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Research report

"Depression is who I am": Mental illness identity, stigma and wellbeing

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ABSTRACT

Background: Previous research has found that in the face of discrimination, people tend to identify more strongly with stigmatized groups. Social identification can, in turn, buffer wellbeing against the negative consequences of discrimination. However, this *rejection identification model* has never been tested in the context of mental illness identity.

Methods: A survey was conducted with 250 people with diagnosed depression or current symptoms of at least moderate clinical severity.

Results: Experiencing mental illness stigma was associated with poorer wellbeing. Furthermore, people who had experienced such stigma were more likely to identify as a depressed person. Social identification as depressed *magnified*, rather than buffered, the relationship between stigma and reduced wellbeing. This relationship was moderated by perceived social norms of the depressed group for engaging in depressive thoughts and behaviors.

Conclusions: These findings suggest that mental illness stigma is a double-edged sword: as well as the direct harms for wellbeing, by increasing identification with other mental illness sufferers, stigma might expose sufferers to harmful social influence processes.

1. Introduction

People who experience compromised mental health are regularly confronted with discrimination – in the workplace, in healthcare settings, and in the community more broadly (Corrigan et al., 2014; Link et al., 1997, 1999). Research has established that the stigma of mental illness actually constitutes a stressor in its own right, with the potential to compound mental illness and reduce the likelihood of recovery (Rüsch et al., 2014; Pascoe and Smart Richman, 2009; Yanos et al., 2010). Although these harmful effects have been established, relatively little research has investigated how people with mental illness negotiate their stigmatized identity. Those (mainly qualitative) studies that do exist suggest that patients often experience depression as self-defining (Karp, 1994), and hold self-stigmatizing beliefs, for example that depression reflects a weakness of character (Cornford et al., 2007; Boardman et al., 2011). Studies have also established that many patients hold a biochemical causal model of depression (Lebowitz et al., 2013; Kvaale et al., 2013), and experience difficulties in transitioning away from a mental illness identity (Howard, 2008).

The question of how people negotiate low-status group membership has been the focus of research attention in social psychology for over 30 years, albeit with social groups other than people with mental illness. This research has revealed a variety of strategies that are used to manage low status group memberships (Tajfel and Turner, 1979). Chief among them is *collective action*, whereby members of a stigmatized group band together to challenge the status quo. However, this social change strategy is only likely to emerge when people perceive the low status of their group to be illegitimate (Ellemers et al., 1993; Hansen and Sassenberg, 2011). When the low status of the group is seen to be legitimate, people are more likely to attempt to leave the group through *individual mobility* strategies, particularly to the extent that the boundaries between low and high status groups are perceived to be permeable (Ellemers et al., 1990). These strategies have implications not only for social and political structure, but also substantial and long-lasting consequences for health (Pascoe and Smart Richman, 2009; Schmitt et al., 2014)

The rejection identification model (RIM; Branscombe et al., 1999) brought attention to the fact that being subject to discrimination due to one's membership of a social group increases the salience of the social identity associated with that social group. For example, a woman who experiences workplace discrimination because of her gender is more likely to think of herself as a woman, particularly when at work. This *social identification,* or subjective self-definition in terms of a social category, has a number of well-established consequences, including for wellbeing. RIM brought attention to the fact that when discrimination encourages and enables social identification with a stigmatized group, some of

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the harms of discrimination may be ameliorated. That is, social identification *buffers* individuals against the negative consequences of stigma. RIM has been investigated in the context of identities including ethnic minorities (Branscombe et al., 1999; Latrofa et al., 2009; Schmitt et al., 2003), older people (Garstka et al., 2004), women (Schmitt et al., 2002) and people with physical disabilities (Fernández et al., 2012), but not, to our knowledge, in the context of mental illness groups.

RIM is part of a burgeoning body of research demonstrating that social identification is the psychological mechanism through which our social reality impacts our individual perception, and, ultimately, our wellbeing (Haslam et al., 2009). For instance, people with depression who engage in recreational social groups, or group psychotherapy, only experience improvement in their symptoms over time to the extent that they *identify* with the group in question (Cruwys et al., 2014b). The benefits of social identification for health have been demonstrated for a wide array of populations and specific conditions, including in pilgrims (Tewari et al., 2012), school children (Turner et al., 2014), people with multiple sclerosis (Wakefield et al., 2013), or people who have experienced a traumatic event (Jones et al., 2011).

However, there has been increasing acknowledgment that we should expect some exceptions to this "rule"; that is, some social identities may do more harm than good. A recent theoretical review of social identity and depression (Cruwys et al., 2014a) hypothesized that the exception to the protective benefits of social identity might be stigmatized groups, or those group where social influence by other group members might prove harmful to mental health. Specifically, some groups have norms (the *content* of a social identity) that endorse thoughts or behaviors that are likely to worsen depression symptoms. In this case, we might predict that identification would be associated with increased norm conformity (Turner, 1991), and thus poorer wellbeing. Very little research has found evidence of this to date, however, one recent study found that people in treatment for substance use disorder had better outcomes to the extent that they disidentified with previous substance using identities (Dingle et al., 2014). One particularly relevant study (Crabtree et al., 2010) explored social identification with mental health support groups and the consequences for social support, stigma-resistance, and self-esteem. Interestingly, while social identification was associated with greater perceived support and stigma resistance, this had the effect of suppressing an otherwise *negative* relationship between identification and self-esteem. Although not investigating mental illness identity per se, these studies suggest the possibility that identification, particularly in the context of stigmatized groups, need not always be beneficial for wellbeing.

People with depression are part of a social category that is both (a) subject to stigma and discrimination, and (b) associated with specific normative thoughts (e.g., hopelessness, negativity) and behaviors (e.g., self-harm) that, if internalized by group members, are likely to worsen mental health. Therefore this social category represents an ideal test case for the theoretical question of whether there are social categories where social identification is negatively associated with wellbeing. Furthermore, depression identity differs from the social categories where the RIM has typically been investigated in at least three important ways. First, being a "depressed person" is usually *concealable*, and many people choose not to disclose their diagnosis to others. Previous research has suggested that concealing stigmatized identities can be associated with reduced wellbeing (Barreto et al., 2006). Second, the boundaries between mental illness and mental health are *permeable*, in that it is possible for a person to leave the stigmatized group via recovery – although perhaps not easily or quickly. Permeable group boundaries may reduce social identification (Ellemers et al., 1990). Third, and perhaps most importantly, depression identity describes a person's *lack of* wellbeing. That is, perhaps more so than any other social category, what it means to be a member of the "depressed" group is to experience poor wellbeing. Thus, even if wellbeing is operationalized in terms of constructs distinct from depression (such as life satisfaction, anxiety, stress), it seems likely that seeing depression as central to one's identity is incompatible with wellbeing.

1.1. The current study

This study, informed by the social identity approach to health, aimed to investigate the relationship between the experience of discrimination, mental illness identity, normative influence, and wellbeing among people experiencing depression symptomatology. Hypotheses one and two were derived from RIM (Branscombe et al., 1999), which has been established for a wide variety of stigmatized group memberships, although never with mental illness identity:

(H1) Personal experience of discrimination towards "depressed people" will be associated with reduced wellbeing (measured as life satisfaction, stress, anxiety symptoms and depression symptoms).

(H2) Personal experience of discrimination towards "depressed people" will positively predict social identification as a depressed person.

Two competing hypotheses were proposed regarding the relationship between social identification as a depressed person and wellbeing. First, also derived from RIM, we proposed a positive relationship between these variables, specifically:

(H3) Social identification as a depressed person will buffer wellbeing against the negative effects of stigma.

In competition with this, however, and derived from a referent informational influence model (Turner, 1991; also H3 of Cruwys et al. (2014a)), we proposed a negative relationship between these variables, specifically:

(H4) Social identification as a depressed person will predict reduced wellbeing.

Finally, and also consistent with a referent informational influence account, we predicted a negative relationship between social identification and wellbeing *only* among those who perceived a strong norm of depressogenic thoughts and behaviors among the depressed group. Specifically:

(H5) Social identification as a depressed person will interact with perceived symptom norms of "depressed people", such that social identification will be associated with reduced wellbeing only among those who characterize people with depression in terms of thoughts and behaviors that are consistent with depressive symptomatology.

2. Method

2.1. Participants

Participants were recruited widely from psychology clinics, health centers, research networks, online depression forums and paid participant pools. People were invited to participate if they met the following criteria: "experiencing persistent and intense feelings of sadness, people who feel depressed, and people who have been formally diagnosed with depression by a health practitioner". The study was not limited only to those diagnosed with depression or currently undergoing treatment because previous evidence suggests that only a minority of people with mental illness seek treatment (Goldman et al., 1999), and that these are not representative of the mentally ill population (Saxena et al., 2007).