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ORIGINAL ARTICLE

What is the impact of self-stigma? Loss of self-respect and the ''why try'' effect

Patrick W. Corrigan[1], Andrea B. Bink[1], Annie Schmidt[1], Nev Jones[2], and Nicolas Rüsch[3]

[1]Department of Psychology, Illinois Institute of Technology, Chicago, IL, USA, [2]Department of Psychology, DePaul University, Chicago, IL, USA, and [3]Department of Psychiatry II, University of Ulm, Ulm, Germany

Abstract

Background: The ''Why Try'' phenomenon, a consequence of self-stigma, is a sense of futility that occurs when people believe they are unworthy or incapable of achieving personal goals because they apply the stereotypes of mental illness to themselves.
Aims: This study examines a four-stage model of self-stigma (aware, agree, apply, and self-stigma harm) and examines the ''why try'' effect as a result. We do that by testing a measure of ''why try.''
Method: Two hypothetical path models were tested. In the first, applying stereotypes to oneself leads to diminished self-respect and a sense of ''why try''. In the second, the effect of applying stereotypes on ''why try'' is mediated by diminished self-respect. Participants completed the ''why try'' measure along with measures of self-stigma, public stigma, recovery, and empowerment.
Results: Results show application of stereotypes to oneself predicts diminished self-respect and ''why try''. ''Why try'' was significantly associated with agreement with public stigma, depression, and diminished sense of personal recovery.
Conclusions: Findings from this study reveal the complex impact of self-stigma demonstrating its emotional and behavioral consequences. Implications for impacting self-stigma are discussed.

Keywords

Self-stigma, stereotypes, psychometrics

History

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Introduction

The stigma of mental illness causes many harmful effects on the lives of people with serious mental illness undermining, among others, work, independent living, and health goals (Arboleda-Flórez & Sartorius, 2008; Hinshaw, 2007). Some people with mental illness internalize stereotypes leading to self-stigma. This article has three goals in trying to make better sense of self-stigma's impact on the person. First, we provide an empirical test of self-stigma framed as regressive phases (see below) leading to harm (Figure 1). Harm is defined in terms of impact on self-respect and behavioral futility (the ''why try'' effect). Because empirical support of ''why try'' is lacking, a second goal of this study is to report on the development and testing of a corresponding scale. Third, this study examines the impact of diminished self-esteem and behavioral futility on depression, recovery and personal empowerment.

The regressive model of self-stigma proposes three phases ending in loss of self-respect; it is outlined in Model 1 of Figure 1 (Corrigan & Rao, 2012). (1) People may be aware of stereotypes about mental illness (e.g. most people believe individuals with mental illness are responsible for their disease); this parallels Link's notion of perceived stigma that grounds his model of self-stigma (Link, 1987). (2) People may agree with the stereotype. (3) They may then apply the stereotypes to themselves. The hierarchical relationships of the three-stage model have been supported in previous research (Corrigan et al., 2006); we seek to replicate these relationships here.

Applying stereotypes to one's self may decrease self-esteem and self-efficacy resulting in decreased self-respect (Corrigan et al., 2006, 2009). The diminished self-esteem that comes from self-stigma impacts symptoms and quality of life (Markowitz, 2001; Vogel et al., 2006). Second, self-stigma undermines a person's confidence in successfully acting in specific situations interfering with self-efficacy. Diminished belief in personal effectiveness has been shown to be associated with failures in the pursuit of work and other independent living goals (Rüsch et al., 2006). Decreases in self-esteem and self-efficacy lead people to question their worthiness and capability in pursuing personal goals. The consequence is the ''why try'' effect. ''Why try to get a job? I am not worthy. Why try to live independently? I am not able''.

Correspondence: Patrick W. Corrigan, Illinois Institute of Technology, 3424 S. State Street, Chicago, IL 60616, USA. Tel: +312 567 6751. Fax: +312 5676753. E-mail: corrigan@iit.edu

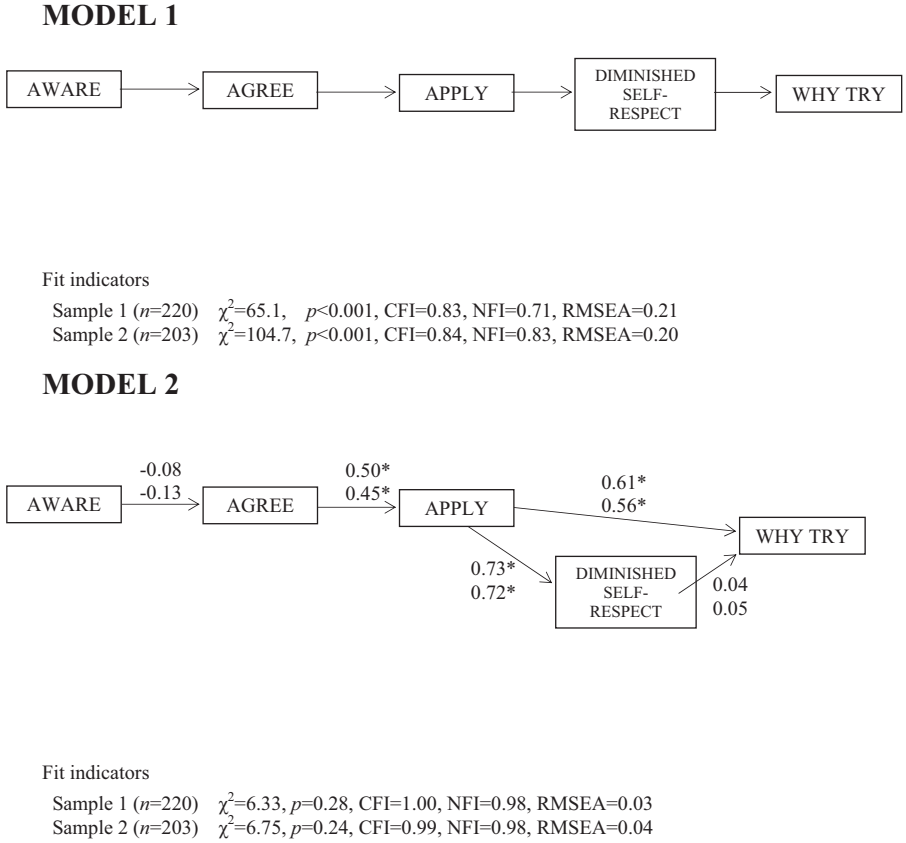

Figure 1. Path model showing the relationship between self-stigma stages and ''why try'' outcome. Results were determined independently for two randomly selected subsamples of the whole ($N = 423$). Two sets of fit indicators are also provided. Two coefficients are provided for each path of the second model; they are β that resulted from the structural equation models of each random sample.

Because ''why try'' and its proxies have not been tested in previous research, a second goal of the study herein is to report on development and testing of a measure of the construct. The models in Figure 1 propose two relationships among stigma application, loss of self-respect and ''why try''. In the first, diminished self-respect mediates the relationship between stereotype application and ''why try,'' while in the second model, ''why try'' is independently impacted by application and lowered self-esteem.

Finally, we examine the impact ''why try'' and diminished self-esteem have on other constructs related to the course of serious mental illness. Impact is partly framed as negative emotional response, similar to depression, which could undermine a person's sense of empowerment and recovery. Hence, we seek to show a significant relationship between ''why try,'' depression, recovery, and empowerment.

Methods

Developing a measure of the ''why try'' effect

The ''why try'' phenomenon was defined as a sense of futility in which people believe they are unworthy or incapable of achieving personal goals because they apply the stereotypes of mental illness to themselves. This led to a measure with items with two stems – ''I am not capable of...'' or ''I am not worthy of...'' – connected with various goals. A community-based participatory research (CBPR) team identified seven domains of personal goals that generated the second half of each item: education/employment, health, family/relationships, recreation/travel/exercise, civic partnership/citizenship, finances, and self-care. A goal from each domain was randomly connected to worth or capability stems: ''I am not capable of working a good job because I have a mental illness''. ''I am not worthy to vote in a government election because I have a mental illness''. The CBPR team then completed cognitive interviews with 12 people with serious mental illness from diverse ethnic/racial and socioeconomic backgrounds. Items were rated for clarity and comprehension of concepts. The seven items with highest ratings resulted in the Why Try Stigma Scale (WTSS). Research participants responded to individual items on a 7-point agreement scale (7 = *strongly agree*). A total WTSS score was determined by summing items, with higher scores representing greater endorsement of the ''why try'' effect.

Testing the regressive model with the ''why try'' effect

Participants

We sought adults with mental illness from across the United States using Mechanical Turk (MTurk) to recruit participants in April and May, 2014. MTurk is a crowdsourcing internet marketplace often used to solicit participants for social science research. Research is mixed regarding the degree to which demographics of MTurk workers match the US population, though there is some consensus that MTurk samples work best for random population modeling (Paolacci et al., 2010). A solicitation was posted on the MTurk Human Intelligence Tasks list requesting U.S. workers to participate in a survey ''examining attitudes and thoughts about mental health issues''. Interested workers were reimbursed 10 cents

Table 1. Summary of demographics of survey participants.

	Means (*SD*s) or frequencies
Age	30.4 (9.1)
Gender	
Female	50.1%
Male	48.2
Transgender/other	1.6
Race[a]	
European/European American	89.6%
African/African American	3.3
Asian/Asian American	6.4
Native American	2.4
Hawaiian/Pacific Islander	1.2
Other	1.2
Ethnicity	
Latino/Latina	4.5%
Highest educational achievement	
Some high school	1.2%
High school diploma	12.5
Associates degree	10.2
Some college	32.2
Bachelor's degree	29.8
Some graduate school	4.5
Graduate degree	9.7
Employment	
Full-time	38.3%
Part-time	20.1
None	22.5
Other	19.1
Annual income	
<20 000	43.8%
20 001–40 000	30.9
40 001–60 000	17.3
60 001–80 000	4.3
80 001–100 000	2.1
>100 000	2.6

[a]Race exceeded 100% because some participants reported multiple racial identities.

for completing a seven-item screen about health. Two items represented mental health experiences: ''I have a current mental illness diagnosis'' and ''I have seen a psychiatrist for treatment of a mental illness''. Those who responded affirmatively to either item were then invited to participate in and complete the full survey; they were reimbursed an additional 40 cents. All aspects of the protocol were approved by the Institutional Review Board at the Illinois Institute of Technology.

We found that 1414 MTurk workers responded to the initial solicitation. Of those, 867 did not endorse screening questions. Others were excluded because they were under 18 years of age ($n = 5$), did not consent online ($n = 4$), had mobile devices which were incompatible with the survey platform ($n = 11$), or failed to fully complete the survey ($n = 79$). An additional concern about online surveys is research participants who do not fully attend to task. Our MTurk survey included validity questions meant to identify people in this group ($n = 25$); e.g. ''Please choose the number ''8'' for your answer below''. As a result, 423 MTurk workers provided useable data. Table 1 summarizes demographic characteristics.

Measures

Research participants completed the WTSS, the short version of the Self-Stigma of Mental Illness Scale (SSMIS), and instruments shown to be impacted by self-stigma: empowerment, recovery and depression. The original SSMIS had 10 items per subscale: aware, agree, and apply leading to diminished self-esteem (Corrigan et al., 2006). Research participants respond to stereotypes that were preceded by stems that correspond with aware (I think the public believes . . . most people with mental illness are dangerous), agree (I think . . . most people with mental illness are dangerous), apply (because I have a mental illness . . . I am dangerous) and diminished self-respect (comprising items representing self-esteem and self-efficacy) (I currently respect myself less . . . because I am dangerous). Subsequent research has shown the SSMIS subscales have good reliability and validity (Rüsch et al., 2006; Schomerus et al., 2011). A shorter version of the SSMIS-SF (five items per subscale) was developed, tested on three samples, and shown to also have good reliability and validity (Corrigan et al., 2012). Research participants respond to individual items using a 9-point agreement scale with scores for each subscale determined by summing corresponding items. Higher scores represent greater endorsement of the subscale. The diminished self-esteem subscale of the SSMIS-SF was shown to be significantly associated with low recovery and personal empowerment as well as depression (Corrigan et al., 2012).

The Recovery Assessment Scale (RAS) is a 41-item scale with individual items representing aspects of recovery – I have goals that I want to reach, – to which participants respond with a 5-point agreement scale (5 = *strongly agree*) (Corrigan et al., 2004). Prior factor analysis yielded a five-factor solution: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and not dominated by symptoms (Corrigan et al., 2004). The Empowerment Scale (ES) is a 28-item scale representing experiences with personal empowerment and self-determination – ''People have a right to make their own decisions, even if they are bad ones'' – to which research participants respond using a 4-point agreement scale (1 = *strongly agree*). Analyses yielded five-factor solutions: self-efficacy, perceived power, optimism about and control over the future, community activism, and righteous anger (Rogers et al., 2010). Both the RAS and ES are long scales for the kind of survey research used to describe stigma. Short versions were developed by selecting items that loaded best into each of the five RS and ES factors yielding five items for each. High scores on the RAS represented high recovery and on the ES represented low empowerment. A recent paper summarized the satisfactory psychometrics of short scales on four samples (Corrigan et al., 2014a).

Depression was assessed using the 10-item Center for Epidemiological Studies Depression Scale (CES-D) with higher scores representing greater depression (Radloff, 1977). We assessed public stigma as a control variable by administering the nine-item version of the Attribution Questionnaire (AQ-9; Corrigan et al., 2014b). Research participants rate Harry, a person with schizophrenia, on 9-point agreement scales (9 = *strongly agree*) representing the stereotype constructs in our attribution model: responsibility, pity, anger, help, danger, fear, avoidance, segregation, and coercion. High scores represent greater endorsement of public stigma.

Data analysis

Factor structure of the WTSS was examined with a principle component analysis and varimax rotation. Hypothesized paths were then examined using EQS-6 structural equations program (Bentler, 2006). Indices were determined to examine goodness-of-data fit to the models; indices (and criteria for fit) included chi squared (with p not significant), normed fit index (NFI) and comparative fit index (CFI) (with NFI and CFI greater than 0.95), and root mean square error of approximation (with RMSEA less than 0.06). In cases where overall fit is supported, β for individual paths represented associations between constructs. Significance of those β was determined by t-tests. The sample was randomly split into two halves to cross validate the findings.

In addition, analyses examined the relationship between measures of self-stigma harm and the ''why try'' effect with indices of recovery, empowerment, and depression using simultaneous multiple regressions. These analyses were controlled by public stigma endorsements (AQ 9).

Results

Mean and standard deviations of measures are summarized in Table 2. Results of a principle component factor analysis with varimax rotation yielded a single factor for the WTSS with eigenvalue of 3.45 accounting for 49.3% of the variance. Item loadings ranged between 0.61 and 0.77. Cronbach's α for the resulting overall score was 0.81. The table also includes internal consistencies for the other scales; all were within acceptable ranges except for a marginal α for RAS and an unacceptable α for the Empowerment Scale. Figure 1 summarizes the two structural equation models. Fit indicators are provided for the two separate samples. Fit was not supported for either sample of Model 1, where diminished self-esteem fully mediated the effect of applying stereotypes and the ''why try'' effect. None of the indicators met criteria for good fit. Conversely, all the indicators supported good fit for both samples of Model 2. Moreover, chi squared tests showed fit indicators for Model 2 were significantly greater than for Model 1 ($\chi^2_{\text{diff}} = 58.8$ and 98.0, respectively, $p < 0.0001$). Model 2 includes β with similar relationships across the two random samples. As expected, agree predicted apply which predicted diminished self-esteem. Apply also predicted ''why try''. Diminished self-esteem was not found to be directly associated with ''why try''. Also, interestingly, a significant path was missing at the beginning of the model. Awareness of stereotypes did not predict whether someone agreed with them.

Results of the regression analyses are summarized in Table 3, with separate equations representing correlates of diminished self-esteem and ''why try''. Empowerment was excluded from these analyses because of its low internal consistency. The top half of the table shows public stigma, recovery, and depression were all significantly associated with diminished self-esteem. People reporting diminished self-esteem admitted to greater depression and public stigma as well as lower recovery. In the second equation with ''why try'' as the dependent variable, significant associations were found with depression, public stigma, and empowerment. Those who endorsed ''why try'' were likely to agree with public stigma. This may correspond with depression and diminished recovery. The equations accounted for 22 and 18% of the variance, respectively.

Discussion

A regressive model of self-stigma suggests that people who are aware of the stereotypes of mental illness and agree with them might do harm when they apply the stereotypes to themselves. Harm manifests itself emotionally (as low self-respect) and behaviorally (why try to pursue personally-important goals). Findings from this study supported many of these assertions. Results of path analyses showed people who agree with and apply stigmatizing beliefs to themselves are likely to suffer self-disrespect. Decrease in self-respect leads to behavioral futility: Why try to pursue my goals? I am not worthy of them or not able to achieve them. The relationship between applying stereotypes and emotional versus behavioral harm seems to be independent. In particular, diminished self-esteem and ''why try'' were associated with greater depression and diminished recovery. These constructs were also associated with a decrease in recovery as well as endorsement of public stigma. These findings suggest self-stigma has both emotional and behavioral impacts.

Table 2. Mean and standard deviations of responses to survey instruments.

Variable	Mean	*SD*	α
SSMIS-SF–Aware	33.3	6.35	0.77
SSMIS-SF–Agree	15.4	6.98	0.84
SSMIS-SF–Apply	12.1	7.18	0.81
SSMIS-SF–Dim. self-esteem	12.7	8.34	0.85
Why Try Effect (WTSS)	13.0	7.08	0.81
Empowerment (ES)	10.7	2.13	0.44
Recovery (RAS)	18.7	3.35	0.69
Depression (CESD)	25.8	7.25	0.86
Public stigma (AQ-9)	32.6	10.32	0.80

SSMIS-SF, Self-Stigma of Mental Illness Scale, Short Form; WTSS, Why Try Stigma Scale; ES, Empowerment Scale; RAS, Recovery Assessment Scale; CES-D, Center for Epidemiological Studies Depression scale, AQ-9, nine-item version of the Attribution Scale.

Table 3. Results of multiple regressions examining correlates of self-stigma harm and the ''why try'' effect.

Variable	β	t
DV: Diminished self-esteem (SSMIS-SF)		
Independent variables		
Public stigma (AQ-9)	0.15	3.50***
Recovery (RAS)	−0.28	−5.51***
Depression (CES-D)	0.23	4.47***
	$R^2 = 0.22$	
DV: ''Why Try''		
Independent variables		
Public stigma (AQ-9)	0.28	6.34***
Recovery (RAS)	−0.19	−3.58***
Depression (CESD)	0.16	3.11**
	$R^2 = 0.18$	

SSMIS-SF, Self-Stigma of Mental Illness Scale, Short Form; WTSS, Why Try Stigma Scale; RAS, Recovery Assessment Scale; CES-D, Center for Epidemiological Studies Depression scale, AQ-9, nine-item version of the Attribution Scale **$p < 0.01$, ***$p < 0.005$.

Interestingly, results of this study failed to support the first stage of the regressive model. Awareness of stigmatizing beliefs is not associated with whether an individual personally agrees with them. Hence, perceived stigma per se may not be a good proxy of self-stigma. Although more than half of research participants met criteria showing they were aware of stereotypes (68.6%), far fewer agreed with them (3.1%). Also interesting here are the 31.4% of participants who were relatively unaware of stigma. This is atypical of other research and may reflect the self-report of mTurkers on this medium (Corrigan et al., 2012). Still, even though raw endorsement of agreement and application did not meet criteria, scores on these domains still predicted diminished self-esteem and ''why try''.

There are limitations to this study. Demographic problems prevented analyses of key indicators that might moderate self-stigma. Previous research has shown race and ethnicity to be related to stigma (Abdullah & Brown, 2011). Our data were skewed towards European Americans, preventing the examination of effects for people of color. The sample was also skewed in terms of socioeconomic status (SES), over-representing those with lower income. This might, however, reflect challenges of people with moderate to serious mental illness. Conversely, 58.4% reported part- or full-time employment, which is much higher than might be expected for people with moderate to serious mental illness. However, people from low SES groups are likely to experience stigma more negatively, so one of the strengths of this study was examining the stigma experience in this group. We lacked data to determine how self-stigma may vary by SES.

We obtained a sample of people with lived experience through online recruitment, which may have omitted an important voice in the research. We did not collect information that allowed us to assess severity of mental health challenges in research participants. Frequency analyses showed 74.7% of the participating sample admitted to a current mental illness diagnosis; 79.7% of that group also admitted to having seen a psychiatrist for treatment of a mental illness. Given that research suggests those with greater psychiatric symptoms experience greater self-stigma (Boyd et al., 2014), future research needs to better unpack the nature and severity of illness on self-stigma. Related to this research would be examining the degree to which people identify with their mental illness. Separate from the experiences of serious illness and disability, the realization for many that ''I am a person with mental illness'' is central to their identity. We presented ''why try'' as a behavioral outcome, the sense of futility that prevents people from pursuing behavioral goals. A more accurate definition would frame ''why try'' as a behavioral intention, or perhaps more accurately, a behavioral dis-intention. Subsequent research needs to determine whether believing people are unworthy or incapable leads to patterns of not engaging their goals.

These findings have implications for subsequent work related to self-stigma change (Corrigan & Rao, 2012). Specifically, results support the construct validity of ''why try'' as the behavioral consequence of self-stigma. Hence, future program development needs to make certain behavioral futility is adequately addressed in its components. Reviews have shown there to be three broad approaches to diminishing self-stigma: education, which often includes cognitive behavioral techniques where participants learn to challenge self-stigmatizing beliefs; peer support which bolsters one's sense of personal empowerment; and disclosure programs where people learn strategies to come out with their mental illness (Mittal et al., 2012). Ongoing research into these approaches needs to capture the varied impacts of self-stigma and behavior consequences to discern specificity of change that results from participating in these kinds of programs. Interventions that promote disclosure leading to peer exchange may be especially potent ways of decreasing self-stigma. For example, a program called ''Coming Out Proud to Erase the Stigma of Mental Illness'' has participants consider the pros and cons of disclosure as well as strategies for how to tell one's story (Rüsch et al., 2014). This kind of approach seems to diminish some of the products of stigma.

Declaration of interest

The authors declare no conflicts of interests. The authors alone are responsible for the content and writing of this article.

References

Abdullah T, Brown TL. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. Clin Psychol Rev, 31, 934–48.

Arboleda-Flórez J, Sartorius N, eds. (2008). Understanding the stigma of mental illness: Theory and interventions. Chichester, UK: John Wiley & Sons, Ltd.

Bentler PM. (2006). EQS 6 structural equations program manual. Encino, CA: Multivariate Software, Inc.

Boyd JE, Adler EP, Otilingam PG, Peters T. (2014). Internalized stigma of mental illness (ISMI) scale: A multinational review. Comprehens Psychiatr, 55, 221–31.

Corrigan PW, Gause M, Michaels PJ, et al. (2014a). The California Assessment of Stigma Change: A short battery to measure improvements in the public stigma of mental illness. Community Mental Health Journal. Advance online publication. doi:10.1007/s10597-014-9797-5.

Corrigan PW, Larson JE, Rüsch N. (2009). Self-stigma and the ''why try'' effect: Impact on life goals and evidence-based practices. World Psychiatr, 8, 75–81.

Corrigan PW, Michaels PJ, Vega E, et al. (2012). Self-stigma of mental illness scale-short form: Reliability and validity. Psychiatr Res, 199, 65–9.

Corrigan PW, Powell KJ, Michaels PJ. (2014b). Brief battery for measurement of stigmatizing versus affirming attitudes about mental illness. Psychiatr Res, 215, 466–70.

Corrigan PW, Rao D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. Can J Psychiatr, 57, 464–9.

Corrigan PW, Salzer M, Ralph RO, et al. (2004). Examining the factor structure of the Recovery Assessment Scale. Schizophrenia Bull, 30, 1035–41.

Corrigan PW, Watson AC, Barr L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. J Soc Clin Psychol, 25, 875–84.

Hinshaw SP. (2007). The mark of shame: Stigma of mental illness and an agenda for change. New York, NY: Oxford University Press.

Link BG. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. Am Soc Rev, 52, 96–112.

Markowitz FE. (2001). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. J Health Soc Behav, 42, 64–79.

Mittal D, Sullivan G, Chekuri L, et al. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. Psychiatr Serv, 63, 974–81.

Paolacci G, Chandler J, Ipeirotis PG. (2010). Running experiments on Amazon Mechanical Turk. Judgm Decision Making, 5, 411–19.

Radloff LS. (1977). The CES-D scale: A self-report depression scale for research in the general population. Appl Psychol Measure, 1, 385–401.

Rogers ES, Ralph R, Salzer MS. (2010). Validating the Empowerment Scale with a multi-site sample of consumers of mental health services. Psychiatr Serv, 61, 933–6.

Rüsch N, Abbruzzese E, Hagedorn E, et al. (2014). The efficacy of coming out proud to reduce the impact of stigma among people with mental illness: Randomized controlled trial. Br J Psychiatr, 204, 391–7.

Rüsch N, Holzer A, Hermann C, et al. (2006). Self-stigma in women with borderline personality disorder and women with social phobia. J Nerv Mental Dis, 194, 766–73.

Schomerus G, Corrigan PW, Klauer T, et al. (2011). Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. Drug Alcohol Depend, 114, 12–17.

Vogel DL, Wade NG, Haake S. (2006). Measuring the self-stigma associated with seeking psychological help. J Counsel Psychol, 53, 325–37.