17

Coming Out
Intrapersonal Loss in the Acquisition of a Stigmatized Identity

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Coming out of the closet is generally viewed by people within the queer communities and "liberal" others as a good thing. The ability to be authentic, engage with fellow members of a community, and form close, meaningful relationships with others of the same sex must surely be seen as goals anyone would desire—sort of like joining the Scouts or Guides. Why then are so many members of these communities plagued by mental health issues?

While I wholly agree with Moradi, Mohr, Worthington, and Fassinger (2009) that "defining a sexual minority population of focus carries with it challenging scientific (and political) tensions and consequences" (p. 6), the length and scope of this piece necessitates choices about population groups. I am choosing to simplify the discussion by focusing on gay or lesbian identified individuals and regret that space considerations do not permit a fuller discussion of bisexual, transgendered, and other queer identities.

According to Frost and Meyer (2009), "Theories of identity development among lesbians, gay men, and bisexuals (LGB) suggest that … overcoming internalized homophobia is essential to the development of a healthy self-concept" (p. 98). For Kashubeck-West, Szymanski, and Meyer (2008), "It is imperative that counseling psychologists adequately assess and address external and internalized heterosexism" (p. 616), because, as Hatzenbuehler (2009) comments after a comprehensive review of the research, "stigma-related stress ultimately influences the pathogenesis of mental health among sexual minorities" (p. 710).

The term *coming out* is considered herein to be the process whereby one's assumption, present throughout one's early years, that one has an exclusively heterosexual orientation is gradually replaced by the recognition of a homosexual

orientation. Troiden (1989) reports on the "identity confusion stage, which usually occurs during adolescence, (followed by) … the identity assumption stage, the individual comes out as a homosexual" (as cited in Beatty, 1999, p. 597). Coming out, then, is an internal process that may or may not involve external declaration, and queers "have internalized an abundance of consistently negative and devaluing messages about homosexuality even before the subjective awareness of sexual attraction to members of the same sex. These values are usually ingrained well before the beginning process of labeling oneself as gay" (Burgoyne, 1994, cited in Cornelson, 1998, p. 265). And "since sexuality is a manifestation and expression of sexual orientation, the ability … to integrate … orientation into [the] overall personality is crucial to [the] achievement and maintenance of a healthy sexuality" (Cornelson, p. 263).

The queer identity then is one that is acquired—unlike some other stigmatized identities that may have been present from birth. Fundamental to the acquisition of this identity is the necessary loss of privileges attending the heterosexual identity, yet this profound loss is scarcely addressed within writings on homophobia. Jones (1985) and Walter (2003) are notable exceptions, as they observe that "these losses … might include rites of passage such as marriage and children in a climate of open support, or the right to speak openly about a partner" (cited in Green & Grant, 2008, p. 282).

What does it mean to lose the assumption that one is heterosexual? Janoff-Bulman (1992) identifies three major categories of assumptions: that the world is benevolent, meaningful, "a good, decent, moral person deserves positive outcomes" (p. 9), and the self is worthy and of value. When queers metaphorically step out of the world of the majority into the realm of the sexual minority (when the "them" becomes "me"), they become "victims" of heterosexism. What characterizes victim populations is that their members hold "basic assumptions about the benevolence of the world, the meaningfulness of the world and their own self-worth [that] are generally more negative than those of their non-victim counterparts" (Janoff-Bulman, p. 73).

It is a commonly held belief that queer-identified people "choose" their orientation (as evidenced by the still-prevalent use of the term *sexual preference*) and therefore deserve to suffer, in accordance with the "just world theory" postulated by Melvin Lerner (cited in Janoff-Bulman, 1992, p. 9). This etiologic myth, combined with the support heterosexism receives from its embedded ideological position within dominant culture, places mourning the loss of heterosexual privilege under the rubric of disenfranchised grief. The "disenfranchised griever is prone to experience an underlying sense of alienation and loneliness, shame and abandonment" (Kauffman, 2002, p. 68). A state of being that approximates that of the victim populations.

At this point I would like to invite you to participate in an exercise I have used repeatedly with individual clients and when providing workshops on diversity awareness, as it invites both empathy and compassion for anyone (including the self) engaged in the coming out process and may enrich the discussion. If you do not have time to do this right now by all means skip ahead, but please consider returning to it later:

1. Write "Gay/Lesbian" in the center of a piece of paper and circle it.
2. Generate as many derogatory terms as you can think of to describe gay men and lesbians, and write them down around the outside of the circle with arrows pointing toward the center. Clients may need to be encouraged to do this fully as some of the words are "rude." The list will generate responses such as *faggot* and *muff-diver*.
3. Now write down (if possible in a different color) the thoughts or feelings behind these words. Examples of thoughts might be, "They threaten the family," or "They should be locked up." Again, send arrows from these words to the center.
4. Consider what messages some of our institutions might add to this circle, and write them down. As an example, some religious institutions may proclaim that homosexuals are damned for eternity. Similarly, a medical establishment may not regard two men as both being a child's father.
5. Have a look at this circle. Notice the thoughts, feelings, and beliefs targeting the center. Now erase the words "gay/lesbian" and replace with the word "Me." Imagine suddenly finding yourself in the middle of this circle. Imagine that happening at 17 if you are a boy, 19 if a girl (the average age of coming out to self; McKay, 2006).
6. Now write down how you think you would feel about yourself. Consider to whom you would turn and with whom you might share this insight into yourself. Imagine for a moment what you have lost. Write down these losses.

This exercise is helpful in normalizing internalized homophobia and locating the source as heterosexism external to the individual. It also begins to normalize associated losses.

What grief theory has to offer queer reality is, I think, an acknowledgment that these losses are legitimate. For Kauffman (2002), the disenfranchised grieving self is turned inward, wishing repair but instead repeatedly attacking itself with its own worthlessness. Self delivers and receives on behalf of society a message such as, "Do not allow this grief to be real for you." Self enforces and abides by the order disallowing grief (Doka, 2002, p. 61). So the mourner is denied the possibility of moving through a process that facilitates integrative healing.

Ramirez (1991) and Steenbarger (1993) stress that multicultural therapists emphasize "it is the lack of fit between the minority client and the dominant culture—and not a deficit internal to the client—that is often the source of presenting problems" (as cited in Leahy & Dowd, 2002, p. 199). Yet merely reframing the experience for individuals and inviting them to consider their losses in light of this understanding are not sufficient interventions to mediate the negative mental health outcomes associated with the acquisition of a queer identity. We must instead look more closely at the process of internalizing negative beliefs and the function of shame in disenfranchised grief. We may then be better positioned to understand how individuals may, in the words of Frost and Meyer (2009), "negotiate this stigma and develop positive self-concepts in the face of it through counseling" (p. 107).

For Kauffman (2002), "Shame is the psychological regulator allowing and disallowing recognition of grief" (p. 63). It seems that without the belief that the mourner is entitled to grieve, grief will not occur. Corr (1998/1999) sees the disenfranchising of the grief process as an "active situation of disavowal, renunciation and rejection" (as cited in Green & Grant, 2008, p. 284). In self-disenfranchisement who may we regard as initiating this activity and who is the recipient?

Given that we are talking about mechanisms that occur within the psyche, an exploration of some of the assumptions about the psyche that inform personality theories may be helpful in pointing to ways self-disenfranchisement may be best approached. The traditional model of grieving is heavily influenced by psychoanalytic assumptions. Sigmund Freud understood grief as an "intrapsychic process of decathexis, the painful divestment of libidinal energy from memories of the lost object" (Whiting & James, 2006, para. 1). Most mainstream bereavement theories "have been psychologically orientated stage or phase theories, whilst others have been task focused" (Corr, 1998/1999; Greenstreet, 2004; Walter, 1999 in Green & Grant, p. 277). In recent years, however, these theories have been criticized for "on the one hand for being overly generalizing and prescriptive, and on the other hand for not acknowledging the socially constructed nature of categories that are highly regulatory and normative" (Corr, 1998/1999; Greenstreet, 2004; Walter, 1999 in Green & Grant, p. 277).

These and other critiques invite us to consider "a more growth-oriented paradigm of bereavement … as counselors … jettison explicit models of grieving altogether … to work in a way that has greater fidelity to the lived experience of their clients" (Neimeyer, cited in Rothaupt & Becker, 2007, p. 13). In support of this shift "both Worden (2002) and Rando (1995) have argued for a fluid understanding of mourning," one in which these elements (formerly ascribed to a specific stage or task) can and do exist simultaneously" (cited in Servaty-Seib, 2004, para. 10).

Contemporary cognitive psychotherapy holds the view that "emotional and behavioral problems … reflect the operation of a cognitive deficit or vulnerability… the primary therapeutic agenda is to change the client's beliefs in the direction of warranted standards of rational and/or objective thinking" (Lyddon & Weill cited in Leahy & Dowd, 2002, p. 198). In practice the goal here is to get clients to think like the therapist. Interpersonal and systems theorists maintain "an ongoing dialectical controversy regarding the relative degree of causation attributable to interpersonal and interactional as opposed to individual forces in determining behaviour" (Barone, Hersen, & Van Hasselt, 2004, p. 57).

All of these frameworks for counseling and therapy have embedded within them the assumption of the single subject, however, as Chandella (2008) points out: "Long before Freud, monistic definitions of self were being supplanted by hypotheses of dipsychism (dual selves) and polypsychism (multiple selves). There has been a discursive explosion in recent years around the concept of 'identity', within a variety of disciplinary areas, all of them, in one way or another critical of the notion of an integral and unified identity" (p. 61).

Bereavement counseling, as currently practiced, is rooted in the notion of a single fixed identity, which makes a discussion of intrapsychic loss problematic and confusing. I would like to introduce the concept of intrapersonal loss to more

clearly define the mourning process that is occurring within the individual. The language forms we have supporting the monolithic model of the personality are not adequate for the task of describing this process and result in confusion. Kauffman's (2002) work exemplifies some of the difficulty: "Giving to oneself, self is, in the very difference between giving and receiving, not itself. That is, in the very act of giving, constituting itself, self is not itself" (pp. 67–68).

The notion of the self may be a relatively recent construct. Passmore (1985) explains that the "historic European idea of 'self' equated personal identity with the continuity of memory: 'identity' was linked to our ability to think of ourselves as being one and the same indivisible self at different times and different places" (cited in Dunning, 1993, para. 7). Revisiting this construct has led Dunning to declare, "The indivisible Cartesian self seems to be an anachronism at the close of the twentieth century" (para. 3). For Howell (2008), "The 'self' is plural, variegated, polyphonic and multi-voiced. We experience an illusion of unity as a result of the mind's capacity to fill in the blanks and to forge links" (p. 38).

Implicit in Freud's decathecting from the internalized loss object is the single "I," yet object relations theory, which may be regarded as the bedrock of grief counseling, offers the possibility of a polypsychic model. Leowald (1962) determined that "internalization may be understood as "certain processes of transformation by which relationships and interactions between the psychic apparatus and the environment are changed into inner relationships and interactions …. This is the process by which internal objects are constituted" (as cited by Kauffman, 2002, p. 73). So *object relations* may refer not simply to one subject engaging with multiple objects but also to multiple internal relationships with multiple internal subjects. Howell (2008) supports this view, stating that "an internalized object must include the assumption of an internalized object relationship (in which) … both the self component and the object component have subjectivity," which inevitably leads us to "conceptualizing a multiple self as internalizing relationships" (p. 42).

Clayton (2005) addresses the resistance the view of multiple selves encounters: "In the health professions there is widespread agreement that dissociative identity is dysfunctional and needs to be cured. This position is based on the assumption that the healthy self is unitary and therefore multiplicity must be disordered" (p. 9). Adopting a more open view of multiplicity then "depends on and informs a major shift in notions of the self, therapeutic research and practice, and social attitudes in general" (Clayton, p. 17). All of these shifts challenge us as counselors and as human beings.

Rowan (1990) regards the development of subpersonalities as "autonomous or semi-autonomous parts of the person" (p. 61), noting that it "seems to be a regular temptation of people working in this field, to try to classify the subpersonalities in some way" (p. 85). He refers to many theorists, including Freud on the superego, Carl Jung's complexes, Ferrucci's subpersonalities, Watkins and Johnson's ego-state theory, Berne's model of transactional analysis, Stewart Shapiro's concept of subselves, the voice dialogue work of Hal Stone and Sidra Winkelman, the "potentials" of Alvin Mahrer, Virginia Satir's work with parts, and the work of Genie Laborde in neurolinguistic programming.

Similarly, Schwartz (1995) observes that "self psychology speaks of grandiose selves versus idealizing selves; Jungians identify archetypes and complexes …. Gestalt therapy works with the top dog and the underdog; and cognitive-behavioural therapists describe a variety of schemata and possible selves … [suggesting] that the mind is far from unitary" (p. 12). For Nerken (1993), "Alone among entities, the self reflects on itself—is at once subject and object" (cited in Rothaupt & Becker, 2007, p. 6), and this theme is echoed again in Rivera (1996): "The unmentioned or hidden 'multiplicity' in all of us comprises the many distinct and separate facets of a person's personality, the many ways of being which make up the 'whole' individual called 'I'" (cited in Clayton, 2005, p. 12).

Schwartz's (1995) Internal Family Systems (IFS) model appears to be the most effective for addressing intrapersonal loss when compared with other models that incorporate multiplicity. Pedigo (1996) notes, "it is apparent that IFS includes a fuller, more articulated concept of self" and that the "multiplicity of the mind is the most fundamental principle in the IFS model" (p. 269). Deacon and Davis (2001) agree that "IFS has moved family therapy into the new realm of the internal system" (p. 45). Rothaupt and Becker (2007) in their review of Western bereavement theories conclude that "new methodologies are providing in-depth exploration into the art and transformation of bereavement" (p. 13). IFS is one such methodology, and "to understand the IFS model is to … appreciate a new paradigm in the fields of individual and family therapy" (Pedigo, p. 269). Within the IFS framework the mind is made up of many parts. A part is a "discrete and autonomous mental system that has an idiosyncratic range of emotion, style of expression, set of abilities, desires and view of the world" (Schwartz, p. 34).

The final concept central to the model is the self. The self has the capacity to view the whole system from an overall metaperspective and may be regarded as the "centerpiece of the IFS model" (Schwartz, 1995, p. 35). The self is characterized by the presence of the following qualities: calmness, clarity, curiousity, compassion, confidence, courage, creativity, and connectedness.

In his book *Internal Family Systems Therapy* (1995), Schwartz offers a critique of many of the embedded beliefs that inform the contemporary view of the self, including original sin; Darwinism and its influence on Freudian, behavioral, and evolutionary psychology; and developmental psychology and learning theory. He offers a move away from the pathogenic view of the human being. His understanding of self corresponds somewhat to the "willingness, openness and … gentle, kindly, friendly awareness" present in mindfulness-based treatment approaches (Baer, 2005, p. 15), but what makes his approach truly salutogenic is his recognition that, unlike the view held by many mindfulness-based practitioners, "avoidance (of painful material) is not necessary and may be maladaptive" (Baer, p. 15). Schwartz maintains that all "parts" (including avoidant parts) are functioning in ways they regard as necessary for maintaining the health and integrity of the system. While some may be "destructive in their present state," these behaviors may be seen as a result of a "good part forced into a bad role" (Baer, p. 16). Bringing the quality of nonjudgmental curiosity to those parts reveals "the reasons that had forced them into those roles and their shame at what they had done" (Baer, p. 16).

However, for Schwartz (2001), the self is not merely the passive observer; it has "emergent compassion, lucidity, and wisdom to get to know and care for these inner personalities" (p. 36). He maintains that "most people have a poor self-concept because they believe that the many extreme thoughts and feelings they experience constitute who they are" (Schwarz, 1995, p. 17), so as Lester (2007) rightly concludes, "The possibility of attributing negatively valued aspects … of oneself to one or more subselves may enable the individual to maintain high self-esteem" (p. 10). Within the IFS model we have a method for working concretely with the parts of the system associated with disenfranchised grief.

Returning to Kauffman's (2002) understanding of shame as the psychological regulator that disallows grief through internal attack, we can now inquire about how the shaming part may be of value to the system. When a part is bringing criticism into the system such as that described by Kauffman, the IFS model understands that part to be a protective "manager." These protectors are invested in controlling "your relationships and environment so that you're never … humiliated, abandoned, rejected, attacked or anything else unexpected and hurtful" (Schwartz, 2001, p. 127). We generally do not like the parts with the critical voice, but if we can bring qualities of self to them—such as curiosity about their role—they will tell us more about their function and beliefs.

We can "interview" a part using direct access whereby the therapist or counselor speaks directly to the part, as in this example from Yalom (2002): "I also know there is some particularly reckless or careless part of you. I want to meet and to converse with that part" (p. 120). Or we can invite the client to focus internally and engage with the part. There may be parts of the client who do not wish to engage with the manager part—so those parts can be asked to step aside and allow the client's self to get to know the protector. When the manager part is asked about its protective role it will often reveal that it is preventing the system from becoming overwhelmed by other parts. In the case of a shaming manager, it might fear that if it did not do its job then parts grieving the loss of heterosexual identity and privilege would overwhelm the system—with what it perceives as disastrous results.

The parts that carry extreme feelings and extreme beliefs that the manager parts seek to protect us from are called "exiled" parts in this model. These are the parts that experience our vulnerability, and according to Schwartz (2001) there are good reasons to fear them: "They can pull us into black holes of emotion or memory, interfere with our functioning, draw us toward or keep us attached to hurtful people, and get us rejected or humiliated by people who disdain vulnerability" (p. 118).

In working with the shaming manager part we can be curious about and address its concerns. It may be worried that the exiles will overwhelm; we can assure it that they can regulate their affect. It may have anxiety that getting to know exiled parts will result in "external" changes in behavior; we can assure it that no change will occur without its permission. It may wish to negotiate a different role—more of a valve than a block—so that it will let some information through to the system from the exiled parts. When its concerns have been heard and addressed and its conditions satisfied, it may be willing to allow access to the exiled parts. When that happens we are in the familiar territory of affect-laden grieving parts. For

people transitioning to a queer identity there will be a part or parts that need to vent their protest, others in shock and disbelief, some with intense sadness, shame, and regret, others still in depression, and even sometimes despairing and suicidal parts—all existing simultaneously and wanting our attention. Small wonder the manager part feels such a strong need to protect us.

When individuals are finally able to hear the parts of their system grieving the loss of heterosexual identity and privilege and when those parts are responded to with compassion, then grief is no longer disenfranchised, and the individuals are freed up to engage in the process that will lead to a healthy integration of the new identity.

I have focused this discussion narrowly on a specific area of disenfranchised grief but the process of working with intrapersonal losses can be of value for any acquired stigmatizing identity—for example, that of becoming disabled or a woman. This method can also be used for any loss in which shame may be a factor inhibiting access to the grieving parts. Additionally I consider the IFS method to be a valuable tool in working with past losses that may be activated by present circumstances.

If indeed as Atig (1996) asserts, "Bereavement therefore prompts us to 'relearn the self'" (cited in Neimeyer, Prigerson, & Davies, 2002, p. 239), then it behooves bereavement theorists to reexamine our understanding of our own self and consider how our unexamined beliefs may inform and limit our practice. If in so doing we notice a voice saying, "I don't need to do that," and another that is more open to the idea, perhaps we may get an inkling of our own interpersonal processes, opening the door to our increased receptivity to the experience of those we seek to serve.

REFERENCES

Baer, R. (2005). *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*. San Diego: Academic Press.

Barone, D. F., Hersen, M., & Van Hasselt, V. B. (Eds.). (1998). *Advanced personality*. New York: Plenum.

Beaty, L. (1999). Identity development of homosexual youth and parental and familial influences on the coming out process. *Adolescence, 34*(135), 597–601.

Burgoyne, R. (1994). Counselling gay male couples living with HIV. *Canadian Journal of Human Sexuality, 3*, 114.

Chandella, N. (2008). I have that within which passeth show. *International Journal of the Humanities, 6*(2), 61–70.

Clayton, K. (2005). Critiquing the requirement of oneness over multiplicity: An examination of dissociative identity (disorder) in five clinical texts. *E-Journal of Applied Psychology, 1*(2), 9–19.

Cornelson, B. (1998). Addressing the sexual health needs of gay and bisexual men in health care settings. *Canadian Journal of Human Sexuality, 7*(3), 261–271.

Corr, C. A. (1998/1999). Enhancing the concept of disenfranchised grief. *Omega: The Journal of Death and Dying, 38*, 1, 1–20.

Deacon, S., & Davis, J. (2001). Internal family systems theory: A technical integration. *Journal of Systemic Therapies, 20*(1), 45–58.

Dunning, W. (1993). Post-modernism and the construct of the divisible self. *British Journal of Aesthetics, 33*(2), 132–141.

Frost, D., & Meyer, I. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56*(1), 97–109.
Gold, S., & Bacigalupe, G. (2004). Interpersonal and systemic theories of the personality. In D. Barone, M. Hersen, & V. Van Hasselt (Eds.), *Advanced personality*. New York: Plenum Press.
Green, L., & Grant, V. (2008). "Gagged grief and beleaguered bereavements?" An analysis of multidisciplinary theory and research relating to same sex partnership bereavement. *Sexualities, 11*(3), 275–300.
Greenstreet, W. (2004). Why nurses need to understand the principles of bereavement theory. *British Journal of Nursing, 13,* 10, 590–593.
Hatzenbuehler, M. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730.
Howell, E. (2008). *The dissociative mind*. New York: Routledge.
Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* Toronto: Maxwell Macmillan.
Jones, L. (1985). The psychological experience of bereavement: Lesbian women's perceptions of the response of the social network to the death of a partner, Dissertation Abstracts International 46/09: 2566.
Kashubeck-West, S., Szymanski, D., & Meyer, J. (2008). Internalized heterosexism: Clinical implications and training considerations. *Counseling Psychologist, 36*(4), 615–630.
Kauffman, J. (2002) The psychology of disenfranchised grief: Liberation, shame, and self-disenfranchisement. In Doka, K. (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice.* Champaign, IL: Research Press.
Leahy, R., & Dowd, T. (2002). *Clinical advances in cognitive psychotherapy: Theory and application.* New York: Springer Publishing Company.
Lester, D. (2007). A subself theory of personality. *Current Psychology, 26*, 1–15.
Lyddon, W. J., & Weill, R. (1997). Cognitive psychotherapy and postmodernism: Emerging themes and challenges. *Journal of Cognitive Psychotherapy, 11*, 2, 75–91.
McKay, A. (2006). Sex research update. (1), 47.
Moradi, B., Mohr, J., Worthington, R., & Fassinger, R. (2009). Counseling psychology research on sexual (orientation) minority issues: Conceptual and methodological challenges and opportunities. *Journal of Counseling Psychology, 56*(1), 5–22.
Neimeyer, R., Prigerson, H., & Davies, B. (2002). Mourning and meaning. *American Behavioral Scientist, 46*(2), 235–251.
Pedigo, T. B. (1996). Richard C. Schwartz: Internal family systems therapy. *Family Journal, 4*(3), 268–277.
Ramirez, M. III. (1991). *Psychotherapy and counseling with minorities: A cognitive approach to individual and cultural differences.* New York: Pergamon.
Rothaupt, J., & Becker, K. (2007). A literature review of Western bereavement theory: From decathecting to continuing bonds. *Family Journal, 15*(1), 6–15.
Rowan, J. (1990). *Subpersonalities: The people inside us*. London: Routledge.
Schwartz, R. (1995). *Internal family systems therapy.* New York: Guilford Press.
Schwartz, R. (2001). *Introduction to the internal family systems model.* Trailheads Publications.
Servaty-Seib, H. (2004). Connections between counseling theories and current theories of grief and mourning. *Journal of Mental Health Counseling, 26*(2), 125–145.
Steenbarger, B. N. (1993). A multicontextual model of counseling: Bridging brevity and diversity. *Journal of Counseling and Development, 72*, 8–15.
Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality, 17*(1/2), 43–73.
Walter, C. A. (2003). *The loss of life partner: Narratives of the bereaved.* New York: Columbia University Press.
Walter, T. (1999). *The revival of death.* London: Routledge.

Whiting, P., & James, E. (2006). *Bearing witness to the story: Narrative reconstruction in grief counseling.* VISTAS 2006 Online: American Counseling Association. Retrieved December 14, 2009 from http://counselingoutfitters.com/James.htm

Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York: HarperCollins Publishers.

Management of a Concealable Stigmatized Identity: A Qualitative Study of Concealment, Disclosure, and Role Flexing Among Young, Resilient Sexual and Gender Minority Individuals. Article. Sep 2016.Â The concepts of parallel process of coming out, coming out as an ongoing process, and the paradox of selfâ€preservation are also discussed. The findings challenge the association of verbal selfâ€disclosure as a hallmark of mental health for lesbians. View. Social identity is the portion of an individual's self-concept derived from perceived membership in a relevant social group. As originally formulated by social psychologists Henri Tajfel and John Turner in the 1970s and the 1980s, social identity theory introduced the concept of a social identity as a way in which to explain intergroup behaviour. Social identity theory is described as a theory that predicts certain intergroup behaviours on the basis of perceived group status differences, the perceived This text is a valuable resource for clinicians who work with clients dealing with non-death, nonfinite, and ambiguous losses in their lives. It explores adjustment to change, transition, and loss from the perspective of the latest thinking in bereavement theory and research. The specific and unique aspects of different types of loss are discussed, such as infertility, aging, chronic illnesses and degenerative conditions, divorce and separation, immigration, adoption, loss of beliefs, and loss of employment. Harris and the contributing authors consider these from an experiential perspective, r