"I never tell people my salary"*. Petronio et al. (1998) claim that the ramifications of the disclosure will determine access to the information contained within it. Once the information is shared, both parties to the disclosure have a responsibility for the management of the information. Petronio (2000) states that boundary rules regulate the flow of information to others, are influenced by motivations and gender, can be altered by events or ritualised. Boundaries must also be coordinated because the individual co-owns different information with different people or groups. Regardless of the nature of the relationship, the information is private and originally belongs to the individual.

In the study by Cross (2002:203) some of the participants stated that they would have difficulty in disclosing:

Psychiatric symptoms,

I would try to and there would still probably be certain things that I would keep to myself. Maybe what I was hearing or seeing [hallucinations] – I might say yes that's happening but not describe it.

Confusing thoughts,

Because sometimes I've just been in a situation where it's just happened and I sometimes my thoughts override what I say so but in general, I would find it difficult to describe.

Taboos,

I found that it would be easier to say things that I'm happy about or that I'm fairly kind of neutral things to me in my life. What I care most about or the money and the religion and stuff and that I found that it would be more difficult to talk about negative aspects of my life – like what I felt bad about or anxious about or things like that.

Families,

I wouldn't talk about my sexual abuse. I wouldn't talk about my father at all or my family. I think it's little things that you just don't want to talk about, the person in yourself. But a lot of the people I talk to … it's confidential so I don't mind expressing how I feel about my father and stuff.

According to Chaudoir and Fisher (2010:236), people with a mental illness carry a "concealable stigmatized identity". This means that they hold personal information that is devalued by society though hidden from others. Other types of information include HIV status, sexual orientation, experiences of abuse or assault. They will be seen as non-stigmatised and as such be acutely aware of the stereotypes and discrimination afforded the hidden identity. Moreover, their sensitivity to negative social cues could make them more burdened by their identity and experience such distress that it impairs performance (Quinn et al., 2004). Choosing to disclose these types of information requires an assessment of the risk depending on the recipient of the information and reasons for the disclosure. The effect

on the recipient of the disclosure and their response predicts whether the disclosure will produce a beneficial outcome or not. This is a complex decision to make.

Chaudoir and Fisher (2010) examine the interaction between internal and external factors involved in self-disclosure through the Disclosure Process Model (DPM). They assert that a feedback loop encompassing the antecedent conditions for disclosure (approach/avoidance goals) coupled with the disclosure event (content of the disclosure and response of the recipient) and mediating processes (alleviation of inhibition, social support and changes in social information) effects the long term outcomes for the individual, their relationships with others and broad social contexts. The interaction of these conditions through the DPM attempts to explain why self-disclosure might be beneficial or not.

Let's apply the example of celebrity (Catherine Zeta Jones; Stephen Fry and others) to the DPM. They have a concealable stigmatised identity. They made the decision to disclose this information at significant personal, professional and social risk. The reaction of the recipient(s) (general public, media) to this information was benign and they are admired for "coming out". Their disclosure led to others with mental illness to also reveal their problems with mental health and other related issues.

In addressing the mediating processes, we must consider three things: alleviation of inhibition, social support and changes in social information. Disclosure in alleviating inhibition permits celebrities to express hidden information leading to reduced suffering, and better overall wellbeing. Disclosure permits them to gain social support leading to greater liking, intimacy and trust. It also has the individual benefits with regard to improving their individual self-esteem. Disclosure contributes fresh information about their concealed Bipolar Disorder to the wider social context and impacts ensuing social exchanges based on the expectations of the community for regulated disclosure. This example is based on the assumption that both had the antecedent condition of a goal approach motivation. If they were motivated by avoidance goals, the outcomes might not have been so positive because they would have had more difficulty attending to positive cues, indeed, focussing on negative cues and the possibility of rejection thus potentially making the decision not to disclose.

More importantly, when celebrities disclose, they are in control of the disclosure event. Using Petronio's et al. (1998) explanation, celebrity self-disclosure in the context of privacy it can be seen why they would seek to want to control who knows private information about them. They can reveal as much or as little as suits them and when and in what situations thereby assuring themselves that sensationalism, "scoops", "tell-alls" are minimised. Boundary management, in this instance, is clear. They have set rules governing the opening of these boundaries to permit the general public to gain limited access to ordinarily personal/private information. In any case the information is private and originally belongs to that individual. The sharing of information induces all those party to the disclosure to be accountable for it (Petronio et al., 1998).

5. Summary

In this chapter we have attempted to shed light on the reasons why celebrities choose to disclose their diagnosis of Bipolar Disorder utilising self-disclosure literature and how this could contribute to reducing the stigma and social exclusion for people with mental illness.

Self disclosure is a complex and risk laden activity. However, where the factors around the antecedent conditions, the disclosing event and the mediating processes are right, the long-term outcomes for the individual and their relationships can be very positive. When celebrities can control these processes, disclosure by them may have a positive effect on society's attitudes to the hidden stigmatised identity. Whilst there is some risk of the disease becoming trendy (the naive "I want to be bipolar" phenomenon (Chan & Sireling, 2010)) or trivialised as the "disease du jour", it would appear that purposeful and deliberate celebrity self disclosure of the type modelled by Stephen Fry can be beneficial in reducing stigma. In this way celebrity self-disclosure can achieve benefits for others as well as the celebrities themselves.

Given that the World Health Organisation estimates that 25% of people will experience a mental illness across their lifetime and that it is the fastest growing occupational disability (World Health Organisation, 2001), there is a dire need for greater understanding of the stigmatisation of people with mental illness and how that can be mitigated. Mental Health organisations and governments are committed to increasing public awareness in the hope of reducing stigma and are undertaking numerous strategies in their quest for non-discrimination and social inclusion. If it takes a celebrity to influence others then we must acknowledge that this is a step in the right direction.

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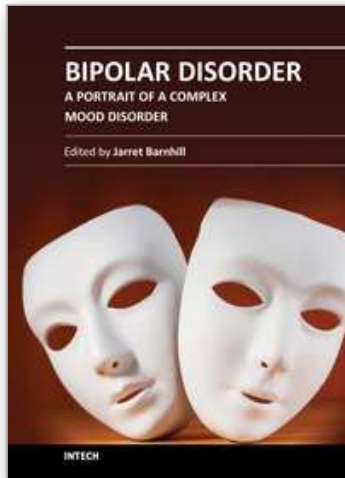
Bipolar Disorder - A Portrait of a Complex Mood Disorder

Edited by Dr. Jarrett Barnhill

Bipolar Disorder: Portrait of a Complex Mood Disorder is a step towards integrating many diverse perspectives on BD. As we shall see, such diversity makes it difficult to clearly define the boundaries of BD. It is helpful to view BD from this perspective, as a final common pathway arises from multiple frames of reference. The integration of epigenetics, molecular pharmacology, and neurophysiology is essential. One solution involves using this diverse data to search for endophenotypes to aid researchers, even though most clinicians prefer broader groupings of symptoms and clinical variables. Our challenge is to consolidate this new information with existing clinical practice in a usable fashion. This need for convergent thinkers who can integrate the findings in this book remains a critical need. This book is a small step in that direction and hopefully guides researchers and clinicians towards a new synthesis of basic neurosciences and clinical psychiatry

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