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Internalized stigma predicts erosion of morale among psychiatric outpatients

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Abstract

Stigma in society causes harm to people with severe mental illness (SMI) and internalized stigma represents its psychological point of impact. We evaluated the extent of internalized stigma in a sample of outpatients with SMI, using the Internalized Stigma of Mental Illness (ISMI) scale, developed with consumer input. About a third of the sample reported high levels of internalized stigma. We tested whether internalized stigma predicted increased depressive symptoms and reduced self-esteem at 4-month follow-up, controlling for baseline levels. Depression was predicted by Alienation, Stereotype Endorsement, Social Withdrawal, and total ISMI score. Reduced self-esteem was predicted by Alienation. ISMI results were stronger than those for the widely used Devaluation-Discrimination scale. The finding that alienation further reduces morale speaks to the difficulty of pulling oneself out of this type of vicious cycle without assistance.

Keywords: Severe mental illness (SMI); Mental disorders; Stereotyping; Social alienation; Risk factors; Depressive symptoms

1. Introduction

As is well recognized by people with severe mental illness (SMI), their families, and many of the mental health professionals who work with them, the stigma of mental illness is strong in our society and causes harm to people with SMI. Stigma can be described as the social-status loss and discrimination triggered by negative stereotypes that have become linked in a particular society to a particular human characteristic such as mental illness (Link and Phelan, 2001). The most obvious form of stigma is when those without the stigmatized status reject, put down and discriminate against those with the stigmatized status in accordance with the negative societal stereotypes. This form of stigma is widely reported by mental health consumers (Link et al., 1997; Wahl, 1999; Dickerson et al., 2002;).

However, it is important to recognize that, in addition, the harmful effects of stigma may work through the internal perceptions, beliefs and emotions of the stigmatized person, above and beyond the effects of direct discrimination by others. For example, in a series of papers, Link and others have shown that, when individuals who have been officially labeled with SMI believe that most people reject and devalue people with mental illnesses, they may suffer a number of negative outcomes, such as demoralization, lowered self-esteem, impaired social adaptation, unemployment, income loss, and reduced psychiatric medication adherence (Link, 1987; Link et al., 1997; Link et al., 2001; Perlick et al., 2001; Sirey et al., 2001). Similarly labeled people who do not hold these beliefs as strongly suffer fewer of these negative consequences. In addition, labeled persons who fear rejection most and who endorse the stigma coping strategy of withdrawal have more insular support networks consisting mainly of household members, who are likely to be affected by stigma themselves (Link et al., 1989; Struening et al., 2001). This body of work investigates one way in which societal stigma can be internalized, that is, when an individual perceives stigma existing in the culture and expects to be treated with devaluation and rejection.

The fact that these researchers find negative consequences for expectations or perceptions of stigma provides a clear motivation for delineating and investigating further layers of internalized stigma. For example, what is the impact of a person with SMI accepting or endorsing negative stereotypes? We would expect a person who endorses negative stereotypes to have lower self-esteem than someone who is aware of negative stereotypes held by others but who does not accept them him/herself. This concept of internalized stigma, in which the application of negative stereotypes to oneself causes shame and devaluation (Corrigan, 1998), is central to both academic and consumer explanations of the inner psychological harm caused by stigma (Corrigan and Watson, 2002). If we think of a series of steps by which objectively experienced external discrimination or stigma becomes increasingly internalized and translated into more subjective experience (Meyer, in press), ultimately resulting in feelings or perceptions about the self such as low self-esteem and depressive symptoms, then we may expect later steps in this process (e.g., stereotype endorsement) to be even more closely connected to and strongly predictive of those psychological outcomes than are earlier steps in the process (e.g., perceived devaluation and discrimination in society).

If internalized stigma corrodes mental health in a long-term outpatient population, it is working directly against the positive effects of ongoing treatment (Rosenfield, 1997). Internalized stigma can even be conceptualized as a side effect of treatment, if the treatment generates the label or the SMI identity that triggers the application of the stereotypes. Treatments could focus more on helping people with SMI overcome the aspect of stigma that is within themselves. This would help them more effectively marshal their resources to fight the aspects of stigma that are external. Internalized stigma may be a more useful and more malleable clinical indicator to monitor and attempt to reduce, as compared to using existing measures of perceived society-wide stigma or exposure to discrimination experiences. Of course, stigma in society is unjust and harmful, and must be reduced. In the meantime, this type of target-hardening approach in treatment may help blunt the impact of stigma on individuals with SMI.

In order to more fully describe and understand internalized stigma, Ritsher and colleagues (2003) developed the Internalized Stigma of Mental Illness (ISMI) scale, which measures five dimensions of internalized stigma – Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal and Stigma Resistance. The scale was developed with substantial consumer input and has good reliability and evidence for construct validity (Ritsher et al., 2003).

In the present paper, we attempt to replicate previous findings that perceived devaluation and discrimination predict lower self-esteem (Link et al., 2001) and depressive symptoms of people with SMI (Link et al., 1997) and to test whether internalized stigma can serve as an even stronger predictor of their later psychological health. We describe the intensity and prevalence of internalized stigma among outpatients with SMI and test whether internalized stigma and perceived devaluation and discrimination predicted deteriorations in self-esteem and depressive symptoms at four-month follow-up, controlling for baseline levels. This is a conservative test of the hypotheses, because we surveyed a small sample of individuals who had already lived with SMI for many years, and we followed them for just a short period of time.

2. Methods

2.1 Participants

Survey participants included 82 outpatients at the mental health service of a US Department of Veterans Affairs (VA) medical center, including 47 who completed the internalized stigma measure at both baseline and followup. Part of a larger sample of mental health outpatients, these 82 were selected for the present analyses on the basis of having a serious mental illness (SMI), operationally defined here as having a diagnosis of a psychotic disorder or both a diagnosis of depression and at least one psychiatric hospitalization during fiscal year 2001 or 2002, all according to central VA records. A total of 162 participants were recruited in the waiting rooms of clinics in the mental health service, and followed up by mail and telephone,

using information from the consent form and from VA records. At each clinic targeted, all patients were invited to participate. Clinics were chosen to be representative of the range of outpatient services offered to patients with mental illness. Of the 82 of these with SMI, 29 (35%) were lost to follow-up. The majority of these individuals were homeless and had only the medical center's address as their contact information on file. Of the remaining 53 available for follow-up, 49 (93%) provided four-month follow-up data, but two of these did not provide complete data on the internalized stigma measure at both time points. Thus, most analyses reported below pertain to those 47 individuals with SMI who provided complete internalized stigma data at both baseline and follow-up. As shown in the results section below, some analyses that include additional variables have fewer cases due to missing data. All participants provided informed consent to study procedures approved by the Stanford University human subjects institutional review board. Sample demographics (Table 1) were typical of the population served by the treatment facility. For example, respondents were mostly men who had been living with mental illness for many years and who were impaired enough to be receiving psychiatric disability payments or other government assistance (Table 1). There were no statistically significant differences at baseline between the 47 completers and the 35 non-completers, or between those with and without SMI ($n=82$ and 71 with usable data) on any of the variables listed in Table 1 or on the internalized stigma, depression, and self-esteem variables (chi square and t-tests, further details not shown but available). Because the follow-up sample size is small, results of the longitudinal analyses should be considered tentative until they can be replicated in a larger sample.

2.2 Measures

2.2.1 Background characteristics. Most demographic questions were written for the survey, and several include response options suggested by focus group members. Chart diagnoses and hospitalization records were collected from the central VA-wide Patient Treatment File database.

2.2.2 Internalized Stigma of Mental Illness (ISMI) scale. The ISMI contains 29 Likert items rated on a 4-point scale ranging from “strongly disagree” to “strongly agree.” The scale was developed with substantial consumer input, and its psychometric properties in this population have been empirically supported, as described in detail elsewhere (Ritsher et al., 2003). To balance clarity with inclusivity, the term “mental illness” is used throughout the questionnaire, but the instructions encourage respondents to “think of it as whatever you feel is the best term for it.” The internal consistency reliability for the scale in this sample (N=82) was .91.

The ISMI contains five subscales: Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal, and Stigma Resistance (Ritsher et al., 2003). The Alienation subscale (alpha=.81) measures the subjective experience of being less than a full member of society, or having a “spoiled identity” (Goffman, 1963), and contains six items such as “I feel out of place in the world because I have a mental illness.” The Stereotype Endorsement subscale (alpha=.77) contains seven items measuring the degree to which respondents agree with common stereotypes about people with mental illness, such as “Mentally ill people tend to be violent.” The Discrimination Experience subscale (alpha=.78) is composed of five items intended to capture respondents’ perception of the way that they currently tend to be treated by others, such as “People ignore me or take me less seriously just because I have a mental illness.” The Social Withdrawal subscale (alpha=.81) was especially heavily influenced by focus-group participants, and contains six items, such as “I don’t talk about myself much because I don’t want to burden others with my mental illness.” The Stigma Resistance subscale (alpha=.62) was intended to portray the experience of resisting or being unaffected by internalized stigma, such as “I can have a good, fulfilling life, despite my mental illness.” The Stigma Resistance items also serve as a validity check because they are reverse-coded.

2.2.3 Perceived Devaluation and Discrimination. This is a 12-item scale that has been widely used to measure societal stigma about mental illness (Link et al., 1997; Link et al., 2001; Perlick et al., 2001). The items are written so that anyone can respond to them, not just people

who have a mental illness. Items include, for example, “Most people think less of a person who has been in a mental hospital.” Asking respondents what “most people” think is intended to reduce the effect of social desirability on responses, giving them tacit permission to express highly stigmatizing attitudes (Link and Cullen, 1983). Like the items on the ISMI, each statement is rated on a 4-point scale ranging from “strongly disagree” to “strongly agree.” The scale has excellent psychometric properties and has been shown to predict deterioration in CES-D depression scores and Rosenberg self-esteem scores in follow-up studies of people treated for mental illness (Link et al., 1997; Link et al., 2001). It also predicts impairment in social functioning with persons outside the family, particularly the psychological isolation component of that area of functioning (Perlick et al., 2001). The scale had good internal consistency in the present sample ($\alpha=.85$).

2.2.4 Morale. As operationalized in the present study, morale consists of depressive symptoms and self-esteem (Dohrenwend, 1990).

2.2.5 Depressive symptoms. Symptoms of depression were measured with the widely-used Center for Epidemiological Studies--Depression (CES-D) scale (Radloff, 1977). The CES-D captures subjective demoralization and dysphoria, which we targeted here as distinct from depression as a diagnostic entity (Dohrenwend et al., 1980; Dohrenwend, 1990). Stigma can affect depressive symptoms regardless of diagnosis (Link et al., 1997). The scale contains 20 items such as “I had crying spells.” For each item, respondents indicate how often they felt this way during the past week, using a 4-point scale coded 1 (rarely or never) to 4 (most of the time). In our sample, the reliability of the CES-D was .89.

2.2.6 Self-esteem. A widely used measure of self-esteem (Rosenberg, 1979) was included in our survey as another indicator of the effect of internalized stigma on morale over time. Prior studies have shown stigma to be related to but distinct from low self-esteem (Link et al., 1997; Link et al., 2001; Ritsher et al., 2003). The Rosenberg self-esteem scale consists of 10 items such

as “I feel that I’m a person of worth, at least on an equal plane with others.” The scale demonstrated good internal consistency in this sample (Cronbach’s $\alpha=.89$).

3. Results

3.1 Prevalence of Internalized Stigma among Outpatients with SMI

A substantial portion of the sample reported experiencing high levels of internalized stigma, defined as having an average score above the midpoint of the possible range (2.5 on a 1-4 scale). For the full 29-item scale, about a third of the sample had a mean over the midpoint (28% of $N=82$ at baseline, 34% of $N=47$ at follow-up). Turning to the subscales, about a third of the sample reported alienation (38% had means over 2.5 at baseline, 34% at follow-up). Fewer participants tended to endorse stereotypes about mental illness (15% at baseline, 28% at follow-up). About half of participants reported believing that others routinely discriminate against them (48% at baseline, 49% at follow-up). About two in five report social withdrawal (40% at baseline, 42% at follow-up). Only about a quarter of respondents showed high levels of stigma-resisting beliefs (29% at baseline, 24% at follow-up).

As expected on the basis of prior studies of similar populations with SMI (Link, 1987; Link et al., 1989; Prince and Prince, 2002), the sample’s mean score on the devaluation-discrimination measure was over the midpoint of the scale, at 2.84 ($SD=.49$). This indicates that the average participant believed that psychiatric patients are routinely devalued and discriminated against. Indeed, almost three quarters (73.2%) of the participants had a mean over the midpoint on this scale.

As another indication that our sample was typical of the SMI population, the mean score on the Rosenberg self-esteem scale (mean 16.7, SD 6.3) was consistent with the values found in other studies of people with SMI. Prince and colleagues (Prince and Prince, 2002) reported a mean of 17.3 ($SD=5.3$), and Gerber and colleagues (Gerber et al., 1997) reported a mean of 14.1 ($SD=4.0$).

3.2 Internalized Stigma as a Risk Factor

We tested the impact of internalized stigma on depressive symptoms over time using linear regression models that controlled for the baseline level of depressive symptoms. We screened each of the items on Table 1 as potential confounders. In order to be a confounder, a variable must be associated with both the predictor variable (baseline internalized stigma) and the outcome variable (depression or self esteem at follow-up). None of the variables was statistically significantly associated with baseline internalized stigma except Native American ethnicity (see Table 1), which was not significantly associated with either outcome variable (for depression, $r=-.17, p=.13$; for self-esteem $r=.11, p=.38$). We concluded from these analyses that none of these variables could be statistical confounders, so we did not control for them in the analyses. By contrast, the baseline level of the outcome variables (depression and self-esteem) were, as expected, significantly correlated with both internalized stigma and their follow-up levels, so we did control for these.

Each ISMI subscale was analyzed in a separate model (Table 2). Alienation at baseline significantly predicted worsened depressive symptoms at follow-up (beta for alienation .26, $N=45, p<.05$), controlling for the level of depressive symptoms at baseline. Endorsing stereotypes about mental illness also predicted exacerbated depressive symptoms (beta .27, $N=45, p<.05$). Similarly, social withdrawal predicted intensification of symptoms (beta .27, $N=45, p<.05$). By contrast, the degree to which one believes that others actually treat one differently (discrimination experience) did not affect depressive symptoms over time, nor did the level of stigma resistance (betas $<.05, p>.05$). The total ISMI score was significantly predictive of depressive symptoms (beta=.24, $p<.05$).

A similar pattern was found for the effect of internalized stigma on self-esteem (Table 2). Alienation at baseline predicted reduced self-esteem at follow-up (beta=.27, $p<.05$), but being treated differently and having stigma-resisting beliefs had no effect on self-esteem (betas $<.10$,

$p > .05$). The results for stereotype endorsement ($\beta = .16$), social withdrawal ($\beta = .15$), and the total ISMI score were in the expected direction but not significant at $p < .05$ with $N = 45$.

Analyses using dichotomous variables also show that those with high levels of alienation were more likely to report experiencing depressive symptoms at follow-up, adjusting for the effect of depressive symptoms at baseline (odds ratio [OR] 36.4, 95% confidence interval [CI] 3.0-441.8). Similarly, high alienation scores predicted low self-esteem (OR=5.6, 95% CI=1.1-29.3).

Participants' beliefs about the level of stigma in society (devaluation-discrimination scale) did not significantly predict demoralization or reduced self-esteem (for demoralization-depressive symptoms, $\beta = -.12$, for self-esteem, $\beta = -.11$, $p > .05$, $N = 45$).

4. Discussion

The results showed that internalized stigma is common in this population, and that high levels of internalized stigma are associated with low levels of morale four months later, even after taking into account the level of morale at baseline. These associations were observed by measuring individuals' internalized stigma, even without knowing their objective history of discrimination experiences. The findings do not conclusively show that internalized stigma erodes morale among our participants, but they are consistent with and clearly suggestive of this conclusion.

The most consistently harmful outcomes were associated with alienation. Individuals who expressed alienation related to their SMI were likely to have even more distress to contend with four months later, as their morale worsened further. Link and Phelan (2001) emphasized the "us/them" divide as an important component of the stigmatizing process in the thinking of the non-stigmatized group. The importance of alienation in the present results suggests that feeling different and divided from others may also be a powerful component of the stigma process as it works through the stigmatized individual. The fact that alienation further reduces self-esteem and

depressive symptoms speaks to the difficulty of pulling oneself out of this type of vicious cycle without assistance. Several of the items in this scale pertain to inferiority, which seems related to low self-esteem. Thus, it is important to note that although our measure correlates with self-esteem, there are several reasons to believe that the two constructs are distinct. First, the alienation items each link the experience to having a mental illness, whereas the self-esteem items are more general. Second, the items from the two scales sorted themselves onto separate factors in two-factor exploratory factor analysis, with the exception of two items that had similar loadings on both factors (Ritsher et al., 2003). Third, the present findings control for baseline levels of self-esteem. Although we were not able to fully separate global self-esteem from the experience of alienation and inferiority connected to being a person with a mental illness, the two scales are different enough that the alienation scale makes an added contribution to our ability to predict later self-esteem.

Endorsing stereotypes about mental illness also predicts a deepening of depressive symptoms. As Link and colleagues have shown, stigma pervades society, and those who become mentally ill are typically well aware of the stereotypes associated with their condition. Thus it is but a short step to apply those stereotypes to oneself, adding to one's sense of helplessness, hopelessness, and demoralization. We did not find that stereotype endorsement significantly predicted a reduction in self-esteem, but there was a trend in the predicted direction. Perhaps those who endorse the stereotypes have already had their self-esteem reduced so much that we could not detect any additional reduction over a 4-month follow-up period. At baseline, the association between self-esteem and stereotype endorsement was substantial ($r = -.55$, $N = 82$, $p < .05$). The fact that we had a small sample constrained our statistical power, so a more definitive answer to this question awaits the results of future work.

As Link and colleagues have found, social withdrawal is one of the mechanisms by which stigma adversely impacts people with SMI (Link et al., 1991). Although for many, social withdrawal represents a coping mechanism, it is a costly one. We found that SMI-related social

withdrawal significantly predicted increased depressive symptoms four months later. There was also a nonsignificant trend for social withdrawal predicting decreased self-esteem. Future studies with larger samples might attempt to replicate these analyses.

It is noteworthy that perceptions of current discrimination do not predict reductions in self-esteem or increases in depressive symptoms. This is consistent with the idea that it is the internalization of stigma that is the most psychologically damaging aspect of stigmatizing experiences. If experiences occur but one does not internalize the stigma, one will be less emotionally damaged (although one's objective life situation, housing, etc, may well be adversely affected). The Discrimination Experience subscale was the closest in content to the Devaluation-Discrimination scale, which asks about how "most people" view those with mental illness. The more "internalized" subscales such as Alienation were more strongly predictive than Devaluation-Discrimination, which has been found to be predictive using these same measures in other, similar, populations. Given the research literature, it seems likely that the present study was simply underpowered to find the effect of other aspects of stigma, rather than that they have no effect.

It is disappointing that the only positively oriented scale -- Stigma Resistance -- did not predict changes in depressive symptoms or self esteem. Neither was it significantly associated with these outcomes in a cross-sectional analysis (Ritsher et al., 2003). Future studies should explore ways that internalized stigma can be resisted. For example, about one third of those with SMI who know they have the diagnosis do not agree that they have a mental illness (Ritsher and Lucksted, 2000). Future work might investigate whether non-acceptance of the label provides any protection against the destructive aspects of internalized stigma. It may also be that more social momentum and greater numbers of stigma resisters working together are needed for stigma resistance to work. Increasing anti-stigma activism may grow into an empowering social movement like those that radically transformed the "stigma" of being an African American or being gay or lesbian. The literatures on internalized racism and internalized homophobia also

underscore the importance of combating both the discrimination in society and the way that it is internalized within individuals (e.g. Ross and Rosser, 1996; Tatum, 1997; Meyer, in press).

It appears from the present results that the aspect of internalized stigma most closely linked to these poor psychological outcomes is alienation. Although we view all harmful outcomes of stigma as originating ultimately in negative reactions to mental illness at the societal level, this finding regarding internalized stigma is important because alienation is such a psychological, individual-level construct that it is a natural target for psychotherapy and self-help strategies.

Several limitations of the data should be noted. The sample is small and not necessarily generally representative of people with SMI. Furthermore, baseline and follow-up data were collected only four months apart, and these two time points were embedded in these adults' long-term struggle with mental illness and stigma. Thus, it seems likely that the study would find participants in a "steady-state" situation with regard to stigma, which would not be optimal for observing changes in stigma and associated changes in depression and self-esteem. Nevertheless, despite the small number of participants and less-than-ideal features of the prospective design, several components of internalized stigma were significantly associated with the psychological outcomes of depressive symptoms and self-esteem controlling for baseline levels of these outcomes. Regarding the representativeness of the sample, clearly the results should be replicated with a non-VA sample that includes more women. Nevertheless, there is no obvious reason to expect that the processes described here involving internalized stigma and psychological well-being would work significantly differently among women or non-veterans. Finally, because the independent and dependent variables are both subjective psychological assessments, it could be argued that both reflect a more general psychological state or outlook. If the data were cross-sectional, this would be a serious limitation. However, the results show that internalized stigma predicts lower morale at follow-up controlling for baseline levels. Thus, internalized stigma predicts a decrease in morale four months later. Also, depression and self-

esteem did not predict an increase in alienation, controlling for baseline levels of alienation ($p > .05$, further details available from authors). This is more difficult to explain in terms of confounding of the independent and dependent measures. It is also possible that participants who responded to the follow-up survey were different than those who did not. For example, those who were more depressed could have been more likely to be followed. However, we found no evidence for this when comparing baseline scores for the two groups on all of the variables presented here, and there was no appreciable difference in mean depression or self esteem for the entire group of participants between baseline and follow-up. Also, participants did not need to attend the mental health clinic again in order to participate in the follow-up survey, since they were actively recruited by study staff by mail and phone. Because anecdotal evidence indicates that the majority of those lost to follow-up were lost because of homelessness, it is likely that their level of distress increased during that time. If so, their exclusion constitutes a bias against the hypotheses that we tested in the present paper, making them an even more conservative test of our model. Future studies should use a wider range of measures, including both observer-ratings and self-ratings, to investigate the potential interplay of illness severity and internalized stigma over time.

5. Conclusion

Surely, internalized stigma must impede recovery from SMI. Although stigma can work at cross-purposes to treatment, treatment approaches that focus on reducing internalized stigma may be able to reverse this trend, producing more effective and longer-lasting results. What is needed is the antidote for alienation: interpersonal engagement, such as that provided by the fellowship of self-help groups, the role recovery inherent in supported employment, or the healing power of the psychotherapeutic alliance. People with SMI must get the message that they are not alone and that others like them have succeeded in building rewarding lives in the community. In addition to trying to lessen the stigma of mental illness in our society, we must work to lessen its psychological impact on people with mental illness.

References

- Corrigan, P. W., 1998. The impact of stigma on severe mental illness. *Cognitive Behavioral Practice*, 5(2), 201-222.
- Corrigan, P. W., Watson, A. C., 2002. The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9, 35-53.
- Dickerson, F. B., Sommerville, J., Origoni, A. E., Ringel, N. B., Parente, F., 2002. Experiences of stigma among outpatients with schizophrenia. *Schizophrenia Bulletin*, 28(1), 143-155.
- Dohrenwend, B. P., 1990. 'The problem of validity in field studies of psychological disorders' revisited. *Psychological Medicine*, 20(1), 195-208.
- Dohrenwend, B. P., Shrout, P. E., Egri, G., Mendelsohn, F. S., 1980. Nonspecific psychological distress and other dimensions of psychopathology. Measures for use in the general population. *Archives of General Psychiatry*, 37(11), 1229-1236.
- Gerber, G. J., Prince, P. N., de Souza, H., Lefave, H. G., 1997. A consortium of agencies serving people with serious mental illness: Promises made and broken. *Psychosocial Rehabilitation Journal*, 20(4), 80-83.
- Goffman, E., 1963. *Stigma: Notes on the management of spoiled identity*. Prentice Hall. Englewood Cliffs, NJ.
- Link, B. G., 1987. Understanding labelling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 52(1), 96-112.
- Link, B. G., Cullen, F. T., 1983. Reconsidering the social rejection of ex-mental patients: levels of attitudinal response. *American Journal of Community Psychology*, 11(3), 261-273.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., Dohrenwend, B. P., 1989. A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54, 400-423.

- Link, B. G., Mirotznik, J., Cullen, F. T., 1991. The effectiveness of stigma coping orientations: can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior*, 32(3), 302-320.
- Link, B. G., Phelan, J. C., 2001. Conceptualizing stigma. *Annual Review of Sociology*, 27.
- Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., Phelan, J. C., 2001. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, 52(12), 1621-1626.
- Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., Nuttbrock, L., 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(2), 177-190.
- Meyer, I. H., in press. Prejudice, social stress and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*.
- Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salah, J., Struening, E. L., et al., 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(12), 1627-1632.
- Prince, P. N., Prince, C. R., 2002. Perceived stigma and community integration among clients of assertive community treatment. *Psychosocial Rehabilitation Journal*, 25(4), 323-331.
- Radloff, L. S., 1977. The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Ritsher, J. B., Lucksted, A., 2000. What do you call your problem? *Psychiatric Rehabilitation Journal*, 23(4), 393-395.
- Ritsher, J. B., Otilingam, P. O., Grajales, M., 2003. Psychometric properties of a new measure of internalized stigma. *Psychiatry Research*, 121, 31-49.
- Rosenberg, M., 1979. *Conceiving the self*. Basic Books, New York.

- Rosenfield, S., 1997. Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociology Review*, 62, 660-672.
- Ross, M. W., Rosser, B. R. S., 1996. Measurement and correlates of internalized homophobia: A factor analytic study. *Journal of Clinical Psychology*, 52, 15-21.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., Meyers, B. S., 2001. Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services*, 52(12), 1615-1620.
- Struening, E. L., Perlick, D. A., Link, B. G., Hellman, F., Herman, D., Sirey, J. A., 2001. Stigma as a barrier to recovery: The extent to which caregivers believe most people devalue consumers and their families. *Psychiatric Services*, 52(12), 1633-1638.
- Tatum, B. D., 1997. Racial identity development and relational theory: The case of Black women in White communities. In J. V. Jordan (Ed.), *Women's growth in diversity: More writings from the Stone Center* (pp. 91-106. New York: Guilford.
- Wahl, O. F., 1999. Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25(3), 467-478.

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Table 1

Sample Characteristics at Baseline

Characteristic	<i>% or Mean (SD)</i>	<i>Correlation with ISMI Total Score</i>	
	<i>N=47 completers^a</i>	<i>N=47 completers^a</i>	<i>N=82 with SMI</i>
Age	51(10)	.10	.18
Male gender	91%	.11	.02
Ethnicity			
White/Caucasian	68%	.27	.15
Black/African-American	22%	-.26	-.14
Hispanic	7%	-.12	-.09
Native American	9%	.32*	.23*
Education (continuous variable)		.17	.14
High school or less (dichotomous variable)	38%		
Some college or tech (dichotomous variable)	40%		
College degree (dichotomous variable)	22%		
Income from government	80%	.20	.22
Income from wages	9%	-.12	-.06
Years since age of illness onset	26(14)	-.16	-.01
Diagnosis (ICD-9, central VA records) ^b			
Schizophrenia	59%	.21	.12
Paranoid Psychosis	36%	.12	.07
Affective Psychosis	45%	.17	.06
Depression	85%	.01	.04
PTSD	43%	.23	.21

* $p < .01$ ^a“Completers” are participants who completed both the baseline and follow-up surveys.^bMany participants had more than one of these diagnoses, thus they do not add to 100%.

Table 2

Results of Longitudinal Linear Regression Models Predicting Depression or Self-Esteem at Follow-Up From Internalized Stigma at Baseline (Beta Weights for Predictors, N=45)

Predictor	Outcome	
	Depressive symptoms	Self-esteem
Alienation	.26*	-.27*
Stereotype endorsement	.27*	-.16
Discrimination experience	.03	.08
Social withdrawal	.27*	-.15
Stigma Resistance	-.12	.04
Total score (29 items)	.24*	-.17

*p<.05

Note. Each model controlled for the baseline level of the outcome variable (not shown).