The Paradox of Self-Stigma and Mental Illness

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Published narratives by persons with serious mental illness eloquently describe the harmful effects of stigma on self-esteem and self-efficacy. However, a more careful review of the research literature suggests a paradox; namely, personal reactions to the stigma of mental illness may result in significant loss in self-esteem for some, while others are energized by prejudice and express righteous anger. Added to this complexity is a third group: persons who neither lose self-esteem nor become righteously angry at stigma, instead seemingly ignoring the effects of public prejudice altogether. This article draws on research from social psychologists on self-stigma in other minority groups to explain this apparent paradox. We describe a situational model of the personal response to mental illness stigma based on the collective representations that are primed in that situation, the person's perception of the legitimacy of stigma in the situation, and the person's identification with the larger group of individuals with mental illness. Implications for a research program on the personal response to mental illness stigma are discussed.

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The stigma of mental illness strikes with double misfortune. On one hand, stigma yields a public that misunderstands the course and impact of mental illness ("They are all dangerous!") and discriminates against people with

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these disorders as a result ("I'm not going to hire them."). Researchers have begun to describe public forms of stigma and ways that it robs persons with mental illness of work, independent living, and other important life opportunities (Corrigan, 2000; Farina, 1998; Phelan, Link, Stueve, & Pescosolido, 2000). The second misfortune that results from stigma is the focus of this article; namely, persons with mental illness, living in a culture steeped in stigmatizing images, may accept these notions and suffer diminished self-esteem and self-efficacy as a result. Persons with mental illness like Kathleen Gallo have written eloquently about this kind of self-stigma.

I perceived myself, quite accurately unfortunately, as having a serious mental illness and therefore as having been relegated to what I called "the social garbage heap." . . . I tortured myself with the persistent and repetitive thought that people I would encounter, even total strangers, did not like me and wished that mentally ill people like me did not exist.

Thus, I would do things such as standing away from others at bus stops and hiding and cringing in the far corners of subway cars. Thinking of myself as garbage, I would even leave the sidewalk in what I thought of as exhibiting the proper deference to those above me in social class. The latter group, of course, included all other human beings. (Gallo, 1994, pp. 407–408).

First-person narratives like this one, as well as other subjective data, provide a compelling illustration of the impact of stigma on the person's self-esteem (Davidson, 1992; Estroff, 1989; Strauss, 1989). Such qualitative data have been augmented by quantitative surveys of persons with mental illness. For example, studies of persons with mental illness and their families showed self-stigma to be a significant problem (Wahl, 1999; Wahl & Harman, 1989). Unfortunately, these studies are largely atheoretical. Few

models have emerged for explaining self-stigma in mental illness or for developing strategies to change it. Social psychologists, however, have been studying the self-stigma of other minority groups for several decades. In the process, they have generated paradigms that have been fruitful for their research. Models by Jennifer Crocker and Brenda Major have been especially germane to issues related to self-stigma (Crocker, 1999; Crocker & Major, 1989; Crocker, Major, & Steele, 1998). The purpose of this article is to bridge social psychological paradigms with models from mental health to advance understanding of self-stigma and serious mental illness.

THE FUNDAMENTAL PARADOX OF SELF-STIGMA

First impressions about the stigma of mental illness suggest that people with psychiatric disability, living in a society that widely endorses stigmatizing ideas, will internalize these ideas and believe that they are less valued because of their psychiatric disorder. Self-esteem suffers, as does confidence in one's future (Corrigan, 1998; Holmes & River, 1998). Given this research, models of self-stigma need to account for the deleterious effects of prejudice on an individual's self-conception. However, research also suggests that, instead of being diminished by the stigma, many persons become righteously angry because of the prejudice that they have experienced (Chamberlin, 1978; Deegan, 1990). This kind of reaction empowers people to change their roles in the mental health system, becoming more active participants in their treatment plan and often pushing for improvements in the quality of services (Corrigan, in press).

Low self-esteem versus righteous anger describes a fundamental paradox in self-stigma. Models that explain the experience of self-stigma need to account for some persons whose sense of self is harmed by social stigma versus others who are energized by, and forcefully react to, the injustice. And there is yet a third group that needs to be considered in describing the impact of stigma on the self. The sense of self for many persons with mental illness is neither hurt nor energized by social stigma, instead showing a seeming indifference to it altogether.[1]

Here we propose a situational model that explains this paradox, arguing that an individual with mental illness may experience diminished self-esteem/self-efficacy, righteous anger, or relative indifference depending on the parameters of the situation. Before outlining this model, we briefly describe the impact of stigma on people with mental illness. In the process, we define key terms related to the experiences of public stigma and self-stigma. A situational model for the paradox of self-stigma is then summarized. Theories and empirical studies from social psychology that support the model are reviewed. Because most of this research was completed on stigmatized groups other than people with mental illness (e.g., ethnic and gender minorities and people with physical disabilities or AIDS), conceptual and methodological issues that arise from extrapolating this social-psychological paradigm to stigma and mental illness are considered at the end of the article. Perhaps the greatest value of our model is as a heuristic tool for guiding future research into self-stigma and mental illness. Hence, testable hypotheses that emerge from our model are highlighted throughout the article.

WHAT IS THE STIGMA OF MENTAL ILLNESS?

Stigmas about mental illness seem to be widely endorsed by the general public. Studies suggest that many citizens in the United States (Link, 1987; Phelan et al., 2000; Rabkin, 1974; Roman & Floyd, 1981) and most Western nations (Bhugra, 1989; Brockington, Hall, Levings, & Murphy, 1993; Greenley, 1984; Hamre, Dahl, & Malt, 1994; Madianos, Madianou, Vlachonikolis, & Stefanis, 1987) sanction stigmatizing attitudes about mental illness. Furthermore, stigmatizing views about mental illness are not limited to un-informed members of the general public. Research has shown that even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness (Keane, 1990; Lyons & Ziviani, 1995; Mirabi, Weinman, Magnetti, & Keppler, 1985; Page, 1980; Scott & Philip, 1985).

One recent study suggests that the general public's understanding of the causes of mental illness has broadened (Phelan et al., 2000). One might hope that stigma is a thing of the past. However, that same study indicates that attitudes about persons with mental illness have become more stigmatizing in terms of dangerousness during the past 30 years.

Several themes describe stigmatizing attitudes. Media analyses of film and print have identified three common misconceptions: people with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should be marveled; or they are rebellious, free spirits (Farina, 1998; Gabbard & Gabbard, 1992; Hyler, Gabbard, & Schneider, 1991; Mayer & Barry, 1992; Monahan, 1992; Wahl, 1995). Results of two inde-

pendent-factor analyses of the survey responses of more than 2000 English and American citizens parallel these findings (Brockington et al., 1993; Taylor & Dear, 1980): (a) fear and exclusion: persons with severe mental illness should be feared and, therefore, be kept out of most communities; (b) authoritarianism: persons with severe mental illness are irresponsible, so life decisions should be made by others; and (c) benevolence: persons with severe mental illness are childlike and need to be cared for.

Although stigmatizing attitudes are not limited to mental illness, the general public seems to disapprove of persons with psychiatric disabilities significantly more than persons with related conditions such as physical illness (Corrigan, River et al., 2000; Piner & Kahle, 1984; Socall & Holtgraves, 1992; Weiner, Perry, & Magnusson, 1988). Severe mental illness has been likened to drug addiction, prostitution, and criminality (Albrecht, Walker, & Levy, 1982; Skinner, Berry, Griffith, & Byers, 1995). Unlike physical disabilities, persons with mental illness are perceived by the public to be in control of their disabilities and responsible for causing them (Corrigan, River, et al., 2000; Weiner et al., 1988). Furthermore, research respondents are less likely to pity persons with mental illness, instead reacting to psychiatric disability with anger and believing that help is not deserved (Corrigan, Rowan, et al., in press; Socall & Holtgraves, 1992; Weiner et al., 1988).

Research has also documented the behavioral impact (or discrimination) that results from stigma related to mental illness. Citizens are less likely to hire persons who are labeled mentally ill (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Olshansky, Grob, & Ekdahl, 1960; Link, 1987), less likely to lease them apartments (Page, 1977, 1983, 1995), and more likely to falsely press charges against them for violent crimes (Sosowsky, 1980; Steadman, 1981).

A SOCIAL COGNITIVE PARADIGM FOR PUBLIC STIGMA

The above data on ways in which stigma impacts persons with mental illness fit neatly into a social-cognitive model of public stigma (Corrigan, 2000). Public stigma is distinguished from self-stigma as the reaction that the general population has to people with mental illness. Three components make up this model, as outlined in Figure 1: stereotypes, prejudice, and discrimination. Social psychologists view stereotypes as knowledge structures that are learned by most members of a social group (Augoustinos, Ahrens, & Innes, 1994; Esses, Haddock, & Zanna, 1994; Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996; Mullen, Rozell, & Johnson, 1996). Stereotypes are especially efficient means of categorizing information about social groups. Stereotypes are considered "social" because they represent collectively agreed-upon notions of groups of persons. They are "efficient" because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994). As outlined above, stereotypes about mental illness include dangerousness, incompetence, and character weakness.

Just because most people have knowledge of a set of stereotypes does not imply that they agree with them (Jussim, Nelson, Manis, & Soffin, 1995). For example, many persons can recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced, on the other hand, endorse these negative stereotypes ("That's right; all persons with mental illness are violent!") and generate negative emotional reactions as a result ("They all scare me!") (Devine, 1988, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996). Prejudice is also viewed as a general attitude toward a group. In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative (generally negative) component (Allport, 1954/1979; Eagly & Chaiken, 1993). According to some social psychological models of attitude structure, prejudice may arise from sources other than stereotypes about members of a group. Affect and past behavior toward members of a group may also form the basis of prejudice (Zanna & Rempel, 1988).

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction (Crocker, Major, & Steele, 1998). Prejudice that yields anger can lead to hostile behavior (e.g., physically harming a minority group) (Weiner, 1995). In terms of mental illness, angry prejudice may lead to withholding help or replacing health care with services provided by the criminal justice system (Corrigan, 2000). Fear leads to avoidance; for example, employers do not want persons with mental illness nearby, so they do not hire them (Corrigan et al., 2001).

A Social-Cognitive Definition of Self-Stigma

Given the breadth of impact that stigma has on persons with mental illness, it is important to define the parame-

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│         Public Stigma           │   │          Self-Stigma            │
│  ─────────────────────────────  │   │  ─────────────────────────────  │
│                                 │   │                                 │
│  - Stereotype:                  │   │  - Stereotype:                  │
│    Negative belief about a group│   │    Negative belief about the self│
│       e.g., dangerousness       │   │       e.g., character weakness  │
│            incompetence         │   │            incompetence         │
│            character weakness   │   │                                 │
│                                 │   │                                 │
│                                 │   │                                 │
│  - Prejudice:                   │   │  - Prejudice:                   │
│    Agreement with belief and/or │   │    Agreement with belief        │
│    negative emotional reaction  │   │    Negative emotional reaction  │
│       e.g., anger               │   │       e.g., low self-esteem     │
│            fear                 │   │            low self-efficacy    │
│                                 │   │                                 │
│                                 │   │                                 │
│  - Discrimination:              │   │  - Discrimination:              │
│    Behavior response to prejudice│  │    Behavior response to prejudice│
│       e.g., avoidance of work and│  │       e.g., fails to pursue work│
│            housing opportunities│   │            and housing          │
│            withhold help        │   │            opportunities        │
│                                 │   │                                 │
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Figure 1. Comparing and contrasting the definitions of public stigma and self-stigma. Note that both forms of stigma include the same three components: stereotype, prejudice, and discrimination.

ters of self-stigma; what experiences would be included under the rubric and which would be separated out? Self-stigma can be understood using the same concepts that compose public stigma in Figure 1. Many persons with mental illness are aware of the stereotypes that exist about their group. Dominant among these is the belief that persons with mental illness are incompetent or lack a strong moral backbone (Hayward & Bright, 1997). Note, however, that awareness of stigma is not synonymous with internalizing it (Crocker & Major, 1989). Many persons with mental illness report being aware of the negative stereotypes about them (Bowden, Schoenfield, & Adams, 1980; Kahn, Obstfeld, & Heiman, 1979; Shurka, 1983; Wright, Gronfein, & Owens, 2000) but do not necessarily agree with these stereotypes (Hayward & Bright, 1997).

Like public stigma, self-stigma also includes prejudice and its two components. First, persons who agree with prejudice concur with the stereotype that they are weak and unable to care for themselves. In addition, self-prejudice leads to negative emotional reactions. Prominent among these is low self-esteem and self-efficacy. Self-esteem is typically operationalized in this kind of research as the rating of agreement of personal worth on Likert scale items (Corrigan, Faber, Rashid, & Leary, 1999; Rosenberg, 1965). Self-efficacy is defined here as the expectation that one can successfully perform a behavior in a specific situation (Bandura, 1977, 1989) and is often assessed with self-report measures (Sherer & Adams, 1983).

Finally, self-prejudice may lead to behavioral responses. Low self-efficacy and demoralization has been shown to be associated with failing to pursue work or independent living opportunities (Link, 1982, 1987). Obviously, this kind of self-stereotype, self-prejudice, and self-discrimination will significantly interfere with a person's life goals and quality of life; this impact is discussed more fully below. However, it is also important to remember that self-stigma is not universal—hence, the paradox which is the focus of this article. Before reviewing the model that explains this paradox, we briefly review evidence about righteous anger.

Righteous Anger as a Response to Stigma

Long-standing theories have represented self-stigma as the automatic result of being a member of a stigmatized group (Allport, 1954/1979; Erikson, 1956; Jones et al., 1984). Hence, African Americans, women, and persons with physical disabilities would all be expected to have lower self-esteem compared to the majority. Several studies have shown, however, that people of color and other ethnic minorities do not have lower self-esteem than the white majority (Hoelter, 1983; Jensen, White, & Gelleher, 1982; Porter & Washington, 1979; Verkuyten, 1994, 1995; Wylie, 1979). Nor are women shown to have lower self-esteem than men (Maccoby & Jacklin, 1974; Wylie, 1979). More specific to the goals of this article, persons with various disabilities are not found to have lower self-

esteem than the general public; groups studied in this research include people with learning disabilities (Johnson, Johnson, & Rynders, 1981), mental retardation (Gibbons, 1985; Stager, Chassin, & Young, 1983; Willy & McCandless, 1973), physical handicaps (Burden & Parish, 1983), and disfiguring conditions like cleft lip and palate (Clifford & Clifford, 1986).

Similar results have been found in persons with mental illness. As discussed above, persons with mental illness are well aware of the stigmatizing views about them. Despite this awareness, several studies have been unable to find a sharp decline in self-esteem in this group (see Hayward & Bright, 1997, for a review).

Crocker and colleagues (Crocker & Lawrence, 1999; Crocker & Major, 1989) highlight an even more amazing trend in stigma and self-esteem. Several stigmatized groups showed higher self-esteem than the majority; participants in these studies included persons of color (Hoelter, 1983; Jensen, White, & Gelleher, 1982; Porter & Washington, 1979) and people with disabilities (Fine & Caldwell, 1967; Willy & McCandless, 1973). It seems that being stigmatized somehow stimulates psychological reactance (Brehm, 1966). As applied to this discussion, reactance suggests that, rather than complying with the perceived threat of stigma and viewing one's self poorly, an individual opposes the negative evaluation and positive self-perceptions emerge.

Research on empowerment in persons with mental illness has illustrated this point. This research represents empowerment and self-stigma as opposite poles on a continuum (Corrigan, in press; Rappaport, 1987; Zimmerman & Rappaport, 1988). At the negative end of the continuum are persons who report being unable to overcome all the pessimistic expectations about mental illness. They have low self-esteem and little confidence in their future success. These persons are the self-stigmatized. At the positive end, however, are persons with psychiatric disability who, despite this disability, have positive self-esteem and are not significantly encumbered by a stigmatizing community. Instead, they seem to be energized by the stigma to righteous anger (Corrigan et al., 1999; Rogers, Chamberlin, Ellison, & Crean, 1997).

Righteous anger arises against those who have unjustly labeled them. Research on groups of African Americans suggests anger is a healthy response to stigma. Anger and depression are inversely related in a group of black adolescents coping with racism (Stevenson, Reed, Bodison, &

Bishop, 1997). Anger seems to be associated with responding to stigmatizing behaviors of the majority through some kind of collective and affirming response (Wright, 1997). Righteous anger is also evident in many of the narratives of persons with serious mental illness: "I was angry that I'd been crazy, but I was even more angry at the inhumane, hurtful, degrading, and judgmental 'treatment' I'd been subjected to" (Unzicker, 1989, p. 71; see also Davidson, Stayner, & Haglund, 1998; Estroff, 1995).

This reaction points to another alternative response to stigma; rather than beating one's self with these negative attitudes, people rebound and respond with strength and indignation. Righteous anger and being untroubled by stigma represent the opposite pole of the self-stigma paradox.

A SITUATIONAL MODEL OF THE PERSONAL RESPONSE TO STIGMA

The loss of self-esteem or emergence of righteous anger that results from stigma might seem to be traits of the person that remain constant over the course of the illness. However, it is more likely that self-reactions to stigma represent statelike responses and vary during the person's life (Crocker, 1999). In some situations, persons with serious mental illness report loss of self-esteem due to stigma, while in other situations the same person might be indignant. Figure 2 outlines our model of the personal response to stigma.[2]

According to the figure, persons with a salient stigmatizing condition such as serious mental illness make sense of that condition—and the negative reactions of others in a specific situation (e.g., landlords refusing to show an apartment or employers failing to offer job interviews)—as the result of collective representations and cognitive primes. People who perceive the negative response to be legitimate are likely to manifest low self-esteem. Conversely, individuals who do not hold negative reactions to be legitimate will keep their self-esteem intact. Perceived legitimacy is mediated by several processes that affect system justification: external attribution of negative feedback, protection afforded by in-group comparisons, and selecting values that protect against self-stigma.

As shown in Figure 2, persons with intact self-esteem might have two subsequent reactions. Those who closely identify with the stigmatized group ("Yes, I admit it; I'm mentally ill and not ashamed!") will show righteous anger. Those individuals are likely to be active in advocacy and
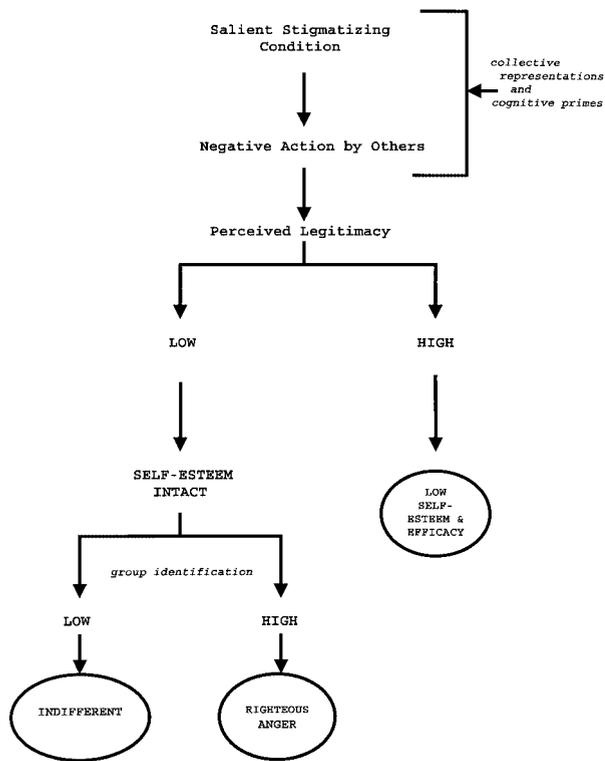
Figure 2. A path diagram explaining the personal response of stigma on the self. People who perceived negative treatment of others as legitimate will have diminished self-esteem. Those who do not believe this treatment is justified will have intact self-esteem. Individuals who identify with the stigmatized group will become angry while those who do not will appear unaware of self-stigma or complacent.

empowerment efforts. Conversely, people who do not seem to identify with the group will appear relatively indifferent to self-stigma. In the remainder of this section of the article, we review evidence that supports individual components of Figure 2: (a) how collective representations and cognitive primes influence the situational appraisal of stigma, (b) how low and high perceived legitimacy leaves self-esteem intact or undermines one's self image, respectively, and (c) how low and high group identification yield indifference or righteous anger.

Collective Representations and Cognitive Priming Lead to Situational Effects

Crocker (1999) identified three components of collective representations relevant to the perception of self-stigma: cultural stereotype, perceived place of the group in the social hierarchy, and sociopolitical ideology. We have discussed cultural stereotypes related to mental illness earlier in the paper (e.g., persons with mental illness are danger-

ous and/or unable to competently care for themselves). The point here is to remember that cultural stereotypes are important mediators of situational experiences with self-stigma.

Perceptions about the social hierarchy are also important for affecting state experiences of self-stigma. Individuals who believe stigma about their group arises from unjust social pressures will deflect negative attitudes from themselves (thereby protecting their sense of self-esteem) to the perception of the social hierarchy. Research has illustrated this point in African Americans. Blacks are more likely than whites to believe that they have personally been discriminated against and that this discrimination is rooted in the American system of government (Crocker & Blanton, 1999; Crocker, Luhtanen, Broadnax, & Blaine, 1999). This kind of system blame seemed to moderate the effect of stigma on self-esteem. Those African Americans who attributed more systemic prejudice to American society showed higher self-esteem. Some advocates with mental illness mirror this concern; namely, there is systemic prejudice against persons with psychiatric disabilities (Chamberlin, 1998; Deegan, 1990). Hence, we would hypothesize that persons with mental illness who recognize system-based prejudice (e.g., the economic system sets up structural barriers that prevent people with psychiatric disabilities from being successful at white collar jobs) would report better self-esteem than a comparison group of people with mental illness.

The third variable that seems to affect self-stigmatizing states is sociopolitical ideology, in particular, the Protestant work ethic. Individualism as embodied in the work ethic has been viewed as the dominant sociopolitical ideology of the Western world (Katz & Hass, 1988; Weber, 1904/1958). Namely, an individual's hard work is the foundation of success; lack of success indicates the person's self-indulgence and poor self-discipline. The Protestant work ethic is related to intolerance and dislike of members of stigmatized groups (Biernat, Vescio, & Theno, 1996; Furnham, 1985). Instead of viewing the stigmatized as victims of systemic prejudice, proponents of the Protestant ethic view lost opportunities of the stigmatized as the rightful consequence of self-indulgence (Quinn & Crocker, 1999). Hence, persons who agree with the Protestant work ethic are more likely to endorse stigma about various minority groups.

A recent study has examined the impact of the Protestant ethic on self-stigma. Quinn and Crocker (1999) found that the self-esteem and psychological well-being

of overweight women were inversely associated with their agreement with the Protestant work ethic; overweight women who endorsed the Protestant work ethic reported lower self-esteem, while no such association was found for women with not overweight. Quinn and Crocker implied that this relationship might be specific to groups stigmatized for weight and not other minority groups. They believed that obesity is stigmatized in Western culture because it is viewed as controllable (Crandall, 1994) and frequently the butt of jokes in the media. As argued earlier, mental illness is also viewed as controllable by the public (Corrigan, 2000) and victimized by disrespectful humor (Wahl, 1995). Hence, we hypothesize that future research would show a inverse relationship between the Protestant work ethic and self-esteem due to stigma in persons with mental illness.

The Effects of Primes on Collective Representations

Cultural stereotypes and other collective representations are activated by information that emerges from the individual situation (Crocker, 1999). For example, the cultural stereotypes of overweight women were manipulated in one study when research participants were asked to read a report from the Surgeon General (Amato & Crocker, 1995). In fact, half the group read a statement that said weight is controllable via diet and exercise, and half the group read a report stating that weight is a function of genetics and is difficult to control through external means. Those reading the diet and exercise report (thereby priming the collective notion that this behavior is controllable) reported significantly lower self-esteem than the group reading received the genetics report. Quinn and Crocker (1999) found a similar result in their study of overweight women and the Protestant work ethic. Overweight women who read a paragraph from a political speech touting the Protestant work ethic (thereby activating this collective representation) showed significantly lower psychological well-being than a similar group who read a relatively neutral speech. We would expect this research design to yield similar results in research on mental illness. Namely, situations that prime the cultural stereotypes and Protestant ideology of persons with mental illness will lead to greater sensitivity to stigmatizing stimuli.

How Perceived Legitimacy Affects Self-Esteem

The effects of cognitive primes and collective representations on self-esteem and self-efficacy are mediated by perceived legitimacy. Sometimes members of stigmatized groups believe negative outcomes that result from stigma are just, while other times they believe these outcomes are not (Finchilescu & de la Rey, 1991; Jetten, Spears, Hogg, & Manstead, 2000; Miller, Jackson, Mueller, & Scherching, 1987). Crocker and Major (1994) explained the effects of justification or legitimacy in terms of equity theory. Namely, a negative outcome (e.g., not hiring someone because they are mentally ill) is perceived as legitimate if a stigmatizing expectation (i.e., persons with mental illness are incompetent and will do poorly at work) is perceived as a corresponding negative input. How do equity theory and legitimacy apply to the self? Persons who view the negative responses of others to them as justified because of stigma will experience diminished self-esteem (Janoff-Bulman, 1979).

Crocker and Major (1989, 1994) identified various mechanisms that protect the person's sense of self from stigma. These factors may also account for a rebound effect where people become energized and react righteously to stigmatizing images about their groups. Hence, these factors may be candidates for mediators of perceived legitimacy. Three of these mechanisms, and their specific relevance to the experience of mental illness stigma, are reviewed here.

External Versus Internal Attribution of Negative Feedback. Research has generally shown that internal attribution of negative feedback ("My weak character must explain why I can't hold a job") and external attribution of positive feedback ("The only reason I was able to keep my job is because of the job coach's hard work") leads to low self-esteem (Crocker, Alloy, & Kayne, 1988; Weiner, 1995). In fact, the first of these two processes, internal attribution of negative feedback, may be an explanatory mechanism for stigma and diminished self-esteem. Hence, the contrary mechanism may be a self-protective factor against stigma; attributing negative feedback to external causes: "The reason I can't work is because employers won't hire the mentally ill!" Persons who attribute negative feedback (like the critical statements that accompany stereotypes) to the prejudice received by their group are less likely to lower their self-esteem (Crocker, Voekl, Cornwell, & Major, 1989; Testa, Crocker, & Major, 1988).

What variables mediate this process? According to Kelley's (1967) model of causal attribution, people attribute causality based on the covariance of events. Persons with mental illness who perceive their group as receiving

negative feedback while other groups do not are likely to attribute stigmatizing images to the prejudice experienced by their group (Crocker & Major, 1989). This kind of experience can lead to indignation. Assessing the covariance of events requires several intervening processes including sensitivity to negative feedback, group comparison, and group identity. However, we would expect research studies that adopted these variables into a comprehensive research design on mental illness self-stigma to echo the results found on other stigmatized groups.

Self-Protective Properties of In-Group Comparisons. The value of one's self-esteem depends on the group with whom one's competence is compared. On specific values related to stigma (e.g., persons with mental illness can't care for themselves), individuals will lose self-esteem when compared to the majority (e.g., "Most persons are able to live independently; I must somehow be bad!"). Research suggests, however, that persons are more likely to compare themselves with in-group members rather than people from the majority (Festinger, 1954; Jones et al., 1984; Tajfel & Turner, 1986). Persons with mental illness, for example, may compare their independent living skills to others with mental illness rather than the general public. One's in-group is more likely to exhibit functioning in the same range as individual members; hence, comparisons will not be so obvious and self-esteem does not suffer. Instead, the person seems relatively indifferent to the impact of stigma on the self.

The protection provided by such in-group comparisons may depend on how central the mental illness self-schema is to an individual's self-concept. Miller (1984) examined how people evaluate their abilities by comparing themselves with others who are similar on attributes that influence performance. Looking specifically at gender schemas, Miller found that people with strong gender self-schemas compared themselves to same-sex others regardless of the relationship of gender to performance. This pattern suggests that individuals with mental illness that do not have strong mental illness self-schemas may not receive the benefit of such in-group comparisons. It should also be noted that individuals with mental illness may be members of other groups which may also be stigmatized (gender, racial, ethnic, sexual orientation, weight, socioeconomic status, occupational). Membership in these groups provides competing self-schemas and in-group comparisons.

Crocker and Major (1989) give several reasons that in-group comparisons may protect persons against stigma. One of them, the proximity effect, seems especially relevant to persons with mental illness. According to the proximity effect, in-group members are more available for social comparison because they frequent a limited set of interpersonal environments (Runciman, 1966). For example, African Americans tend to live in close proximity and women were frequently relegated to a narrowly described set of jobs (Treiman & Hartmann, 1981). Environmental proximity may alternatively be attributed to preference to be near similar people or forced segregation. Either way, this ready access facilitates in-group comparisons. More than likely, the institutional pressures that force persons with mental illness into separate places for inpatient care, housing, and work will accentuate this kind of environmental proximity. Hence, we hypothesize that in-group comparisons would be greater in persons with mental illness who work or live in institutional settings.

Selectivity of Values as Self-Protection. One of the reasons that stigma might lower self-esteem is the person's affiliation with a group that reflects characteristics devalued by the majority. For example, the majority values industry and productivity as exhibited in the Protestant work ethic; persons with mental illness are stigmatized because they are not able to meet the demands of this work ethic. Individuals can protect themselves from this kind of stigma by simply devaluing those qualities on which stigma is based (Nieva & Gutek, 1981; Taylor, 1983). Hence, persons with mental illness suffer little harm to their self-esteem when they do not endorse those values that form the basis of stigma about them. Turning one's back on the values of the majority is consistent with the kind of righteous anger that some survivors of the mental health system tout (Chamberlin, 1978; Deegan, 1990).

Steele (1997) described a negative consequence of this kind of devaluation. He argued that negative stereotypes undermine a person's identification with a specific domain (e.g., school, work, social interactions) and lessen the person's motivation to achieve in that domain. Steele coined the phenomenon that causes this cascade "stereotype threat"—the social-psychological threat that occurs when members of a stereotyped out-group (e.g., African Americans, women, persons with serious mental illness) find themselves in a situation specific to a domain for

which a negative stereotype applies. For example, a negative stereotype about African Americans suggests they are intellectually inferior and not likely to do well scholastically (Hernstein & Murray, 1994). Therefore, African Americans experiencing stereotype threat may feel anxious when faced with an achievement exam in school.

Persons who occasionally experience the emotional distress that results from stereotype stress may disengage from the situations in which this stress occurs (Crocker, Major, & Steele, 1998; Major, Spencer, Schmader, Wolfe, & Crocker, 1998). African Americans, for example, may report that the kind of scholastic ability required in a specific situation that elicits stereotype threat is not important. This kind of disengagement seems to protect minority group members from the low self-esteem that may arise in these stigmatizing situations (Major et al., 1998). Alternatively, people who experience stereotype threat and emotional distress over a prolonged time may disidentify with the domain and task altogether (Steele, 1997). Minority group members who may have once believed that cognitive performance in a specific domain was an important part of their identity (e.g., "doing well in school is essential for my success") may no longer recognize performance in this domain as part of their self-evaluative framework. Disengaging from and disidentifying with performance domains undermines achievement motivation for tasks in that domain and interferes with cognitive performance. This kind of process has been shown in several groups in addition to ethnic minorities. These groups include women (Brown & Josephs, 1999; Shih, Pittinsky, & Ambady, 1999; Spencer, Steele, & Quinn, 1999), the elderly (Levy, 1996), and persons with low socioeconomic status (Croizet & Claire, 1998).

We have speculated elsewhere that a similar process of disengagement may account for the poor cognitive processes that disable the social functions of many persons with mental illness (Corrigan & Calabrese, 2001; Corrigan & Holzman, 2001). Recognizing that the majority views mental illness as "crazy and out of touch with reality," persons with psychiatric disabilities devalue careful cognition and seem disoriented or confused in social interactions. They disengage from the perceptual and comprehension mechanisms that are needed to understand the rules and roles that define interpersonal situations. This is an especially provocative point given that current research primarily attributes cognitive deficits to neurobiological processes (Green, 1999) rather than to self-protection from stigma. Future research needs to determine whether this kind of devaluation process might secondarily lead to, or otherwise exacerbate, diminished social cognitive processes.

High Group Identification Leads to Righteous Anger

According to Figure 2, persons with intact self-esteem might turn their reactions to stigma into righteous anger or might be personally indifferent to prejudice. Identification with the broader group of persons with mental illness is a key variable that influences whether the person is indignant or indifferent (Frable, Wortman, & Joseph, 1997). On one hand, individuals who belong to stigmatized groups may internalize the negativity aimed at that group. Of equal interest, however, are persons who develop a positive identity by interacting with peers from the stigmatized group (e.g., despite the negative views about homosexuality, gays have much to be proud of). As a result, they develop more positive self-perceptions (Porter & Washington, 1993; Tajfel, 1978). This assertion has been supported in research on several stigmatized groups.

In a study of more than 800 gay and bisexual men, Frable and colleagues (1997) found that positive gay identity (i.e., believing that group membership is important to the individual) was positively associated with self-esteem and well-being. Additionally, having gay friends and attending gay social events was indirectly related to high self-esteem, high well-being, and low distress through its affect on positive gay identity. In another approach to group identity, Phinney and Alipuria (1990) examined commitment to ethnic identity and self-esteem among college students. Their analysis suggests that levels of identity search and ethnic commitment are positively related to self-esteem for persons of color. Similarly, Munford (1994) found racial identification to be positively related to self-esteem in a sample of students and members of the general population.

This pattern also seems to apply to group identity and gender. Ossana, Helms, and Leonard (1992) found that a highly developed gender identity was associated with higher self-esteem. Increased self-esteem may be the result of women coming to terms with their identity as women and internalizing positive feelings about themselves. The authors also suggested that some women with less developed gender identities may benefit from joining women's support groups.

Thus, the evidence suggests that high group identification helps individuals shield themselves from the deleterious effects of stigma and maintain their self-esteem. Regarding themselves positively, members of stigmatized groups may become righteously indignant about the negative social identity and discrimination bestowed on them by society. Extrapolating these findings to mental illness, we would expect that persons with psychiatric stigma who identify with peers would show a greater sense of empowerment. Consistent with previous factor analyses on empowerment, this increment would correspond with increased self-esteem and righteous anger (Corrigan et al., 1999; Rogers et al., 1997).

SPECIAL CONCEPTUAL AND METHODOLOGICAL CONSIDERATIONS

Many of the assumptions of our model of personal responses to stigma are based on social psychological research on other groups including persons of color and women. There are two significant characteristics of people with mental illness that mediate the application of these theories to mental illness stigma. These factors must be incorporated into methodological considerations of future research in this area. First, unlike other stigmatized groups, diminished self-esteem and self-efficacy are intrinsic to definitions of some specific mental illnesses (American Psychiatric Association [APA], 1994; Millon, 1981). Problems with self-esteem/self-efficacy arise directly from mental illness, not secondarily from the stigma experienced by the group. Neither ethnic groups, gender, nor physical disabilities are inherently defined in terms of poor self-esteem. Hence, investigators need to develop research strategies that distinguish the problems of self-esteem resulting from mental illness versus problems that are caused by stigma alone.

Second, serious mental illnesses such as schizophrenia and bipolar disorder include problems with such social psychological variables as interpersonal motivation (Glynn, 1998), social skills (Mueser & Tarrier, 1998), and social cognition (Corrigan & Penn, in press). Given that these dysfunctions permeate many of the disabilities of serious mental illness, it is likely that they also influence factors that affect self-stigma. Hence, research designs need to distinguish deficits of mental illness from social psychological mediators. Specific implications of these conceptual confounds for future research are discussed here.

Sorting Out the Causes of Low Self-Esteem

Many persons with affective and schizoaffective disorders report low self-esteem; it is one of the diagnostic indicators of these syndromes (APA, 1994). In addition, persons with schizophrenia often experience co-morbid depression that could manifest itself as low self-esteem (DeLisi, 1990; Siris, 1995). Finally, subclinical depression and low self-esteem are common in persons who are not able to achieve their life goals and who report a poor quality of life as a result (Corrigan & Buican, 1995; Estroff, 1989).

Further complicating this question is the way self-esteem varies across diagnostic subgroups. People with schizophrenia may show diminished self-esteem as a result of reactive depression (Siris, 1995); individuals with borderline personality disorder may suffer problems with self-esteem because of emotional dysregulation (Linehan, 1993); and those with narcissistic personality disorder may show poor self-esteem because their overvalued self-worth is not validated by the social environment (Millon, 1981). Hence, future research in this area needs to incorporate carefully considered diagnostic strategies.

Given these concerns, researchers must develop a measurement strategy that distinguishes the diminished self-esteem that results from the psychiatric disorder per se from that which emerges from internalizing stigma. Three considerations will facilitate development of this kind of measure. First, cognitive behavioral models suggest low self-esteem and depression are manifested in negative self-statements about the person, his or her world, and his or her future (Beck, 1967; Clark, Beck, & Alford, 1999). Diminished self-esteem due to self-stigma might be especially evident in two of these three groups of statements—about the self and the future—as outlined in Table 1.

It is conceivable, however, that persons whose diminished self-esteem arises from depression might also endorse these negative statements; hence, such statements are not unique to persons who self-stigmatize. A second factor would help determine whether endorsement of the items in Table 1 represents self-stigma or depression. To yield self-stigma, people must be aware of the public stigma which corresponds with the negative self-statement ("Yes, I realize most people think the mentally ill can't take care of themselves") and agree that it is true ("Most people are correct. The mentally ill can't take care of themselves"). These assumptions are supported by research that suggests many persons with psychiatric dis-

Table 1. Examples of depressogenic self-statements that might mirror the low self-esteem that results from self-stigma

Statements About the Self
  • I cannot take care of myself.
  • I must be dangerous.
  • I'm not responsible for my actions.

Statements About the Future
  • I'll never be able to get a job because I can't handle it.
  • I'll never get out of the hospital because I'm a risk to society.
  • I'll never be able to live on my own because I can't cope.

ability are aware of the stigma about their group and agree with it (Hayward & Bright, 1997).

A third factor may further distinguish diminished self-esteem due to a psychiatric disorder from that which arises from self-stigma. The symptoms of depression, including low self-esteem, are frequently episodic (Gruenberg & Goldstein, 1997), though the waxing and waning of symptoms is less apparent in persons with dysthymic disorder. Hence, one might attribute low self-esteem to a person's psychiatric disorder when negative self-statements increase and decrease with the dysphoria commensurate with the individual's affective disorder. Moreover, treatments of the depressive syndrome (e.g., medication and some psychotherapies) will lead to improved low self-esteem that results from psychiatric disorders, but not from self-stigma. Poor self-esteem due to self-stigma should not show this kind of variable course.

Although self-stigma does not change with the course of depression, we do not mean to imply that self-stigma is an unvarying trait. As we have suggested, the low self-esteem caused by self-stigma is constructed in the situation and hence better described as a state. In support of this notion, Wright and colleagues (2000) found substantial flux in feelings of self-worth related to stigma in a sample of persons with mental illness. Thus, the impact of self-stigma on self-esteem may show a variable course dependent on situational features as opposed to illness course. This realization further confounds the development of a self-stigma measure and needs to be included into research considerations.

Self-Stigma Research and the Social Psychological Dysfunctions of Serious Mental Illness

As stated earlier, fundamental problems of mental illness may interact with key social-psychological variables in our research model on self-stigma. These dysfunctions include diminished interpersonal efficacy, poor social cognition, diminished awareness of one's disease, and poor identity with the social group of persons with mental illness. Implications of each of these for research are discussed here.

Self-Stigma and Poor Social Efficacy. The defining factor that turns a mental illness into a psychiatric disability is poor skills and low self-efficacy that interfere with the attainment of social goals (Corrigan, in press). Many people with mental illness are not successful in meeting work and other independent-living goals. Hence, it is unclear whether poor social efficacy is due to the limitations imposed by stigma or by the skill deficits that result from psychiatric disabilities. This poses a methodological conundrum for assessing an efficacy-based model of self-esteem and stigma (McDermott, 1995). The problem may be resolved in a manner similar to discerning the effects of depression and stigma on self-esteem. Namely, problems with personal success that covary with the individual's awareness of public stigma might be attributed to an efficacy-based model of self-esteem and stigma.

Self-Stigma and Poor Social Cognition. Persons must perceive subtle stigmatizing messages made by others to be harmed by them. However, many people with serious mental illness have social-cognitive deficits that interfere with the accurate perception of these kind of external cues (Corrigan & Penn, in press). These perceptual deficits are especially marked on more abstract social tasks such as inferring the rules and roles that define an interpersonal interaction (Corrigan, Silverman, Stephenson, Nugent-Hirschbeck, & Buican, 1996; Corrigan & Green, 1993; Corrigan & Nelson, 1998). Social-perceptual deficits may impair the person's recognition of stigma, perhaps serving as a buffer to self-stigma in the process.

Self-Stigma and Disease Awareness. There is an additional cognitive dysfunction especially germane to this discussion that is likely to affect a person's experience of self-stigma. Many persons with psychotic disorders are unaware of the nature of their mental illness or its impact on the breadth of life functioning domains (Amador & Seckinger, 1997; Amador et al., 1994). Research is still unclear whether lack of disease awareness is due to psychosocial processes or frontal lobe deficit (Amador,

Strauss, & Gorman, 1991). Either way, it suggests that some persons with mental illness may not realize they belong to a group of people who are stigmatized. Hence, they may be relatively immune to self-stigma. Investigations have begun to include disease awareness in research on psychosocial processes (Amador et al., 1993) and treatment outcomes (Cuffel, Alford, Fischer, & Owen, 1996). In a like manner, research examining the impact of self-stigma on persons with mental illness should include awareness as a covariate.

There is some research that illustrates both the conceptual and methodological complexity of questions about awareness vis-à-vis self-stigma and self-esteem (Warner, Taylor, Powers, & Hyman, 1989). On one hand, awareness of the disorder may be viewed as enhancing good outcome and self-esteem. Persons aware of the impact that the disorder has on their life are likely to better manage their disabilities. This kind of treatment outcome has significant impact on self-esteem when the person has perceived control over treatment (Strauss & Carpenter, 1981). On the other hand, accepting one's mental illness entails adopting the stigmatizing label. Internalizing this kind of label causes dissonance, which is resolved by lowering one's sense of self-worth (Warner, 1985). These two views lead to differing expectations about awareness and self-stigma that have not yet been resolved by research.

Self-Stigma and Poor Group Identity. Many persons who show the deficit symptoms related to schizophrenia lack the kind of social motivation needed to form strong relationships with peers (Andreasen, Roy, & Flaum, 1995; Glynn, 1998). Although several studies have shown that the negative symptoms of schizophrenia are associated with poor social functioning, one specific symptom, social apathy or amotivation, is of particular interest here. Persons with deficit symptoms are not motivated to seek out peers with similar interests and identify with their goals. One might expect social apathy to diminish the formation of a strong group identity. Thus, people with deficit syndromes may be less affected by the stigma of mental illness because they are not motivated to identify with persons who have similar disabilities. Note that these assumptions suggest that motivation has a distinct impact on self-stigma compared to the deficits on social perception and poor awareness described above. Hence, research on the influences of person variables needs to sort out the separate impact of these influences on self-stigma.

Additional Moderators of Stigma and Their Implication for Research

Friedman and Brownell (1995) noted that the individual differences in low self-esteem that result from stigma may be so great that within-group variability overwhelms any between-group effects. Hence, simply sorting reactions to stigma into independent categories of low self-esteem, righteous anger, or indifference fails to capture the diversity of responses. Friedman and Brownell believed this complexity could be further understood, in part, by identifying risk factors that moderate the impact of self-stigma. Three such moderators discussed in Crocker and Major (1989) that are especially relevant to the experiences of people with mental illness are reviewed here.

Time Since Acquisition of Stigma. Some persons have been struggling with the stigma associated with their mental illness for a short time, while others have had years to adapt. Researchers suggest that persons with longer time to adjust to stigma will develop a self-concept better insulated against prejudice and will suffer less decrement to self-esteem (Harter, 1986; Jones et al., 1984). Hence, time since disease onset becomes an important research covariate. However, researchers need to distinguish onset of symptoms from onset of the stigma experience. The experience of stigma may not occur until persons are labeled with mental illness when entering the mental health service system.

Concealability of Stigma. Some stigmas are based on obvious marks such as skin color or wheelchair use. Other stigmas, such as mental illness, are based on concealable attributes. (Goffman, 1963). The public need not know a person is mentally ill unless he or she publicly reports it. Researchers are mixed about whether hidden stigma has a less deleterious effect on self-esteem than stigma which is apparent. On one hand, Jones and colleagues (1984) believed that persons who can hide their stigma from public eyes are likely to be better adjusted. They can be free of the disapproval and social pressures that follow from belonging to an openly stigmatized group. On the other hand, the concealability of mental illness stigma may undermine group cohesion and identity (Corrigan & Lundin, in press; Frable et al., 1997). One of the benefits of an obvious mark like skin color is the person's ability to recognize similar members of his or her group, which thereby fosters group identity and support. Persons with

mental illness may be hidden from each other and therefore cannot readily benefit from group membership. This may be one of the additional benefits of self-help and consumer advocacy groups that have become especially prominent among persons with mental illness during the past decade (Davidson et al., 1999).

Responsibility for Stigmatizing Conditions. Stigma is also a function of perceived controllability (Weiner, 1995). Members of the general public, who believe an individual is responsible for the qualities that define a stigma (e.g., "that person caused her mental illness because she's lazy and won't pull herself up by her bootstraps") will emotionally react to that person with anger and follow up their anger with punishment or by withholding help. For example, stigmatized behavior (failure to work) that is attributed to the person ("They don't work because they want to live on the dole") is likely to result in public hostility. An angry public will oppose work or housing programs that are meant to assist this disadvantaged group.

What kind of effect does this have in terms of self-stigma? In-group members who view themselves as responsible for a stigmatizing feature will likely turn anger inward, experience low self-esteem, and become depressed (Foersterling, 1986; Metalsky, Laird, Heck, & Joiner, 1995). Some support for this can be found in the literature on other stigmas. Tiggeman and Rothblum (1997) found that overweight women with internal locus of control had lower self-esteem than a comparison group with external weight locus of control. Interestingly, this relationship was not found for men, suggesting that this phenomenon interacts with gender.

The relationship between public attitude about the controllability of mental illness and hostility has been partially supported in recent studies (Corrigan, 2000; Corrigan, Rowan et al., in press). Research participants who viewed persons with mental illness as controlling their mental illness were likely to be angry and respond punitively. However, the impact between self-attributions of responsibility for mental illness (e.g., "I'm not trying hard enough. I must be morally weak") and self-stigma remains to be tested.

CONCLUSIONS

Depending on the situation, persons with mental illness may respond to stigma with low self-esteem and diminished self-efficacy, righteous anger, or indifference. The

cultural stereotypes and other collective representations that people with mental illness acquire over time influence their perceptions of a situation. These representations are activated by information from the situation. Individuals with mental illness who then perceive negative actions by others to be legitimate will manifest lower self-esteem and diminished self-efficacy.

Alternatively, people who view the negative responses of others as unjust or irrelevant to them will experience no reduction in self-esteem due to stigma. Persons with intact self-esteem will respond to stigma with indifference or indignation depending on their identification with the generic group of people with mental illness. Those with high group identification will show righteous anger. Those who do not identify with the group will be indifferent to stigma.

Although this model is useful for explaining situational reactions to stigma, it fails to account for consistent patterns which people show in their self-image across situations. This absence ignores research that has suggested that self-esteem and self-image are relatively consistent over time and across situations (Choca, Retzlaff, Strack, & Mouton, 1997; Laukkanen, Halonen, & Viinamacki, 1999). Hence, further model development needs to integrate more personologic perspectives on stigma and self-esteem. Possible factors that may explain the interaction of situational and personality manifestations of self-esteem, and that should be the focus of future research, might include the number of individuals involved in a situation, the ease with which situational relationships are terminated, the presence of a legitimate chain of authority, and the level of intimacy expressed in the situation (Donahue & Harary, 1998).

Nevertheless, this model is a fruitful heuristic tool for future research into self-stigma; several hypotheses to govern subsequent studies were posed in this article. Researchers adopting social–psychological approaches developed on other stigmatized groups need to consider the special characteristics of mental illness (e.g., mental illness is inherently defined as poor self-esteem, and people with mental illness often experience deficits that may be mediators in stigma models). With these considerations in mind, a fruitful research program awaits. Moreover, this approach has eventual implications for ways in which persons with mental illness might cope with self-stigma as well as policy changes that will develop an environment in which stigma festers.

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