Ingroup perception and responses to stigma among persons with mental illness


Objective: Mental illness stigma is common, but it is unclear why it affects some individuals more than others. We tested the hypothesis that the way persons with mental illness perceive their ingroup (people with mental illness) in terms of group value, group identification and entitativity (perception of the ingroup as a coherent unit) shapes their reaction to stigma.

Method: Ingroup perceptions, perceived legitimacy of discrimination and reactions to stigma (educating or helping others, social performance, secrecy, social distance, hopelessness) were assessed among 85 people with mental illness using questionnaires and a standardized role-play test.

Results: Controlling for depression and perceived discrimination, high group value and low perceived legitimacy of discrimination predicted positive reactions to stigma. High group identification and entitativity predicted positive reactions only in the context of high group value or low perceived legitimacy of discrimination.

Conclusion: Group value and perceived legitimacy of discrimination may be useful targets to help people with mental illness to better cope with stigma.

Significant outcomes

- If people with mental illness hold their group in high regard (high group value) or reject stigma as unfair (low perceived legitimacy of discrimination), they may be more resilient to stigma.
- Initiatives to reduce self-stigma should aim to increase group value and decrease perceived legitimacy of discrimination.

Limitations

- Our cross-sectional data do not allow firm conclusions on causality and findings are restricted to persons with serious mental illness such as bipolar disorder and schizophrenia.

Introduction

Mental illness stigma is widespread (1–4), but it is not clear why it affects some people with mental illness more than others. Some internalize stigma, resulting in hopelessness and other negative reactions, while others remain unaffected or react positively (5, 6). Social psychological research on other minorities (7) found that the ingroup (in our case, the group of people with mental illness) can be a threat or a resource for stigmatized individuals, depending on how they perceive their ingroup. Applying this social psychological framework to mental illness stigma, we studied how three aspects of ingroup perception (i.e., how people with mental illness see their own group) influence the way persons with mental illness react to stigma (Fig. 1): perceived group value, or whether group members evaluate their ingroup positively or negatively; group identification, or how strongly individuals identify with and feel attached to their ingroup; and entitativity, or the degree to which the group of
people with mental illness is perceived as a coherent unit. Previous research found higher levels of symptoms or more insight were associated with more internalized stigma (8–10). Building on this important work, we focus here on the role of ingroup perception for reactions to stigma.

To test a more comprehensive model, we included two stigma perception variables that influence how stigmatized individuals react to stigma. First, the level of perceived discrimination because of personal exposure to stigma varies among individuals with mental illness (11) and social cognitive deficits may lead to differences in perceived discrimination (12). Second, we looked at perceived legitimacy of discrimination because a group member can reject discrimination as unfair independently of ingroup perception, which likely leads to a more positive and energized response to stigma (13, 14). Finally, we controlled for depressive symptoms that undermine positive and increase negative reactions to stigma (Fig. 1) and examined psychiatric diagnoses as predictors of stigma-related behavior. We tested the hypotheses that: i) people with mental illness exhibit higher levels of ingroup perception variables (group value, identification, entitativity) than members of the public; ii) in people with mental illness high group value and low perceived legitimacy of discrimination predict more positive reactions to stigma; iii) while group identification and entitativity are associated with positive or negative reactions, depending on group value and perceived legitimacy. Controlling for stigma perception and depression, we chose a conservative design.

Aims of the study

To examine levels of ingroup perceptions in people with mental illness as compared to members of the public and to assess the impact of ingroup perception and perceived legitimacy of discrimination on reactions to stigma among people with mental illness.

Material and methods

Participants

Eighty-five persons with mental illness were recruited at centers offering mental health services in the Chicago area. None of the subjects received psychiatric in-patient treatment at the time of assessment. To provide a quantitative reference point for ingroup perception variables such as perceived group value, 50 controls were recruited, matched for age, gender and ethnicity and screened for any life-time or current axis I disorder. An eighth grade reading level as assessed by the Wide Range Achievement Test (15) was required for all subjects. Participants gave written informed consent and the study was approved by the institutional review boards of the Illinois Institute of Technology and of the collaborating organizations.

Measures of ingroup perception

High group value is expected to have a positive impact on group members as long as group identification and entitativity are large enough to render ingroup processes relevant for the individual. A group could be regarded highly by a group member, but in the absence of a strong link between individual and group (low group identification) or if the group is perceived as meaningless and incoherent (low entitativity), high group value is unlikely to have a significant positive impact on the individual. Alternatively, negative group value is expected to affect group members negatively only if they show at least some group identification and entitativity which render the ingroup personally relevant (7). This is consistent with recent research showing that group identification can be positively or negatively related to self-esteem in stigmatized minorities (16, 17). Adding group value to the investigation of group identification’s impact on group members may help to reconcile apparently contradictory findings on negative (14) vs. positive
(13) correlations between group identification and self-esteem in mental illness. In the same sample, we found that lower group value was associated with perceiving stigma as more stressful (18, 19).

Perceived value of the group of people with mental illness in terms of valence and power was measured by two items: ‘I think the group of people with mental illness is ... very bad/very good’ and ‘... not powerful at all/very powerful’ (items rated from 1 to 9). The split-half reliability of this scale was satisfactory [0.74 according to the Spearman Brown formula, the equivalent of Cronbach’s alpha for two-item scales (20)] with higher mean scores indicating higher perceived value of the group. Initially, we had planned to assess perceived value as a broader concept, including one item each for measuring the group’s reputation, consensus, and the sense of belonging and acceptance between the member and the group as discussed by Correll and Park (7). However, a broader scale including these latter three items had unsatisfactory internal reliability (Cronbach’s alpha = 0.54). Therefore, we used the two-item scale that was restricted to valence and power, the latter being a key element of intergroup relations in the context of stigma (21).

Identification with the group of people with mental illness was conceptualized with five items adapted from Jetten et al. (14, 22), e.g. ‘I feel strong ties with the group of people with mental illness’ (Cronbach’s alpha = 0.85). Items were rated from 1 to 7, with higher mean scores indicating higher group identification.

Entitativity refers to the perception of a group as a meaningful and coherent entity (23, 24). Some collections of people, such as people waiting in line for a bus, have low entitativity because they are usually perceived as transient and meaningless. Others, such as a professional sports team, are seen as a more coherent group with higher entitativity. First, participants were introduced to the concept of entitativity following Lickel and colleagues (24): ‘We are interested in your perceptions of people with mental illness as a group. All groups are a collection of people. However, not all collections of people are considered to be a group. For example, most people would consider the members of a planning committee to be a group, but would not consider a bunch of people who happen to be on an elevator together to be a group’. Then, participants were asked to rate two examples from 1 (not a group at all) to 9 (very much a group): people waiting in line for a bus (M = 2.6, SD = 2.3) and Chicago police officers (M = 8.5, SD = 1.0). The large difference between both ratings suggests participants could distinguish between these examples of low and high entitativity. Then four items measured perceived entitativity of the group of people with mental illness. The first item (24) referred to ‘People with mental illness ... are not a group at all/are very much a group’. The other three items assessed three further components of entitativity, following Campbell (23) and Rothbart and Park (25): similarity (‘People with mental illness have many characteristics in common’); common fate and common goals (‘People with mental illness share a common fate and common goals’); and being a distinguishable and recognizable group in society (‘People with mental illness can be recognized as a distinct group in larger society’). The four-item scale with a mean score between 1 and 9 had satisfactory internal consistency (Cronbach’s alpha = 0.73).

Measures of stigma perception and depression

We used Link’s (26) 12-item Perceived Devaluation and Discrimination Questionnaire to measure the perceived level of discrimination against persons with mental illness in society, with an average score between 1 and 6 and higher scores reflecting higher perceived discrimination (Cronbach’s alpha = 0.85). Perceived legitimacy of discrimination can be defined as an individual’s subjective perception that the social hierarchy and the lower status of their group are fair. It was assessed with three items adapted from Schmader et al. (27) such as ‘Do you think it is justified that people without a mental disorder have a higher status than people with a mental disorder?’ Higher mean scores between 1 and 7 reflected higher perceived legitimacy of discrimination (Cronbach’s alpha = 0.82). In the diagnosed group, depression was measured using the 20-item Center for Epidemiologic Studies Depression Scale (28) with a sum score between 0 and 60 and higher scores indicating higher levels of depression (M = 23.0, SD = 13.3, Cronbach’s alpha = 0.92).

Measures of stigma-related behavioral intentions

Stigma-related intentions and behavior were assessed in two dimensions. First, we measured negative vs. positive behaviors; second, we assessed intentions or behaviors targeting the outgroup of ‘normals’ (i.e. members of the public), the ingroup of people with mental illness, or oneself and own goals. For each measure, means and standard deviations are reported below as well as Cronbach’s alpha as an index of internal consistency. Two behavioral intentions towards the majority outgroup (‘normals’) were assessed. First, educating
others about mental illness is a positive behavior, taking an active approach to diminish stigma in the environment. We used Link's revised three-item Educating Others Scale (29, 30) with a higher average score between 1 and 6 indicating a stronger intention to educate others (M = 4.1, SD = 1.0, Cronbach's alpha = 0.73). Second, as a negative behavioral intention the tendency to keep one's mental illness a secret was assessed by Link's revised nine-item Secrecy Scale (29) (M = 3.7, SD = 1.2, Cronbach's alpha = 0.92). Referring to secrecy as a negative reaction, we do not want to imply that it is always harmful. Individuals may find it a helpful option in certain situations. However, research suggests that secrecy is generally associated with lower self-esteem and more depression (29).

The next two measures assessed intentions towards the ingroup of people with mental illness. As a positive intention, we assessed the readiness to help other consumers using the three-item Help Scale of Corrigan's Attribution Questionnaire (31) (M = 21.2, SD = 4.5, Cronbach's alpha = 0.64), with higher sum scores between 9 and 27 indicating greater intention to help. As a negative behavioral intention towards ingroup members, desire for social distance from a person with mental illness was measured using a case-vignette describing schizophrenia and five items following Link et al. (32) (M = 3.7, SD = 1.2, Cronbach's alpha = 0.87) with higher mean scores, from 1 to 6, indicating stronger desire for distance from other consumers.

We also measured the readiness of participants, with an average score from 1 to 9, to support three initiatives to help people with mental illness and to fight stigma (donate money to an association of people with mental illness that fights stigma; sign a petition against mental illness stigma; and participate in a peer-support program) (M = 7.4, SD = 1.7, Cronbach's alpha = 0.67). This measure combines both ingroup- and outgroup-oriented positive behavioral intentions.

Finally, we assessed behaviors and attitudes to pursuing own goals and hopes which may be undermined by stigma. On the negative side, we measured hopelessness, a proxy for demoralization as a possible consequence of stigma, using Beck’s 20-item Hopelessness Scale (33–36) with higher sum scores between 20 and 100 indicating more hopelessness (M = 48.4, SD = 15.6, Cronbach's alpha = 0.92). On the positive side, we used a standardized and widely used role-play test, the Maryland Assessment of Social Competence [(37, 38) developed as part of the Social Problem Solving Assessment Battery (39)], as measure of social performance in the pursuit of social, treatment- and employment-related goals. This role-play test is a good proxy of the ability and motivation to interact with outgroup members and to achieve goals in domains that are threatened by stigma: building new social contacts and assertiveness in treatment and employment situations. Following a short practice scene, three 3-min social scenes were administered by a trained confederate in a standardized manner. We adapted previously used scenes that were provided by Dr. Bellack as well as administration and coding manuals. The three scenes involved speaking with a new neighbor, talking to a psychiatrist about difficulties with new medication and symptom monitoring, and negotiating with a supervisor of a job training program. Videotapes were rated in terms of conversational and non-verbal content and effectiveness from 1, very poor, to 5, very good. Inter-rater reliability between three raters that rated all subjects was high with intra-class correlation coefficients of 0.85 for verbal content, 0.84 for non-verbal content and 0.90 for effectiveness respectively. As an index of overall social performance a mean score across all scenes and evaluated domains was calculated (M = 3.25, SD = 0.83).

Statistical analyses

Analyses were conducted using SPSS for Windows with a significance level of \( P < 0.05 \) for all analyses. Group perception and stigma perception variables were compared between diagnosed and control groups using two-sample \( t \)-tests (Table 1). Here, the control group served as a quantitative reference point for the diagnosed group. All other analyses refer to the group of 85 people with mental illness. To assess the influence of ingroup and stigma perception variables on stigma-related behavioral intentions among people with mental illness, stepwise forward linear regression analyses were calculated on seven stigma-related intentions or behaviors. Table 2 illustrates that independent variables were only moderately interrelated (all correlation coefficients < 0.50). A set of nine independent variables was used for all regressions: first the three ingroup perception variables group value, group identification and entitativity; then two variables of stigma perception, perceived level of discrimination and perceived legitimacy of discrimination, as well as depression; finally three interaction terms between ingroup perception variables (group identification by entitativity, group identification by group value, and entitativity by group value; because scaling differed between scales, all three were \( z \)-standardized before computing interaction terms). In case an interaction term \((a \times b)\) entered a regression equation in the stepwise forward process,
both respective independent variables (a and b) were forced into the regression in addition to the respective interaction term, and the interaction term (a × b) was only retained in the equation if it remained significant in the presence of both respective single variables [for hierarchical testing of interaction effects on top of main effects in regression analyses see (40)]. To interpret the meaning of a significant interaction of, for instance, group identification and entitativity, the sample was split along the median into subgroups of low vs. high entitativity. Then correlations of group identification and the dependent variable were assessed separately within each subgroup. In a post hoc fashion, three major psychiatric diagnoses (life-time psychotic disorder, life-time bipolar I or II disorder, current comorbid alcohol- or substance-related abuse or dependence) were entered as independent variables in the seven regressions to examine whether psychiatric diagnoses explained additional variance of stigma-related behavior.

Results

Sociodemographic and clinical characteristics of the diagnosed group

Participants with mental illness were on average about 45 years old, had 13.5 years of education and about two-thirds were male. More than half were African-American, about a third Caucasian, while a few reported Hispanic, mixed or other ethnicities (Table I). Axis I diagnoses were made using the Mini-International Neuropsychiatric Interview (41). A third of participants had a current major depression, 61% a life-time bipolar I or II disorder, 53% a life-time psychotic disorder. In the overall sample, 39% had a comorbid current alcohol- or substance-related abuse or dependence in addition to other axis I diagnoses.

Means of group and stigma perception variables across groups

Examining our first hypothesis, we compared levels of ingroup perception variables between groups. Table I illustrates that people with mental illness valued their group more highly than members of the public, though both group means were close. As predicted group identification and entitativity were much stronger among ingroup members as compared to members of the public. Both groups perceived similar levels of discrimination against people with mental illness in society, however diagnosed individuals considered discrimination as more unfair (Table I).

Predicting positive behavioral intentions

Testing our second and third hypotheses, we examined ingroup perception variables and
perceived legitimacy of discrimination as predictors of positive behaviors towards outgroup, ingroup and self (Table 3). Educating members of the public about mental illness and helping another person with mental illness were predicted by high group value and high entitativity. Helping was additionally associated with less perceived discrimination. Good social performance in pursuit of own goals was predicted by low perceived legitimacy of discrimination and low group identification. To clarify a possible link between group identification and perceived group value in predicting social performance, we assessed the correlation between role-play performance and group identification separately for subjects with high perceived group value ($r = 0.06$, $P = 0.70$, $n = 45$) and low group value ($r = 0.39$, $P = 0.01$, $n = 40$). Thus feeling more attached to the ingroup was associated with poorer social performance only in the subgroup of consumers who held their ingroup in low regard. Finally, the intention to support anti-stigma initiatives was predicted by high entitativity and low perceived legitimacy of discrimination (Table 3). When examining psychiatric diagnoses as predictors of positive behavior, current comorbid alcohol- or substance-related abuse or dependence predicted a weaker intention to help other people with mental illness ($P = 0.005$, adj. $R^2$ increased from 0.24 to 0.31, all other predictors remained significant). No other psychiatric diagnosis predicted significant additional variance of helping intentions or other positive behaviors.

Predicting negative behavioral intentions

Examining our second and third hypotheses with respect to negative behaviors (Table 4), keeping one’s mental illness a secret from the public was predicted by high levels of perceived discrimination,
low group value, low group identification and an interaction between group value and entitativity; namely, that low group value was associated with high secrecy in subjects with low entitativity \( (r = -0.57, P < 0.001, n = 41) \), but not in subjects with high entitativity \( (r = -0.02, P = 0.91, n = 44) \). Social distance from other people with mental illness was associated only with high perceived legitimacy of discrimination. Finally, low group value predicted hopelessness above and beyond the variance explained by depression (Table 4). In terms of psychiatric diagnoses as predictors of negative behavior, a life-time bipolar disorder predicted increased desire for social distance from other people with mental illness \( (P = 0.03, \text{adj. } R^2 \text{ increased from 0.06 to 0.10, the other predictor remained significant}) \). No other psychiatric diagnosis predicted significant additional variance of social distance or other negative behaviors.

Discussion

Our results offer support for the model that ingroup perceptions and perceived legitimacy of discrimination shape an individual’s response to mental illness stigma. Even when taking into account depression and the level of perceived discrimination, perceived group value, entitativity and group identification explained significant proportions of both functional and dysfunctional stigma-related behaviors. More functional behaviors were associated with either valuing the ingroup highly or with rejecting public stigma as unfair, while the inverse was true for more dysfunctional behaviors.

Compared to members of the public, individuals with mental illness valued their ingroup more highly, identified with it more strongly and perceived it as a more meaningful unit in society, which supports our first hypothesis. However, perceived group value showed the smallest difference between both groups. This could mean that people with mental illness internalize negative public views of their group to a large degree, leaving them vulnerable to stigma.

All positive reactions to stigma were predicted either by high perceived group value or by low perceived legitimacy of discrimination, confirming our second hypothesis. The fact that both variables did not predict positive behaviors simultaneously suggests that either holding one’s ingroup in high regard or disregarding public discrimination as illegitimate causes positive, energized reactions to stigma. Rejecting public stigma as unfair may be particularly helpful for assertive behaviors such as anti-stigma activism and role-play performance. All negative behavioral intentions were predicted either by low group value or by high perceived legitimacy of discrimination. Secrecy and hopelessness, two common and particularly harmful reactions to stigma, were strongly associated with low group value. This further emphasizes the risks faced by people with mental illness who hold their ingroup in low regard.

Entitativity or group identification, as well as the interaction of both, predicted both positive and negative behavioral intentions. This is consistent with our hypothesis that higher levels of entitativity or group identification would predict more positive behavior in the context of high group value or low perceived legitimacy. Perceiving one’s group as coherent and feeling attached to it seems to increase the positive impact of holding the group in high regard or of rejecting stigma as unfair. However, the link between poor role-play performance and high group identification among consumers who held their ingroup in low regard suggests that group identification and entitativity can be a double-edged sword. For stigmatized individuals who do not think highly of their ingroup, strong group identification is a threat to be identified as a member of a devalued group in social interactions with ‘normals’.

Results on secrecy were partially unexpected. As predicted, low group value led to higher secrecy, but low, instead of high, group identification was associated with secrecy. This can be understood such that secrecy was unique among the dependent variables in our study, i.e. a direct behavioral equivalent of disidentification with the group. A person who does not feel close to other people with mental illness in the first place will have little desire to be identified as one of them in public. Beyond low group value \textit{per se}, an interaction of low group value and low entitativity predicted secrecy. To regard one’s ingroup both as worthless and as incoherent appears to be a particularly strong disincentive for coming out as a member of that group.

Some limitations of our study need to be considered. First, our cross-sectional data preclude conclusions on causality. Therefore reactions to stigma such as secrecy could inversely influence ingroup perception, e.g. reduce group identification. Longitudinal studies are needed to clarify causation in our model, including possible feedback loops. Second, a larger sample would have allowed structural equation modeling and yielded increased power to detect smaller effects, particularly interaction effects. Third, our conclusions are limited to persons with serious and chronic mental illness.
such as schizophrenia or bipolar disorder. The fact that major psychiatric diagnoses did not change predictive patterns of stigma-related behavior suggests that despite the diagnostic heterogeneity of the sample our findings apply to people with serious mental illness in general. Finally, future studies should include comprehensive measures of insight into having a mental illness and, beyond controlling for depression, assess positive and negative symptoms. Insight in particular may affect ingroup perception.

Our findings have implications for attempts to reduce the impact of stigma on people with mental illness, whether in group trainings run by professionals (42) or in peer-support programs (43, 44). Cognitive methods could be used to bolster perceived group value and decrease perceived legitimacy of discrimination so that people with mental illness are more likely to see their own group in a less negative light and reject stigma as unfair. On this basis, increased group identification and entitativity would help to augment the positive impact that higher group value or recognition of stigma’s unfairness can have on people with mental illness. Individuals with mental illness who not only regard their ingroup highly, but also see it as a coherent entity to which they feel attached are more likely to react to stigma in a positive and energized way. Focusing on ingroup and stigma perceptions in this study, we by no means mean to imply that stigma is a problem to be solved by people with mental illness alone. On the contrary, it is an unfair discrimination by society against individuals with mental illness. But for the time being, a better understanding of how people with mental illness see their ingroup and how these perceptions affect their behavior in the context of stigma may help to find better ways of coping with this unfair reality.

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Declaration of interest

None by any author.

References


