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The Impact of Illness Identity on Recovery from Severe Mental Illness

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Abstract

The impact of the experience and diagnosis of mental illness on one's identity has long been recognized; however, little is known about the impact of illness identity, which we define as the set of roles and attitudes that a person has developed in relation to his or her understanding of having a mental illness. The present article proposes a theoretically driven model of the impact of illness identity on the course and recovery from severe mental illness and reviews relevant research. We propose that accepting a definition of oneself as mentally ill and assuming that mental illness means incompetence and inadequacy impact hope and self-esteem, which further impact suicide risk, coping, social interaction, vocational functioning, and symptom severity. Evidence supports most of the predictions made by the model. Implications for psychiatric rehabilitation services are discussed.

Accumulating evidence from long term follow-up studies carried out over the last two decades has demonstrated that most people diagnosed with schizophrenia-spectrum disorders achieve full or partial recovery (Harding, Zubin, & Strauss, 1992; Hopper, Harrison, Janca, & Sartorius, 2007). These research findings, along with first person accounts (Deegan, 1988) and ideology (Anthony, 1993) have begun to erode pessimistic and deterministic attitudes regarding severe mental illness, and brought the vision of recovery into policy documents and initiatives (DHHS, 2003). Focus has gradually shifted away from the question of whether people can recover from severe mental illness to what facilitates recovery (Onken, Ridgway, Dornan, & Ralph, 2002). Several important directions have been taken, including addressing structural (Yanos, Knight, & Roe, 2007) and stigma barriers (Corrigan et al, 2001; Corrigan & Gelb, 2006), transforming policy (DHHS, 2005), and identifying and delivering evidence-based practices (Mueser, Torrey, Lynde, Singer & Drake, 2003). These approaches are important in targeting processes that impact the course of recovery ranging from broad societal and system issues of legislation, oppression, and discrimination, to more individualized matters such as effective services.

In addition to objectively defined domains, there is just as crucial a need to study subjectively defined domains of recovery such as core identity and sense of self (Davidson & Strauss, 1992; Estroff, 1989; Roe & Davidson, 2005), particularly in light of recovery understood as an inherently personal, subjective and self-defined process (Bellack, 2006; Onken et al., 2007). The impact of the experience and diagnosis of mental illness on one's identity has long been

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recognized (Estroff, 1989; Goffman, 1961); however, little is known about the impact of what we here term "illness identity" on the course and recovery from severe mental illness. We define illness identity as the set of roles and attitudes that a person has developed about him or herself in relation to his or her understanding of mental illness. It is thus an aspect of one's experience of oneself that is affected by both the experience of objective aspects of illness as well as by how each individual person makes meaning of the "illness." Our conception of illness identity is primarily influenced by the sociological concept of identity, which typically refers to the social categories that a person uses to describe him or herself (e.g., "patient," "father," "survivor") as well as the social categories that others use to describe that person (Thoits, 1999). We use the term illness identity as an alternative to earlier terms such as "engulfment" (Lally, 1989) to allow for the multiple ways in which people might make sense of having a mental illness. Thus, our conceptualization includes other ways of making sense of having a mental illness, including "empowered" identities and ones in which mental illness is irrelevant.

No comprehensive theoretical model currently exists regarding how illness identity impacts important aspects of recovery. The purpose of the present paper is to propose a theoretically driven model of the impact of illness identity on the course and recovery from severe mental illness and review the existing empirical research that supports it.

The Model

We hypothesize that illness identity may play a major role in the course of severe mental illness, affecting both subjective and objective outcomes related to recovery. As presented in Figure 1, we hypothesize that the impact of any awareness of having a psychiatric problem is moderated by the meanings that the person attaches to that problem (that is, how the illness is conceptualized and what that means about the person experiencing it)[1]. As an illustration consider the following example: With the onset of schizophrenia a person starts having a broad range of new challenges such as hearing voices, having unusual beliefs and having difficulties with studies or work. This might lead him or her to seek help; after a psychiatric evaluation that person may be advised by mental health professional that he or she has a mental illness. At this time the person has a decision to make. Should the person conclude that the experiences he or she has been having are caused by "mental illness"? We suggest that once a person has decided to characterize usual experiences at least partly as being the result of mental illness, what that illness means about them becomes a key issue. Does the illness, for example, mean they are a weak person? Is it just another barrier to be overcome? Does the illness have no personal meaning or does it mean the end of previous dreams?

The second step in our model is that illness identity affects hope and self-esteem. Self-esteem refers to the evaluative aspects of the self, or self-regard (Baker & Gallant, 1985). It is at this point specifically at which stigma becomes an important consideration. Does the person attach stigmatizing meanings to the characterization of their experiences as mental illness? Does the person in our example accept that mental illness is synonymous with dangerousness and incompetence, and in essence internalize stigma, leading to the loss of a previously held identity (e.g., as student, worker, parent, etc.) and to lesser hope and self-esteem? Does the person, alternatively, believe that what he or she has been diagnosed with is a challenge that can be surmounted, allowing for hope and self-esteem to remain intact? At this juncture, "group identification" may play an important role in how one assigns meaning to the definition of one's experience as mental illness (Watson et al. 2007). Specifically, some persons may identify with having a mental illness and ascribe widely-held stigmatizing views to this status, while

[1]Note that the model presented here is very similar to that presented in Yanos et al. (2008), but differs slightly in that the emphasis on meanings attached to illness is broader, rather than restricted to the impact of internalized stigma.

others may make a similar identification but take on a positive identity by way of identification with peers (e.g.,believing that having a mental illness is a mark of advantage). There are two key ideas here: first, persons diagnosed with severe mental illness do not merely experience symptoms but they also interpret their experience of having an "illness" and assign meanings to it which in turn qualify and affect hope and self-esteem. Second, internalization of these meanings, and in particular, stigma can infect personal constructions of illness damaging hope and self-esteem. It is important to note that stigmatizing perceptions reflect larger societal views that broad population surveys indicate that many in general public continue to hold (Martin, Pescosolido, & Tuch 2000). These beliefs include heightened expectations of violent and disorderly behavior as well as the conviction that persons with severe mental illness cannot sustain gainful employment or make informed decisions about their own welfare (Link et al., 1999; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Phelan, Link, Stueve & Pescosolido, 2000).

Next, the model posits that hopefulness and self-esteem in turn influence three variables central to the process of recovery from severe mental illness. First, lack of hope and low self-esteem may increase depression and create a risk for suicide, while greater hope may act as a protective factor against suicide. Continuing with our example, if a person views the illness that they are diagnosed with as a something which represents a complete disruption of their dreams, he or she may be prone to contemplate suicide. Hope and self-esteem may also influence social interaction (though this is likely to be moderated by family support and other sources of existing social support). Individuals with lower self-esteem may drift away from others and become isolated. Degree of hope and self-esteem may also have an effect on the types of coping strategies that are used in response to symptoms and stressors. Following our example, if hopelessness prevailed we might expect that the individual would use more avoidant strategies such as removing him or herself from anxiety-provoking situations, or using alcohol or drugs to numb unpleasant emotional states.

In the next phase of the model, we suggest that the types of coping strategies that are used can directly affect vocational outcomes, symptom severity, as well as social interaction. Here, as individuals use more avoidant strategies they may be more likely to avoid new and challenging work situations (such as those that are offered through rehabilitation or supported employment programs). Following our example, if a stigmatized view of mental illness diminished hope and then led to a preference for avoidant coping we hypothesize that the person would be at risk for not being able to manage job-related stress and therefore to lose his or her job. Conversely, another individual who uses more problem-oriented strategies might be better able to maintain employment as he or she deals with work-related stress in a more adaptive manner. Regarding social interaction, just as hopelessness might lead to withdrawal and isolation, so might a generally avoidant stance to naturally arising conflict with others. Finally, we hypothesize that the types of coping strategies used, social interactions, and vocational functioning all impact the severity of psychotic symptoms. We are not claiming that psychotic symptoms are caused by these factors, but rather that psychotic symptoms can be made more or less severe and disabling depending on the degree to which individuals remain socially isolated, have or lack the structure of employment, and continue to use avoidant coping strategies. Concluding our example, if a stigmatized view of mental illness diminished hope and then led to social withdrawal, and a preference for avoidant coping, which led to job loss, we might imagine that the combined stress might increase levels of hallucinations or delusions beyond where they initially began.

Review of Evidence for the Model

General Evidence for Relationship between Illness identity and Recovery—

Before discussing the evidence for specific relationships predicted by the model, we first

discuss the general evidence for a relationship between understandings of illness and their effects on personal identity and recovery-related outcomes. There is substantial evidence that transforming identity is an important part of the process of improving outcomes for people with severe mental illness. In a series of qualitative studies, Davidson and colleagues (Davidson & Strauss, 1992; Davidson et al., 2005) described how the process of constructing a new "sense of self" has been found to be an important part of the process of recovery from mental illness. These studies describe how persons with severe mental illness who displayed significant improvement in global functioning expressed themes of the discovery of ways of recapturing a sense of purpose through daily activities. A longitudinal qualitative study (Roe, 2001) assessing the process of recovery from severe mental illness has supported this conclusion, finding that individuals who improved functioning over a 1 year period showed a progression from the identity of "patient" to "person" in their narratives, suggesting that maintaining a patient identity can be detrimental to recovery. Multiple quantitative longitudinal single case studies have also suggested that as persons progress towards recovery one of the first steps tends to be the reclamation of a sense of oneself as active agent (Lysaker, Davis, et al., 2005; Lysaker, Davis, et al., 2007).

Qualitative research on the impact of participation in the mental health consumer movement (i.e., organizations run by and for persons diagnosed with mental illness, that provide advocacy and self-help services) has also supported that participation in these organizations can facilitate recovery by encouraging participants, through rituals of self-disclosure and advocacy, to transform identities of "mental patient" to "consumer advocate" (McCoy & Aronoff, 1994; Onken & Slaten, 2000). This transformation enabled consumers to reframe the experience of mental illness so that it no longer carried a negative connotation but instead was seen as something that was "okay," or even a mark of social advantage. These studies and those described above suggest that an essential part of the recovery process involves transforming undervalued identities associated with internalized stigma and replacing them with more individualized "empowered" identities.

Studies supporting that identity transformation is an important part of the recovery process provide a general framework of empirical support for our conceptual model. We now discuss the research evidence supporting specific relationships hypothesized by the model.

Relationship Between Illness identity and Hope/ Self-Esteem—As is indicated in the conceptual model represented in Figure 1, we hypothesize that the nature of illness identity directly impacts the hope and self-esteem of people diagnosed with severe mental illness. Specifically, we hypothesize that individuals who both identify themselves as having a mental illness and accept stigmatizing attitudes regarding this identity will have diminished hope and self-esteem, while the opposite will be true of individuals who accept that they have a mental illness but do not accept stigmatizing attitudes.

There is good evidence for this hypothesized relationship from the literatures on the relationship between insight and self-esteem and the literature on internalized stigma. Cross-sectional studies have found that greater insight is associated with higher levels of dysphoria (Mintz, Dobson, & Romney, 2003), lowered self-esteem (Warner et al., 1989) and decreased well-being and quality of life (Hasson-Ohayon, Kravetz, Roe, & Weiser, 2006). Several studies have also established that there is a relationship between internalized stigma and diminished self-esteem and hope (Watson, Corrigan, Larson, & Sells, 2007). One cross-sectional study found that "engulfment" of the mental patient role (similar to internalization of stigma) was strongly negatively associated with hope and self-esteem (McCay & Seeman, 1998), while another (Corrigan, Watson, & Barr, 2006) found that internalized stigma was strongly negatively associated with both self-esteem and self-efficacy, even when controlling for depressive symptoms. Link and colleagues' research (Link et al, 2001) on a "modified labeling

perspective," though not explicitly addressing internalized stigma, has also provided considerable support for the impact that internalizing the label of being "mentally ill" can have on a variety of subjective outcomes related to recovery. Link's research and related studies have measured incorporation of stigmatizing attitudes by using a scale that measures the extent to which a person with mental illness agrees that "most people" have devaluing and discriminating attitudes toward the mentally ill. There is evidence from a body of studies that the degree to which one believes that others have devaluing and discriminating attitudes is related to diminished self-esteem (Link et al., 2001), and a decreased sense of mastery (Wright, Gronfein, & Owens, 2000), even when controlling for symptoms. Consistent with this is research on personal narratives of self and illness that found that participants with greater levels of self-stigma tended to tell stories about their lives which were scored by blinded raters as having lesser themes of social worth (Lysaker et al., 2008).

Lysaker, Roe and Yanos, (2007) attempted to link findings regarding both awareness and internalized stigma by exploring the hypothesis that the effects of awareness of illness of schizophrenia on self-esteem and hope might be moderated by the degree to which the person internalizes stigmatizing views about mental illness. A cluster analysis of persons in a stable phase of illness revealed two groups of persons who were relatively aware of having a mental illness: persons who did, and did not, endorse having internalized stigmatizing beliefs about their condition. Persons with high insight who endorsed internalized stigma beliefs (roughly a third of the sample) had lower levels of self-esteem, hope, and fewer interpersonal relationships than those with insight who rejected stigmatizing beliefs. The cluster analyses also produced a third group that had low insight into illness and also endorsed stigmatizing beliefs, though to a lesser degree than did the high insight/ high stigma group. This group also had higher levels of self-esteem and hope than the group with high insight and high stigma, but did not differ from them in social functioning. This last finding may suggest that both the acceptance of stigma and denial of mental illness may lead to social isolation. Taken together, these findings support the view that the meanings a person attributes to having a mental illness can have important implications for how awareness or insight into illness impacts outcomes.

Impact of Hope and Self-Esteem on Suicide Risk, Coping and Social Isolation— As indicated in Figure 1, we also hypothesize that hope and self-esteem impact suicide risk, the choice of coping strategies used to deal with symptoms and stressors, and the social interactions of persons with severe mental illness. There is evidence supporting all three of these hypothesized relationships.

There is good support for the relationship between hopelessness and suicide risk among persons with severe mental illness. In their recent review of the predictors of suicidal behavior among people diagnosed with schizophrenia, Bolton et al. (2007) identified 8 studies finding support for a relationship between hopelessness and suicide risk/behavior among people with schizophrenia. In discussing the reasons why some individuals with schizophrenia experience more hopelessness, the review discussed the hypothesis that negative self-evaluation related to the meaning attributed to having a mental illness can increase risk for hopelessness. This hypothesis is supported by the work of Birchwood and colleagues (Birchwood, Iqbal, & Upthegrove, 2005) who have researched what they termed "post-psychotic depression," which they hypothesized results from the "loss of social goals, roles and status" and "social shame" that accompanies the realization that one has a psychotic disorder. They found that roughly 35% of a sample of persons with psychotic disorders showed evidence of post-psychotic depression, and that these individuals had beliefs that were characterized by feelings of shame and humiliation (which are very consistent with the construct of internalized stigma) along with high levels of awareness of having a mental illness (in separate research, Rusch et al., [2006] have also found shame to be related to internalized stigma). In a related study, Tarrier et al. (2004) examined the predictors of suicidal ideation and behavior among people with

schizophrenia and found that suicidal ideation and behavior were strongly predicted by hopelessness, which was in turn greatly predicted by negative self-evaluation. A more recent study by Fialko et al. (2006) also found that both diminished self-esteem and belief in decreased control over one's illness were related to suicidal ideation among persons with psychotic disorders. Collectively, these findings suggest that diminished hope and self-esteem impact suicidal ideation among people with severe mental illness, and that diminished hope and self-esteem are likely impacted by illness identity factors.

With regard to the relationship between hope/self-esteem and coping, three cross-sectional studies have found support for this relationship. Lysaker, Campbell, and Johannsen (2005) found that individuals with greater insight and hope were more likely to use problem-centered and less likely to use avoidant coping strategies than both individuals with high insight but low hope and individuals with high hope and low insight. Cooke et al. (2007) found that poor self-esteem was significantly associated with the use of avoidant coping strategies (specifically behavioral disengagement). Similarly, Hoffman et al. (2000) found that poor self-concept was significantly associated with the use of “depressive-resigned coping” among persons with schizophrenia participating in vocational rehabilitation.

A few cross-sectional studies have examined the link between hope/self-esteem and social isolation among persons with severe mental illness. Lysaker, Davis and Hunter (2004) examined the correlates of hopelessness and found evidence supporting that persons with both diminished levels of hope linked to personal agency and expectations of the future had fewer social interactions than persons with greater hope of either type. Tarrier et al (2004) found that hopelessness was related to greater social isolation in a sample of individuals with recent onset schizophrenia. Similarly, using data from a large multi-center study of Scandinavian countries, Sörgaard et al. (2002) found that self-esteem was positively related to size of social network and frequency of social interaction.

Impact of Hope, Self-Esteem and Coping on Vocational Outcomes—As is indicated in the conceptual model represented in Figure 1, we also hypothesize that hope/self-esteem will impact vocational outcomes. There is limited evidence for this relationship, as few studies have addressed the impact between psychological variables and vocational outcomes. In their review of the “person-related” predictors of employment outcomes for adults with severe mental illness, Michon et al (2005) did not identify any studies examining the impact of hopelessness or self-esteem on employment outcomes, although they did identify three studies finding support that “work-related self-efficacy” (or positive expectations regarding work success) was a predictor of good work outcomes. More specifically with regard to hope, Davis et al. (2004) found that different dimensions of hopelessness were related to different aspects of subsequent work performance. Specifically, loss of motivation was related to poorer social skills and work cooperation, suggesting that individuals who have given up on working as a possibility do not invest the effort in behavior necessary for good job success. Of related interest is Hoffman et al.'s (2003) work, which, while not directly assessing the impact of hope or self-esteem on vocational outcomes, found evidence supporting that external locus of control (a related construct) predicted impaired work behavior in vocational rehabilitation and a reduced likelihood of eventually obtaining competitive employment.

The relationship between coping and vocational outcomes has been relatively unstudied. One prospective study (Yau et al., 2005), however, found that avoidant coping (depressive resignation) was related to impaired work skills among Clubhouse participants with severe mental illness, and that reductions in avoidant coping over time predicted improvements in work skills. While this study does not necessarily support a relationship between coping and competitive employment, it indicates that coping impacts skills related to employment success. In addition, two qualitative studies (Cunningham, Wolbert, & Brockmeir, 2000; Becker,

Whitley, Bailey, & Drake, 2007) examined the variables perceived as being related to job success among persons with severe mental illness who had found and maintained employment. In both studies, participants highlighted the importance of using effective coping skills to deal with work-related stress. Of note, Cunningham et al. (2000) compared groups of mental health consumers who had and had not been successful in finding gainful employment, and found differences in the way employed and unemployed consumers talked about coping, with employed consumers discussing more problem-oriented coping.

Impact of Coping, Vocational Outcomes and Social Isolation on Symptoms—As indicated in Figure 1, we also hypothesize that coping, vocational outcomes and social interactions impact symptom severity among persons with severe mental illness. There is evidence supporting all three of these hypothesized relationships.

With regard to coping, while considerable research has explored the relationship between coping and outcomes such as social functioning and quality of life, little research has addressed the relationship between coping and symptom severity. Nevertheless, there is cross-sectional (Lysaker et al., 2005) evidence that the types of coping strategies typically used by persons with severe mental illness are related to symptom severity. Similarly, Strous et al. (2005) found that changes in coping strategies were associated with changes in symptom severity over time. In both cases, the direction of the relationship is unclear, and plausible interpretations could be made in either manner. However, one prospective study, conducted by Meyer (2001) found support that coping may influence symptoms; specifically, the author found that preferences for adaptive coping at baseline predicted fewer psychotic symptoms at follow-up.

Both cross-sectional and prospective research supports a relationship between employment and symptoms. Priebe, Warner, Hubschmid and Eckle (1998) conducted a study of employed and unemployed persons with schizophrenia in three countries, and found that employed participants had significantly fewer symptoms. While this study does not support a causal link between employment and reduced symptoms, experimental evidence from a large randomized trial of supported employment (Bond et al., 2001), found that participants with severe mental illness who participated in competitive work showed higher rates of improvement in symptoms over time, in contrast with participants who did not participate in competitive work. This supports the view that involvement in work can alleviate symptoms.

Although much research has documented an association between degree of social interaction and symptom severity (e.g., Sorgaard et al., 2001), few studies have examined this issue prospectively, making it difficult to evaluate the direction of this relationship (our model hypothesizes that this is a bidirectional relationship). However, strong evidence from studies employing the Experience Sampling Method (a method which collects data on mood, cognition and activity at multiple time points during a day) has found that social interactions with acquaintances and family members are associated with reductions in the experience of delusions (Myin-Germeys, Nicolson, & Delespaul, 2001). Similar findings were not observed for hallucinations (Delespaul et al., 2002), however, suggesting that social interaction may reduce the intensity of some types of symptoms but not others.

Integrative Studies

One recent study (Yanos, Roe, Markus & Lysaker, 2008) has attempted to conduct an integrated study of some of the relationships discussed above. Using data collected from 102 study participants with schizophrenia spectrum disorder, a path analysis supported the hypothesis that internalized stigma impacted avoidant coping, active social avoidance, depressive symptoms, and that these relationships were mediated by the impact of internalized stigma on hope and self-esteem. There was also evidence that internalized stigma effects positive symptom severity by way of its impact on social avoidance, but a predicted relationship

between avoidant coping and symptom severity was not supported. While causal inferences cannot be drawn from this cross-sectional study, the data provide preliminary support for an integrated conceptualization of the relationship between internalized stigma, hope and self-esteem, and other outcomes related to recovery.

Limitations of the Existing Evidence and Recommendations for Future Research

There is good empirical evidence for many of the connections predicted by the model. Specifically, there is compelling evidence for the relationship between hope/self-esteem and suicidality, as well as for the impact of employment on symptoms and other outcomes. Nevertheless, research has not always been adequate to fully test the relationships predicted in the model. In some areas, such as the hope/self-esteem and employment, research has been mainly exploratory or cross-sectional. Clearly, more prospective research is needed to address many of the areas we have discussed above. In addition, there is a need for research to test multiple facets of the model in an integrated fashion. This would allow for better estimates of the magnitude of the relationships between the various domains in the model, since most prior studies of connections between two of the domains in the model have not controlled for many of the other domains. It would also allow for consideration of the extent to which the effects of illness identity are "direct" versus the extent to which it is mediated by hope/self-esteem and coping as we hypothesize in our model.

Discussion

Well-documented findings regarding the heterogeneous outcome of severe mental illness have generated efforts to identify variables that are related to positive outcomes and recovery. However, an essential question for the mental health field continues to be how and why progress in moving towards recovery varies between individuals, and how service systems can facilitate the potential for recovery. The purpose of the present article is to present a theoretically-driven model and review the research evidence supporting the model to clarify how illness identity may be an important variable in influencing recovery among persons diagnosed with severe mental illness.

Evidence in support of our proposed model suggests that ignoring the importance of illness identity may lead to difficult roadblocks in treatment and rehabilitation for many persons with severe mental illness. Specifically, some persons who are offered high quality evidence-based services such as supported employment or illness management may not take advantage of or benefit from them because they lack hope that any progress in treatment is possible. They may certainly engage in such activities but be at high risk to fail given the expectation of failure or a lack of schemata with which to make sense of and enjoy success. The proposed model demonstrates how illness identity appears to be a crucial and central intersection influencing various domains of recovery directly, as well as indirectly, through mediating processes.

If illness identity has such important effects, the question is raised: how can the illness identity of people with severe mental illness be transformed to facilitate recovery? We believe that treatment specifically focused on illness identity can have a positive effect on outcomes in this area and can allow persons with severe mental illness to benefit from other high quality services. Specifically, we believe that cognitive-behavioral therapy (CBT) approaches focused on addressing attitudes related to illness identity can have a favorable impact in this regard. Theoretical discussions (Corrigan & Calabrese, 2005) and case studies (Holmes & River, 1998) discussing how techniques based in CBT show promise as methods of altering self-conceptions reflective of illness identity. A CBT approach to helping individuals recover their identity would address self-stigmatizing views as cognitive distortions or dysfunctional attitudes, which are major areas of focus in most CBT. As Holmes and River (1998) discussed, CBT techniques such as psychoeducation (providing information that counteracts exaggerated

stigmatizing views), teaching skills to conduct cognitive restructuring (collecting evidence to test and challenge the validity of dysfunctional beliefs), and exposure may all be used to address internalized stigma. Coping techniques may also be helpful in facilitating a process of constructing and negotiating meanings (Roe, Yanos & Lysaker, 2006). This process includes not only changes in appraisal of a stressor, but also experiencing and perceiving oneself differently in relation to stressors and the sense of threat or suffering they generate. For example, a person may use cognitive coping efforts to generate an internal dialogue that redefines how he or she feels about setbacks experienced as a result of having a mental illness, and changes how strongly such setbacks impact perceptions of the self.

An additional treatment approach that we believe holds promise in transforming illness identity is narrative enhancement. Phenomenological observations suggest that severe mental illness often involves a profound diminishment in a person's ability to narrate his or her own life's evolving story (Gallagher, 2003; Lysaker, Wickett, Wilke & Lysaker, 2003). Helping those with severe mental illness to accept themselves as sufficiently privileged to construct and develop a meaningful story of one's self and disorder that promotes recovery may be crucial to the transformation of one's illness identity. Such a process helps clients to tell stories about what is wrong, not wrong, about hopes, losses and what could be done (Lysaker, Buck & Roe, 2006; Lysaker, & Buck, 2006; Roe, & Ben Yishai, 1999). The end goal of such a process would be to help clients to tell more coherent stories about their lives in which their role as a protagonist is developed and transformed and themes of empowerment and agency emphasized (Lysaker, Lysaker, & Lysaker, 2001). Thus, for an individual whose story stresses themes of being unable to overcome impairments associated with having a mental illness, a narratively focused psychotherapy aims to guide a person toward a reassessed conceptualization, wherein his or her life story emphasizes personal strength, change and success over adversity. In this way, disempowered narratives in which themes dominated by internalized stigma prevail, can be gradually reframed and revised so that themes of agency and potential and personal strength come to predominate.

In summary, we have offered a model of how a collection of social, psychological and clinical forces may interact to create substantial barriers to recovery. In particular, we have suggested that, beginning with a definition of oneself as mentally ill and the assumption that mental illness means incompetence and inadequacy, a process may unfold in which persons become at risk of ceasing to try to work and fit into their communities. We have suggested that when stigma leads to an impoverished sense of self, low self-esteem and suicide risk follow. These then not only lead to avoidance and poorer psychosocial outcomes but also may be a factor that sustains symptom severity, leading a vicious cycle. This model has the benefit of being tested empirically but also may point to a chain of thoughts and behaviors which could be individually targeted for intervention.

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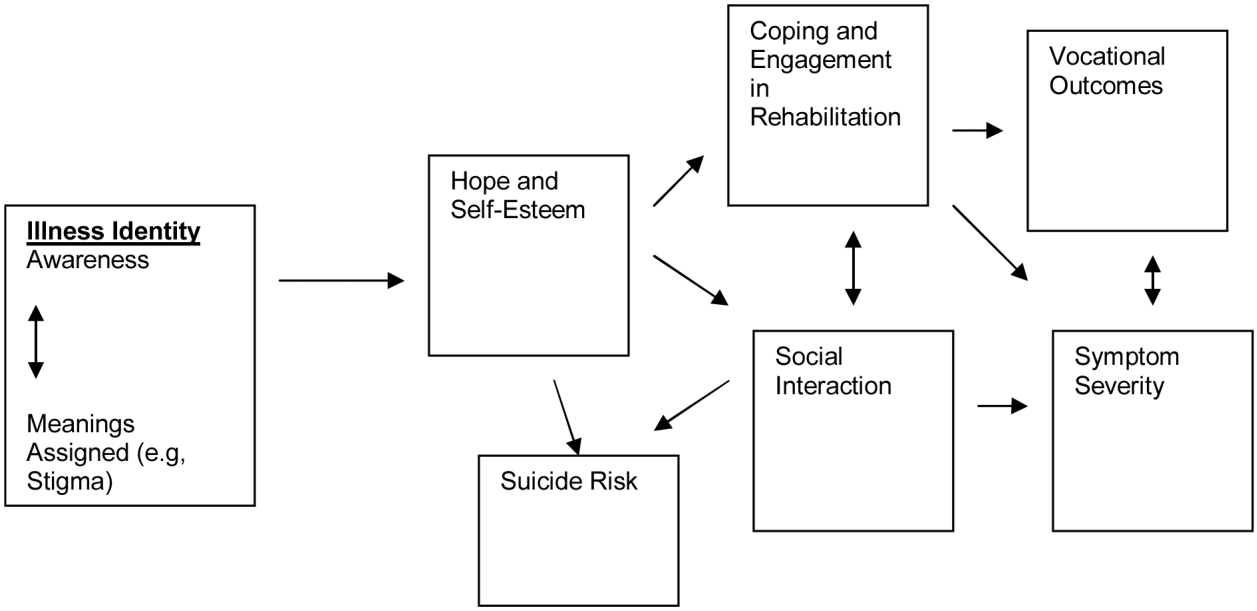

Figure 1.
Impact of Illness Identity on Recovery-Related Outcomes