

## **THE SELF-STIGMA OF MENTAL ILLNESS: IMPLICATIONS FOR SELF-ESTEEM AND SELF-EFFICACY**

PATRICK W. CORRIGAN, AMY C. WATSON, AND LEAH BARR  
*Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare*

Self-stigma is distinguished from perceived stigma (stereotype awareness) and presented as a three-level model: stereotype agreement, self-concurrence, and self-esteem decrement. The relationships between elements of this model and self-esteem, self-efficacy, and depression are examined in this study. In Study 1, 54 people with psychiatric disabilities completed a draft version of the Self-Stigma of Mental Illness Scale (SSMIS) to determine internal consistency and test-retest reliability of composite scales. In Study 2, 60 people with psychiatric disabilities completed the revised SSMIS plus instruments that represent self-esteem, self-efficacy, and depression. Stereotype awareness was found to not be significantly associated with the three levels of self-stigma. The remaining three levels were significantly intercorrelated. Self-concurrence and self-esteem decrement were significantly associated with measures of self-esteem and self-efficacy. These associations remained significant after partialing out concurrent depression. Implications for better understanding self-stigma are discussed.

The stigma of mental illness has been differentiated into public stigma (the general population endorses prejudice and manifests discrimination toward people with mental illness) and self-stigma (people with mental illness who internalize stigma experience diminished self-esteem and self-efficacy) (Corrigan & Watson, 2002). Self-stigma has been shown to yield deleterious effects on the lives of people with mental illness. First-person narratives and other subjective data provide compelling illustration of the impact of stigma on the person's self-esteem (Davidson, 1992; Estroff, 1989). Such qualitative data have been augmented by quantitative surveys of persons with mental illness. Studies

---

Correspondence concerning this article should be addressed to Patrick W. Corrigan, Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare, 1033 University Place, Ste. 440-450, Evanston, IL, 60201. E-mail: p-corrigan@uchicago.edu.

of persons with mental illness and their families showed self-stigma to be a significant problem leading to diminished self-esteem (Wahl & Harmon, 1989; Wahl, 1999). Of special relevance to this study, people who endorse self-stigma are more likely to report diminished self-esteem and self-efficacy (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Markowitz, 1998; Ritsher, Otilingam, & Grajales, 2003; Rosenfield, 1997). A study by Link, Struening, Rahav, & Phelan (1997) showed that the negative effects of self-stigma on these indices of psychological well-being endure even when psychiatric symptoms have remitted because of treatment.

The effects of self-stigma on self-esteem, psychological well-being, and self-efficacy also impact behavioral goals. Research has shown that self-stigma may undermine adherence to empirically validated services (Fenton, Blyer, & Heinssen, 1997; Sirey, Bruce, Alexopoulos, Perlick, Friedman et al., 2001; Sirey, Bruce, Alexopoulos, Perlick, Raue et al., 2001). Self-stigma may also interfere with the pursuit of such rehabilitation goals as living independently and obtaining competitive work. For example, a classic study by Link (1982) found that people with diminished self-efficacy that results from self-stigma were less likely to pursue employment and independent living opportunities. Participants in the research had accepted the stigma and convinced themselves that they were unable to work or live outside of institutions. Low self-efficacy and low self-esteem is also associated with failure to develop social networks for leisure (Perlick et al., 2001).

Much of the research on the self-stigma of mental illness is based on a model by Link (Link, 1987; Link & Phelan, 2001). According to Link, self-stigma begins when people develop a lay theory about mental illness from childhood conceptualizations that reflect cultural images of mental illness. Given cultural images in the U.S., American lay theory is likely to represent several negative stereotypes about mental illness. These public beliefs become especially poignant for adults who develop serious mental illness because the possibility of devaluation and discrimination becomes personally relevant. We define Link's process of perceived discrimination as *stereotype awareness*: namely, the person is aware of the general negative beliefs about mental illness held by one's culture. We argued that perceived discrimination or stereotype awareness is not a measure of self-stigma per se (Watson & River, 2005). Instead, self-stigma begins with *stereotype agreement*: endorsing the same stereotypes perceived to be common in the public. For example, "I agree with the public; all people with mental illness are morally weak." The process becomes harmful with the addition of *self-concurrence* in which people believe that culturally internalized beliefs in fact apply to them: "That's right, I am morally weak for being mentally ill!" This, in turn,

yields *self-esteem decrement*: the person's self-esteem is diminished due to concurrence with the negative belief.

How might the elements of this model of self-stigma be associated with self-esteem and self-efficacy? We do not expect that perceiving or agreeing with stereotypes will be associated with self-esteem or self-efficacy. This could occur purely as a cognitive process without any impact on the self. Instead, only when the person concurs with the stigma and experiences diminished self-esteem will a significant association be seen.

Many persons with serious mental illnesses such as affective and schizoaffective disorders typically report low self-esteem; it is one of the diagnostic indicators of these syndromes (American Psychiatric Association, 1994). In addition, persons with schizophrenia often experience comorbid depression that could manifest itself as low self-esteem (Siris et al., 2001). In these instances, it is not clear whether diminished self-esteem and self-efficacy in people with mental illness is due solely to depression or also to the effects of self-stigma. We hypothesize the latter and expect to show that self-stigma accounts for unique significant variance in self-esteem and self-efficacy after the effects of depression are removed.

## METHODS

This article reports on two studies relevant to our hypotheses. Study 1 provides initial findings in terms of the reliability and internal consistency of items selected for our four-level instrument: the Self-stigma of Mental Illness Scale (SSMIS). This information was used to revise the scale. Study 2 examines the construct validity of the revised SSMIS.

### STUDY 1: ITEM SELECTION AND ANALYSIS

Sixty items were generated for the four levels of the Self-Stigma in Mental Illness Scale (SSMIS), 15 items per level. For stereotype awareness, research participants responded to items with the following format; "I think the public believes most persons with mental illness..." Subsequent clauses were adapted from the Devaluation-Discrimination subscale of Link's (1982) perceived stigma measure. A focus group of 12 people with mental illness and their families reviewed these items and generated an additional 25 candidates. Candidate items were subsequently reduced to 15 due to redundancy; examples include "I think the public believes most people with mental illness: (1) will not recover or get better, (2) are unpredictable, (3) cannot be trusted."

Subsequent levels of the SSMIS used the same 15 items except for different introductory clauses. The introduction for stereotype agreement

TABLE 1. Cronbach's Alphas and Test-Retest Reliabilities for the Original and Revised Versions of the Four Levels of the Self-Stigma of Mental Illness Scale

Self-Stigma of Mental Illness Subscale	Version	Cronbach's Alpha	Test-Retest Reliability
Stereotype awareness	Original	0.85	0.72
	Revised	0.91	0.73
Stereotype agreement	Original	0.64	0.62
	Revised	0.72	0.68
Self-concurrence	Original	0.72	0.72
	Revised	0.81	0.82
Self-esteem decrement	Original	0.87	0.75
	Revised	0.88	0.78

was "I think most persons with mental illness are..." The introductory clause for self-concurrence was "Because I have a mental illness, I..." The introduction for self-esteem decrement was "I currently respect myself less because I..." The order of items within each subscale was randomized to diminish order effects.

Research participants were asked to respond to each item using a nine-point agreement scale (9 = strongly agree). Fifty-four people with psychiatric disability as determined by the Social Security Administration completed this measure twice with one week intervening. The mean age of participants was 41.8 years old ( $SD = 9.6$ ) and the group was 46.0% female. The sample was 22.0% African American, 74.0% European American, and 4% other including Native and Asian American. In terms of marital status, 38.0% were never married, 12.0% were currently married, 44.0% were separated or divorced, and 6.0% were widowed.

Cronbach's alphas and test-retest reliabilities are listed in Table 1. Five items were omitted from each subscale of the original SSMIS draft to maximize internal consistency and reliability. Table 1 includes the psychometric values for the revised version of the test. Note that the range of indices falls within satisfactory limits.

## STUDY 2: CONSTRUCT VALIDITY

Sixty persons with psychiatric disabilities according to the Social Security Administration, and who did not participate in the first study, were recruited for Study 2. On average they were 44.5 years old ( $SD = 8.5$ ) and 55.0% female. The sample was 23.3% African American, 70.0% European American, and 6% other including Native and Asian American.

Only 1.7% of participants acknowledged Hispanic ethnicity. In terms of marital status, 41.7% were never married, 6.7% were currently married, 48.3% were separated or divorced, and 3.3% were widowed.

Research participants were administered the revised version of the SSMIS as well as measures of self-esteem, self-efficacy, and depression. The Rosenberg Self-esteem Scale (1965) was used to measure self-esteem. This 10-item scale yields a single overall, reliable score that has been widely shown to be valid and is frequently used in psychological research on self-esteem (Torrey, Mueser, McHugo, & Drake, 2000).

The Self-efficacy Scale of Sherer and Adams (1983) was included to assess self-efficacy. Perceived self-efficacy is concerned with people's beliefs in their capabilities to mobilize personal resources that help them to exercise control over events in their life. People tend to avoid situations that they believe exceed their abilities, limiting themselves to situations they judge themselves capable of handling (Bandura, 1989). The Self-efficacy Scale, comprises 23 items measuring expectation of personal ability to initiate and persist in behavior. Of its various scales, we selected the General Self-Efficacy Scale which has demonstrated reliability and validity (Sherer & Adams, 1983).

The UCLA Extended Version of the Brief Psychiatric Rating Scale (Ventura, Green, Shaner, & Liberman, 1993) was administered to assess depression. We used the UCLA version of the BPRS because it has been shown by independent research groups to yield reliable and valid measures of various proxies of symptoms including depression (Mueser, Curran, & McHugo, 1997; Ventura et al., 1993). Raters administering the BPRS were trained to criterion levels of interrater reliability ( $ICC > .80$ ) in our lab. BPRS scores will allow us to determine how variance in self-esteem or self-efficacy is significantly and independently associated with self-stigma after depression is partialled out.

## RESULTS

As outlined in Table 2, Cronbach alphas for the four subscales of the SSMIS are within satisfactory limits. Table 2 also lists the intercorrelations among the four SSMIS subscales. As expected, stereotype awareness (representing the person's perceptions of public stigma) was not significantly associated with any of the other three levels of the model. Significant correlations ( $p < .001$ ) with moderate effect sizes were found between stereotype agreement and the indices representing self-concurrence and self-esteem decrement. Self-concurrence and self-esteem decrement were highly correlated.

TABLE 2. Cronbach's Alphas for the Four Self-Stigma Scales. Pearson's Product Moment Correlations among Four Self-Stigma Scales. Correlations between Self-Stigma Scales and Measures of Self-Esteem, Self-Efficacy, Righteous Anger, and Depression

	Stereotype Awareness	Stereotype Agreement	Self-Concurrence	Self-Esteem Decrement
Cronbach's Alpha	.89	.80	.72	.81
Stereotype Awareness	1.00	.11	.15	.11
Stereotype Agreement		1.00	.55***	.47***
Self-concurrence			1.00	.84***
Self-esteem decrement				1.00
General Self-efficacy (SASES)	-.39**	-.05	-.42***	-.47***
Self-esteem (RA)	-.39**	-.16	-.46***	-.48***
Depression (BPRS)	.23	.13	.43***	.42***

Note. ES = Empowerment Scale; RA = Rosenberg Assessment Scale; SASES = Sherer and Adams Self-Efficacy Scale; BPRS = Brief Psychiatric Rating Scale; \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$

Table 2 also included correlations between the four levels of the SSMIS and measures of self-esteem and self-efficacy. Consistent with findings on perceived stigma by Link and colleagues (1997, 2001), stereotype awareness was significantly associated with the inverse of self-esteem and self-efficacy. Stereotype agreement was not significantly associated with self-esteem or self efficacy. Self-concurrence and self-esteem decrement were each significantly associated with self-esteem and self-efficacy.

The results in Table 2 also showed that depression as measured on the BPRS was significantly associated with self-concurrence and self-esteem decrement. Multiple-regression analyses sought to show that self-esteem and self-efficacy were independently associated with depression and self-stigma measures. These findings are summarized in Table 3. The first regression analysis in Table 3 showed that depression and self-concurrence independently accounted for more than 40% of the variance in self-esteem. The second regression analysis showed that depression and self-esteem decrement uniquely accounted for about 45% of the self-esteem variance. The third and fourth regression analyses examined the impact of depression and self-stigma on general self-efficacy. Equation 3 showed that depression and self-concurrence independently accounted for almost 30% of the variance in general self-efficacy. Equation 4 showed that depression and self-esteem decrement accounted for 32% of the variance in general self-efficacy.

TABLE 3. Results from Multiple Regression of Self-Esteem and Self-Efficacy as Dependent Variables and Depression Scales as Independent Variables

Regression Analysis	Dependent Variable	Independent Variable	Beta	t-Test	R
#1	Self-esteem	Depression	-.52	-4.74***	
		Self-concurrence	-.24	-2.21*	
#2	Self-esteem	Depression	-.52	-4.76***	
		Self-esteem Decrement	-.26	-2.42*	
#3	General Self-efficacy	Depression	-.37	-2.94**	
		Self-concurrence	-.26	-2.08*	
#4	General Self-efficacy	Depression	-.34	-2.85**	
		Self-esteem Decrement	-.33	-2.68**	

## DISCUSSION

In this article, self-stigma was distinguished from perceived stigma—stereotype awareness—and framed as a three-level process: stereotype agreement, self-concurrence, and self-esteem decrement. The results showed that perception of public stigma was not significantly associated with the three levels of self-stigma. Stereotype agreement was significantly associated with self-concurrence and self-esteem decrement. This occurs because stereotype agreement is primary to self-concurrence. The person has to agree with a stigma before applying it to him or herself. Self-concurrence and self-esteem decrement were found to be highly associated, which makes sense; namely, people who apply stigma to themselves (self-concurrence) are automatically likely to experience diminished self-esteem.

Self-esteem and self-efficacy were not found to be significantly associated with stereotype agreement. Just because people endorse stigma of mental illness does not mean they will internalize it and suffer diminished self-esteem and self-efficacy. Self-esteem and self-efficacy were shown to be significantly associated with stereotype awareness. This finding, although consistent with Link et al. (1997, 2001) is puzzling nonetheless in light of the nonsignificant association between stereotype agreement and self-esteem or self-efficacy. Future research needs to determine why recognizing public stigma would lead to decrements in self-esteem/self-efficacy, but endorsing those stigma (stereotype agreement) does not. Perhaps there is a pessimism associated with the former that leads to diminished sense of self.

Results showed that self-concurrence and self-esteem decrement were significantly associated with lower self-esteem and self-efficacy,

in some ways an obvious finding. Depression, which is a common experience in many people with serious mental illness, may explain the low self-esteem and self-efficacy experienced by people who report self-stigma due to mental illness. To rule out this alternative explanation, multiple-regression analyses were conducted in which depression was first removed. Analyses showed that self-concurrence and self-esteem decrement still accounted for significant variance in these analyses suggesting that the significant association between self-concurrence/self-esteem decrement and self-esteem/self-efficacy is not due to depression.

There are some limitations to the findings in this article that need to be considered for future research. Path analysis using structural equation models would have provided a better, omnibus test of the different constructs in our model. However, the sample size was too small for this kind of analysis. Future research should attempt to replicate these findings by recruiting an appropriate sample size. Second, the relationship between self-esteem decrement and self-esteem needs to be interpreted cautiously. The two measures have shared method variance, which may explain the high correlation between the corresponding constructs. Similar association between self-esteem decrement and self-efficacy supports the general trends discussed in this article. Future research needs to include self-esteem measures that do not overlap in method with the SSMIS.

These findings have implications for the improved understanding of self-stigma. The model shows that self-stigma is a multilevel process that begins with awareness of public stigma. Self-stigma begins when the person internalizes the stigma and applies it to people with mental illness in general (stereotype agreement) or to him or herself (self-concurrence). Efforts to change self-stigma need to be mindful of these various levels in order to develop comprehensive stigma programs.

## REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25*, 729–735.
- Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*, 35–53.
- Davidson, L. (1992). Developing an empirical-phenomenological approach to schizophrenia research. *Journal of Phenomenological Psychology, 23*, 3–15.
- Estroff, S. (1989). Self, identity, and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin, 15*, 189–196.



- Fenton, W. S., Blyler, C. R., & Heinssen, R. K. (1997). Determinants of medication compliance in schizophrenia: Empirical and clinical findings. *Schizophrenia Bulletin*, *23*, 637–651.
- Link, B. (1982). Mental patient status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review*, *47*, 202–215.
- Link, B., Struening, E., Neese-Todd, S., Asmussen, S., & Phelan, J. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, *52*, 1621–1626.
- Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, *52*, 96–112.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385.
- Link, B. G., Struening, E. L., Rahav, M., & Phelan, J. C. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*, 177–190.
- Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behavior*, *39*, 335–347.
- Mueser, K. T., Curran, P. J., & McHugo, G. J. (1997). Factor structure of the Brief Psychiatric Rating Scale in schizophrenia. *Psychological Assessment*, *9*, 196–204.
- Perlick, D., Rosenheck, R., Clarkin, J., Sirey, J., Salahi, J., Struening, E., & Link, B. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, *52*, 1627–1632.
- Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, *121*, 31–49.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review*, *62*, 660–672.
- Sherer, M., & Adams, C. H. (1983). Construct validation of the Self-efficacy Scale. *Psychological Reports*, *53*, 899–902.
- Sirey, J., Bruce, M. L., Alexopoulos, G. S., Perlick, D., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services*, *52*, 1615–1620.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, *158*, 479–481.
- Siris, S. G., Addington, D., Azorin, J.-M., Falloon, I. R., Gerlach, J., & Hirsch, S. R. (2001). Depression in schizophrenia: Recognition and management in the USA. *Schizophrenia Research*, *47*, 185–197.
- Torrey, W. C., Mueser, K. T., McHugo, G. H., & Drake, R. E. (2000). Self-esteem as an outcome measure in studies of vocational rehabilitation for adults with severe mental illness. *Psychiatric Services*, *51*, 229–233.
- Ventura, J., Green, M. F., Shaner, A., & Liberman, R. P. (1993). Training and quality assurance with the Brief Psychiatric Rating Scale: "The drift busters." *American Journal of Public Health*, *3*, 221–244.
- Wahl, O. F., & Harmon, C. R. (1989). Family views of stigma. *Schizophrenia Bulletin*, *15*, 131–139.

- Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25, 467-478.
- Watson, A. C., & River, L. P. (2005). A social cognitive model of personal responses to stigma. In P. W. Corrigan (Ed.), *On the stigma of mental illness. Practical strategies for research and social change* (pp. 145-164). Washington, DC: American Psychological Association.

Copyright of Journal of Social & Clinical Psychology is the property of Guilford Publications Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.