Psychological Services

Stigma Matters: An African American Psychology Professor Comes Out of the Mental Illness Closet

Lisa Whitten

Online First Publication, August 27, 2020. http://dx.doi.org/10.1037/ser0000486

CITATION
Whitten, L. (2020, August 27). Stigma Matters: An African American Psychology Professor Comes Out of the Mental Illness Closet. *Psychological Services*. Advance online publication. http://dx.doi.org/10.1037/ser0000486

Psychological Services

ISSN: 1541-1559

http://dx.doi.org/10.1037/ser0000486

Stigma Matters: An African American Psychology Professor Comes Out of the Mental Illness Closet

Lisa Whitten
State University of New York, Old Westbury

The debilitating stigma of mental illness is present in psychologists, psychology departments, and in the larger higher education environment. My reflections on my experience as an African American psychology professor living with bipolar disorder can shed light on how stigma can prevent colleagues from intervening and providing much-needed support to a colleague in crisis. I summarize the history of my struggle with mental illness and with the decision to write about it. I emphasize the importance of vigilance with respect to the fact that changes in medication can rapidly and radically impact one's mood and behavior. My insights as a prosumer can inform administrators, staff, and faculty as they develop policies and practices to assist employees with mental health concerns, which should include providing trusted colleagues with permission to contact a spouse, friend, therapist, and/or family member in the event of a change in behavior. The aim is reduced stigma, greater authenticity on the part of the person living with mental illness, and early intervention, similar to the response one would expect to a heart attack, to interrupt or prevent a prolonged episode of psychological distress.

Impact Statement

Due to concerns about stigma and its impact on their professional and personal lives, mental health professionals, especially those of African descent, rarely share the details of their own mental health concerns. Accounts of lived experience could enhance empathy for people with mental illness and inform the general public, the media, students, administrators, clinicians, and policy makers about the multifaceted challenges of improving mental health and reducing stigma.

Keywords: lived experience of mental illness, bipolar disorder, prosumer, African American professors, African American psychologists

The decision to write this article was not an easy one. It's clear to many of my friends, family members, colleagues, and students that I'm moody, sensitive, and not always good at masking my anxiety. But admitting to everyone that I live with bipolar disorder? That's a different matter. What would people think—especially my students and former patients? My colleagues might whisper, "Now she's really lost it!" Then there's the fact that few African American professionals of any discipline have written about their mental illnesses. It's just not a public conversation in our communities, in general. A noteworthy exception is the work of Terri Williams, a social worker and entrepreneur whose 2009 book *Black Pain: It Just Looks Like We're Not Hurting* was groundbreaking (Williams, 2009). Maybe, I thought, I should offer my insights.

It helps that I struggled with these questions in 2009 when I was writing my acceptance speech for the Association of Black Psychologists (ABPsi) Distinguished Psychologist Award. After considerable soul-searching and consultation with friends and family, I devoted about 8 min at the end of my 20-min speech to the serious manic episode I/we endured between 2000 and 2001 and the importance of reducing the stigma of mental illness. Having been involved in the organization for almost 30 years at the time, I felt it was a safe space to debut my new, even more open persona. My fantasy that I would be invited to speak or write about my experience by at least one person was not realized. I was also disappointed that not one of the 150 or so people in the audience asked for copies of my publications, which I had offered, half in jest, to "sign after the lecture." I do not know whether people were stunned by my revelation, embarrassed for me, or put off by the fact that I had "aired my dirty laundry in public." Maybe it was all of the above.

"What happened?" I asked myself. "What's the point of talking about this, of baring my soul and outing not just myself but my family?" I wanted it to make a difference! In the end, I decided that hearing my story could be useful to faculty, staff, administrators, and mental health professionals. After almost 20 years of reflection, I have some ideas about how I—and the mental health professionals with whom I was connected at the time—managed and mismanaged my acute illness.

I acknowledge my village for contributing to my mental health and happiness and Henry Wilkenson and Katherine Giscombe for their comments on this article.

Correspondence concerning this article should be addressed to Lisa Whitten, Department of Psychology, State University of New York, Old Westbury, P.O. Box 210, Old Westbury, NY 11568-0210. E-mail: whittenl@oldwestbury.edu

During childhood, adolescence, and young adulthood, my mood vacillated between normal and depressed. My mother shared with me that when I was a toddler, my grandmother once asked her, “Don’t you think Lisa looks a little sad?” At that time (the late 1950s), mental health professionals were just beginning to acknowledge that children could be diagnosed with depression. I was depressed on and off during most of my childhood. Whereas my younger sister was outside laughing, playing, and honing her naturally strong social skills, because of my social anxiety and depression I was inside watching TV, reading, or sewing. At times, my sister managed to drag me out to ride our bikes, but it was always hard for me. I remember that I often hated being a child and longed to be free of the uncertainty and lack of control associated with it. I was painfully self-conscious and frequently felt that I was the focus of adults’ ridicule. During my training as a clinical psychologist, I was certain that I would never treat children, because much of my childhood experience was so uncomfortable and unpleasant.

In adolescence, I became more active. During high school and college, my depressive episodes lasted approximately six to eight weeks at a time. In college, I spent many hours each week studying and visiting professors to prove that I was not wasting the numerous privileges that derived from my upper-middle-class status and because that level of commitment was necessary to earn good grades. That practice also allowed me to remain in my comfort zone—alone.

My social anxiety and depression were a significant burden in college. I knew I needed treatment, and during my sophomore or junior year at the University of Michigan I forced myself to find the counseling center. I distinctly remember that I picked up a brochure, turned around, walked out, and never returned. Perhaps if a receptionist or counselor had engaged me, I would have stayed. Further, I didn’t mention that visit to anyone.

I finally began many years of treatment at age 21 when I began working on my doctorate in New York. As I moved into graduate school and my professional career, I was involved in the ABPsi locally and nationally, as well as community service. I also spent time with friends and family in Detroit and New York. People often asked, “Don’t you ever get tired?” I didn’t—a strength I rely on to this day. I believe my constant activity was a counterdepressive measure. When I was focused on a task, I blunted the impact of my depression. Perhaps it was an indicator of potential hypomania. It’s impossible to know for sure. Either way, my depression and I remained close partners through my 20s and 30s with many extended periods of wellness.

When I reached perimenopause at the tender age of 40, my depression worsened significantly. In 1997, my psychologist of several years, upon my insistence, reluctantly gave me the name of a psychiatrist. I had resisted taking medication for several years because of the stigma associated with it, but I was really suffering. I started on a selective serotonin reuptake inhibitor (SSRI) antidepressant; 10 days later, I felt like a new person. It was as if a dark curtain had been lifted, revealing a world of possibilities. I bought an apartment and moved from Queens to Harlem, which improved my life significantly. Unfortunately, I was not pleased with the sexual side effects (muting my sexual responsiveness), so my psychiatrist and I began testing other medications.

My family history and some indicators that my enhanced mood could escalate into mania had prompted us to add a mood stabilizer to the SSRI I was taking at the time. I had already experienced a hypomanic episode in 1998 that lasted several months, precipitated by an antidepressant. It ended precipitously with another major depression. In 2000, I spoke with my psychiatrist about the fact that I had gained 20 pounds. He said that a new drug was being used as a mood stabilizer, and it was causing people to lose weight. I jumped at the opportunity. The significance of my near-obsession with staying thin would need to be addressed in a different article. Soon after I started taking the new drug, my life began to unravel. In September 2000, I lost the 20 pounds—and then I lost my mind.

Without delving into all of the unpleasant details, I undoubtedly met the criteria for Bipolar I. Initially, I felt powerful, sexy, brilliant, and creative. The self-conscious, painfully shy, anxious Lisa was gone! That part was actually liberating and enjoyable. Within a few months, though, the confidence gave way to humiliation, isolation, fear, and desperation. The medication removed many boundaries and filters; my judgment and impulse control were abysmal, and I experienced pain in every joint of my body. The pain became the focus of my life. I ran around to acupuncturists, chiropractors, massage therapists, and anyone else I could find to try to stop the pain. Fortunately, I had earned my tenure at SUNY Old Westbury, and I had teaching assistants who covered for me when I was late, which was 100% of the time. I was able to maintain my small practice without incident, in part because I was seeing only a few patients and because being in the room with my patients seemed to help me focus and feel competent. But what a miserable experience!

I now know firsthand the impatience, contempt, insensitivity, and anger people often express when interacting with people who are in psychological distress. I couldn’t understand why so few people seemed to have a clue as to what I needed to heal. I thought I was making my needs crystal clear.

Several faculty and administrators spoke to the chair of my department in 2001 after I arrived one-half hour late at the Honors Convocation, marched onto the stage to present the honors to our students, and botched the presentation, ruining our students’ special day. My colleagues knew something was awry; several of them asked my chair, “What’s wrong with Lisa?” but no one seemed to know what to do. I am certain that my mania could have been contained earlier if my colleagues had alerted my family. Hearing directly from someone at my college could have prompted my family to act more quickly and decisively.

Soon after the Honors Convocation debacle, someone announced in a department meeting that one of our outstanding alumni had been murdered. I began sobbing, and no one moved or said anything until I said, “I’m crying Is anyone going to comfort me?” I stood and started, then, screaming about the stress I was under and their lack of support. I stormed out of the room. Although one of my colleagues gathered my belongings and put them in my office, no one followed me out of the room and no one contacted me. One person sent me a brief e-mail several months later. My highly atypical emotional outburst was the mental illness equivalent of a heart attack, a seizure, or a stroke. In any of those instances, everyone would have launched into action, calling 911 and the Student Health Center. That’s the type of response I urgently needed. Three experienced, licensed, practicing clinical psychologists with whom I had worked for 10−15 years were present in the room, yet none of them was moved to respond to my distress.

After a year, I was exhausted and desperate to bring my nightmare to an end. I had been journaling with some regularity for about 30 years; it's part of what allowed me to extract myself from the quagmire in which I found myself. After the attacks on September 11, I was moved to pick up my journal. I hadn't written anything since the previous September, but I had recorded the date that I began the new drug that was supposedly a mood stabilizer. I realized that my life began to unravel soon after beginning the new regimen. I immediately contacted my psychiatrist, and we designed a plan to eliminate the problematic drug. I plunged rapidly into a deep depression. It took 9 months and several combinations and permutations of medication to stabilize me. I can still remember the day I began to feel better. Walking down the hall at school, I felt my heel lift from the floor with a bit more "spring."

It is important for me to share some recommendations that have grown out of my experience. I learned something critical from a psychiatric nurse, Ilene Gotkin, with whom I worked at a Woodhull Hospital, part of the New York City Health and Hospitals Corporation. When I described my ordeal to her, she said that her maxim in similar situations is "if a person taking medication begins to behave differently, consider the medication first." In addition, I think a good practice is to keep a record of major life events, fluctuations in one's mood, and any change in medication. Ideally, this information should be saved in more than one place, including an online site—because paper journals are easily mislaid, especially when one is in the middle of a manic episode. Fortunately, I never removed mine from my home, or it surely would have been lost along with the collection of glasses, cell phones, cameras, books, friends, money, and other valuables I lost that year due to the cognitive and emotional hurricane created by my Bipolar I diagnosis.

It would be a good idea for people living with mental illness to compile a list of individuals who should be called in the event of a change in their mental health status and a statement clearly describing how that change might look. The key, as with any illness, is to intervene *before* an acute mental health crisis has blossomed into a chronic mental health emergency. It's critical that people know what one's behavior might look like at the beginning of an episode so that it can be addressed early. In my case, that would include a longstanding depressed mood (more than two weeks) or hypomania (compulsive talking, interrupting others inappropriately, heightened irritability, and unusual behavior in meetings or the classroom).

The statement and list of contacts can be shared with as many trusted colleagues as possible and placed in the Human Resources file. Because this goes against current popular wisdom and legal protocol related to sharing private health information, a signed (and perhaps notarized) consent form that the individual has agreed to make it available should be included. Alerting the appropriate contacts could interrupt or avoid a prolonged episode. In addition, it's wise to share with friends and family any steps that should be taken in the event of a recurrence of problematic behavior. An excellent resource is the Wellness Recovery Action Plan (Copeland, 2010), a comprehensive system for anticipating and managing crises and moving toward wellness. It has been adapted to assist people with a range of difficult life situations.

I have struggled to accept that I am living with bipolar disorder. The fact that I'm an African American woman means that I am often stigmatized and subjected to a different level and type of scrutiny and evaluation by students, colleagues, and the larger society. This reality always informs my behavior. I strive to keep in mind the second principle of the Nguzo Saba (Swahili for "Seven Principles") of Kwanzaa: Kujichagulia (Swahili for "self-determination"), the African American cultural celebration designed by Maulana Karenga in 1966. *Kujichagulia* means defining, creating, naming, and speaking for oneself (Karenga, 2008). Given my tendency to personalize and to be self-critical, this is an ongoing challenge.

With the help of several talented therapists, I have learned to monitor and regulate my moods and my behavior. My family and some of my friends and colleagues gathered around me, establishing a supportive "village" as I recovered from my manic episode. They have played a vital role in my 20 years of emotional stability. They made it possible to recover without the additional stigma of hospitalization. I have learned that had I been hospitalized, I would not have been able to obtain long-term care insurance, a vital resource for me because I live alone and have no children.

I am still striving to embrace my mood disorder as part of who I am, without judgment. As I try to reframe and destigmatize my mental health issues, I remind myself that my hypomanic tendencies probably helped me to earn a doctoral degree, tenure, and promotion, as well as the ABPsi Distinguished Psychologist Award. Even though the wrong medication threw me off for a while, the correct combination of medications continues to be tremendously beneficial; I do not regret having started it. Enduring my severe manic episode also gave me meaningful insight into the experience of others with even more severe and persistent mental illness. I recall that when I was manic, I felt a distinct kinship with and empathy for individuals who were acting out in public or seemed otherwise to be mentally ill or in distress. This has been invaluable in my evolution as a human being, therapist, and teacher.

I believe that sometime soon, living with a mental illness will be seen as different—maybe even unusual—but not as a deficiency or as worthy of stigma. Shame, the efforts to mask one's symptoms, and self-stigma drain valuable energy that could be better devoted to self-improvement and to building strong families, careers, and communities. One of the principles of Ntu psychotherapy, an African-centered model developed by a late past president of ABPsi, Fred Phillips (Phillips, 1990), is authenticity. I hope that by reducing and ultimately eliminating stigma, we can provide space for more people with mental health issues to be their authentic selves.

References

Copeland, M. E. (2010). *WRAP: Wellness recovery action plan plus*. Dummerston, VT: Peach Press.

Karenga, M. (2008). *Kwanzaa: A celebration of family, community and culture* (2nd ed.). Los Angeles, CA: University of Sankore Press.

Phillips, F. B. (1990). NTU psychotherapy: An Afrocentric approach. *Journal of Black Psychology, 17,* 55–74. http://dx.doi.org/10.1177/00957984900171005

Williams, T. (2009). *Black pain: It just looks like we're not hurting*. New York, NY: Scribner.

Received May 15, 2019
Revision received May 27, 2020
Accepted June 6, 2020 ■