Correlations between stigma and self-esteem in mental health consumers

Marilyn Dee Pitts

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Social Work Commons

Recommended Citation
Pitts, Marilyn Dee, "Correlations between stigma and self-esteem in mental health consumers" (2004). Theses Digitization Project. 2596.
https://scholarworks.lib.csusb.edu/etd-project/2596
CORRELATIONS BETWEEN STIGMA AND SELF-ESTEEM

IN MENTAL HEALTH CONSUMERS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

Marilyn Dee Pitts

June 2004
CORRELATIONS BETWEEN STIGMA AND SELF-ESTEEM
IN MENTAL HEALTH CONSUMERS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

by
Marilyn Dee Pitts
June 2004

Approved by:

Dr. Tom Davis, Faculty Supervisor
Social Work

Dr. Ryan Quist, Research Specialist
Riverside County Dept. of Mental Health

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator
ABSTRACT

The experience of being stigmatized is a significant issue among those who have a severe mental illness. Not only is the experience of social rejection painful, stigma may instigate negative outcomes for the consumer. This research project investigated the correlation between stigma experiences and self-esteem using standardized and published instruments. A survey was administered to individuals with a severe mental illness who are participating in programs designed to increase socialization and employment opportunities. As expected, the study found a negative correlation between stigma and self-esteem. That is, the higher the measure of stigmatization, the lower this population measured in self-esteem.
ACKNOWLEDGMENTS

I would like to thank Dr. Thomas Davis for supervising this work with enthusiasm and giving me encouragement through the process. I also want to thank Dr. Rosemary McCaslin for her assistance in gaining approval from the Institutional Review Board.

I’m grateful to my husband, Bob Pitts, my parents, Betty and Rowland Manchester, and my children, Rachael Boggs and Emily Giddings for their support and belief in me. I could not have made it without them.
DEDICATION

This work is dedicated to two people who have inspired me and sustained me through the process. The first is to my Lord Jesus Christ who redeemed me, gave my life purpose, and placed in my heart a tenderness toward individuals with mental illness.

The second person is my husband, Bob Pitts who showed his love for me sacrificially in word and action. He listened, encouraged, and cheered me on every step of the way.

A portion of scripture that has been meaningful to me is in Isaiah 50:4, which reads:

“The Sovereign Lord has given me an instructed tongue, to know the word that sustains the weary. He wakens me morning by morning, wakens my ear to listen like one being taught.”
TABLE OF CONTENTS

ABSTRACT .......................................................... iii
ACKNOWLEDGMENTS ........................................ iv
LIST OF TABLES ................................................. vii

CHAPTER ONE: INTRODUCTION
    Problem Statement ........................................ 1
    Purpose of the Study .................................... 3
    Significance of the Project for Social Work ....... 5

CHAPTER TWO: LITERATURE REVIEW
    Introduction .............................................. 9
    Terms Defined ............................................ 9
        Stigma ............................................. 9
        Self-esteem ..................................... 15
    Impact of Stigma ....................................... 17
    Theory Guiding Conceptualization .................. 22
    Summary ................................................ 26

CHAPTER THREE: METHODS
    Introduction .............................................. 27
    Study Design ............................................ 27
    Sampling ................................................ 28
    Data Collection and Instruments ................... 29
    Procedures .............................................. 31
    Protection of Human Subjects ....................... 33
    Data Analysis ......................................... 34
    Summary ................................................ 35
CHAPTER FOUR: RESULTS

Introduction ........................................... 36
Presentation of the Findings ......................... 36
Summary .............................................. 44

CHAPTER FIVE: DISCUSSION

Introduction ........................................... 45
Discussion ............................................. 45
Limitations ........................................... 50
Recommendations for Social Work Practice,
Policy and Research ................................. 51
Conclusions ........................................... 53

APPENDIX A: QUESTIONNAIRE ......................... 54
APPENDIX B: INFORMED CONSENT .................... 58
APPENDIX C: DEBRIEFING STATEMENT ............... 61
APPENDIX D: INSTITUTIONAL REVIEW BOARD ....... 63
REFERENCES .......................................... 65
LIST OF TABLES

Table 1. Responses to Survey Stigma Items ............. 38
Table 2. Responses to Survey Self-esteem Items ........ 41
Table 3. Correlations: Stigma and Self-esteem Items ........................................ 43
CHAPTER ONE
INTRODUCTION

Problem Statement

Research has demonstrated that individuals with a severe mental illness not only have to deal with the symptoms of their illness and the side effects of their medication, but also with the stigma that is attached to their condition. In addition to rejection, the stigmatized are also discriminated against in various ways. Among those who bear the label “mentally ill,” is also the burden of high unemployment, low income, and demoralization (Link, 1987; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Thesen, 2001).

Mental health consumers also suffer discrimination when promised resources and services become less obtainable, thereby communicating a less worthy status than other programs or needs. Sayce (1998) argues that mental health providers have “not yet created a public mood of disapproval of discrimination on mental health grounds, to compare with the sensitisation that has begun to occur in fields such as HIV/AIDS or physical disability” (p. 334).
Rosenfield (1997) found a significant relationship between stigma and a lower quality of life experienced by consumers. Symptoms of depression and a sense of helplessness are also common, she adds. Link et al. (1989) claim that even when the illness is stabilized, the effects of stigma still persist. In addition to these troubling statements, Thesen (2001) asserts that the consequences of having a mental illness affect the “total life situation in terms of isolation and loneliness, low self-esteem, no paid work, lack of money, discrimination, and harassment of yourself and your children” (p. 29).

Although there has been improvement in public acceptance of some mental disorders, such as anxiety and mood, fear of those with psychotic symptoms has increased over the last 50 years (Phelan, Link, Stueve, & Pescosolido, 2000). This is believed to be due in part to the media’s excessive portrayal of people with schizophrenia as being violent (Wahl, 1995). Inaccurate depictions of individuals with a mental illness add to the stigma already experienced.

Wright, Gronfein, and Owens (2000) warn that the more stigmatization that is experienced by a person, the lower their self-esteem will become. In their research, they noted that stigma significantly affects negative
self-esteem. It's as though the good and worthy view of self is overridden by a negative view that "casts" the individual as being undesirable and "deficient" (p. 83).

In an effort to explain stigma, the modified labeling theory was developed, which stated that society in general is socialized with certain negative beliefs about mentally ill persons (Link et al., 1989). When a person experiences a psychiatric disorder and the label is applied to them, they will cope with other people knowing about their illness in three basic ways; some will be secretive, others will withdraw, or they may educate people around them. In time their means of coping will effect their social connections and their opportunities in life. Those with the greatest fear of being stigmatized will insulate themselves from the general population, which produces negative outcomes. Link et al. go on to say that these "negative outcomes...may place mental patients at risk for the recurrence" of their illness" (p. 404).

Purpose of the Study

The purpose of this study was to measure correlations of stigma with self-esteem among individuals who are receiving treatment for a mental illness. Over the past two decades interest in this area has grown. The number of
research articles printed illustrates this; in 1980 there were 33 but in 1999 there were 275 (Link & Phelan, 2001). During that time, progress has been made in defining terms, developing instruments, and understanding the process of being stigmatized.

Although the body of knowledge in this subject is growing, Link and Phelan (2001) indicate that relatively little research has been conducted concerning the relationship between stigma and self-esteem. This study adds to that body of knowledge and further develops the modified labeling theory. Although self-esteem is only one of the many outcomes of stigma, its relevance to psychological well-being is salient. When a clear understanding of the connection between stigma and self-esteem is made, effective intervention can be developed and applied.

This research project was exploratory in nature and investigated correlations between stigma and self-esteem using the modified labeling theory. As such, it was quantitative research using the self-esteem scale developed by Rosenberg (Corcoran, & Fischer, 2000), and a modified Consumer Experiences of Stigma Questionnaire (CESQ) developed by Wahl with input from members of the National Association of the Mentally Ill (Dickerson,
Sommerville, Origoni, Ringel, & Parente, 2002). These instruments were administered in a cross-sectional survey that was given on two separate occasions to two different groups.

The data was obtained from surveys of 30 individuals participating in transitional programs, which provide socialization, education and job opportunities for consumers. While these men and women have a mental illness as classified in the DSM-IV, they were sufficiently stabilized to give consent and complete the questionnaire accurately. Conducting the survey at a facility where respondents were receiving treatment allowed this project to come closer to replicating research that has been done.

Significance of the Project for Social Work

The primary mission of social work is to help all people, especially those who are "vulnerable, oppressed, and living in poverty" (Code of Ethics, 1999). Individuals with severe mental illness are being stigmatized and discriminated against, which can profoundly affect their opportunities in life. Dickerson et al. (2002) state that "stigma remains a significant impediment for persons with an already devastating illness" (p. 153).
This research project is significant because it touches on the subject of disenfranchised individuals who need to have the support of social workers who can bring change to their life. Until enough research has been conducted to support a general acceptance that stigma is related to poor outcome, it will be difficult to enact real change.

Link and Phelan (2001) believe that for change to occur it must be "multifaceted and multilevel" (p. 381). They argue that since there are many aspects of stigma, no single intervention will be sufficient to make a notable difference. Focusing on one problem area for consumers is too narrow. In the same way, different levels of stigma, from individual to structural, also need to be addressed simultaneously.

Although this is a tall task, social workers are in a unique position to contribute. This is true not only because of the broad nature of social work, but because it is a reflection of valuing the dignity and worth of each person as represented in the social worker’s Code of Ethics (1999).

For example, public educational programs need to be on the forefront in order to effect change in the attitudes of the public toward the mentally ill. This
could occur through media and billboard campaigns as well as special programs that would educate children about mental illness, replacing myths with facts. In direct practice settings, there is a need for social workers to develop interventions and programs that would enable those with mental illness to better cope with the affects of stigma and demoralization. As an expression of the principles that social workers uphold in challenging social injustice, they need to continue to advocate in the legislature for laws to prevent discrimination against those with mental illness in housing, employment, and other areas.

Discrimination is an ugly part of stigma. As a society we have made some movement in the direction of greater acceptance for those who are of another ethnic group or sexual orientation, but essentially little if any movement has been made in accepting those with a severe mental illness. Therefore, this issue not only affects the consumers of mental health services and those who are employed in the behavioral health setting, it ultimately affects society as a whole.

This study seeks to add to the body of knowledge that already exists in order to eventually see movement toward
greater acceptance and empathy for those with a severe mental illness.
CHAPTER TWO

LITERATURE REVIEW

Introduction

Since this research project concerns stigma and self-esteem, it seems appropriate that it should begin with defining the terms. Following that, an examination of how individuals are stigmatized will be done, who is responsible, and the long-term consequences as demonstrated through research. Finally, the theory that has guided this study, the modified labeling theory, is explained and various studies that have supported it are given.

Terms Defined

Stigma

Goffman (1963), one of the early writers on stigma, explains that in social settings people have certain expectations of what the person across from them will be like, which he calls the "virtual social identity" (p. 2). Since this identity is based on an expectation, it is different than the "actual social identity," or the true nature of the person (p. 2). When this person is not behaving in the expected way, their identity becomes "blemished" (p. 1). In other words, when people do not
live up to the behavior that is expected of them, they are judged as being flawed. Goffman conceptualized stigma as a state of being “discredited” in social relationships when the “normal” person becomes aware of the other’s actual identity (p. 4, 5).

Furthermore, Goffman (1963) believed that the stigmatized person carries the stress of trying to fit in with the mainstream, or how to pass as a normal. Living with the secret of their blemish and being on guard to protect it from showing are cumbersome and anxiety provoking. For the stigmatized to inform others of their blemish requires a risky gamble. If it leads to a prejudicial response the relationship is biased from then on, the information cannot be taken back. Even when treatment is received and the person is symptom free, the status of stigma is not dropped. According to Goffman (1963), they are still known as someone who has a history with the blemish.

Stigma can become a “master status” in the life of a consumer becoming the prominent characteristic that excludes all others, claim Ainlay, Coleman, and Becker (1986, p. 6). They assert that the stigmatized person then becomes known, first and foremost, by the stigma causing trait. Jones et al. (1984) agree by stating that when a
person feels insecure about some aspect of their self-esteem, they will depend more heavily on the views of others about this characteristic. Some consumers will take hold of how others define them, build a “schema” around it, and give it an important position in their self-concept (p. 115). Jones et al. believe that the process of stigma is in operation when it becomes a central part of a person’s self-concept.

Corrigan and Penn (1999) relate stigma to negative stereotypes and “erroneous attitudes” about those who are mentally ill (p. 765). Not all stereotypes are hurtful or will lead to discrimination. Humans categorize things to enable the brain to make a quick judgments about one thing while doing another. “They are efficient because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group,” write Corrigan and Penn (1999, p. 766). On the other hand, stigma is seen as prejudice when a person uses overgeneralizations based on poor information to hurt and discriminate against a consumer.

Corrigan and Penn (1999) reported that three categories of erroneous beliefs about those who are mentally ill were revealed in a survey response of over 2,000 people in the general public. The first category
indicated that people with a severe mental illness should be feared and avoided. The second factor was the belief that consumers are unable to be responsible or make proper decisions about their lives. The implication is that others need to make decisions for them. The third faulty belief is that individuals with a mental illness are simple and need to be under the care of another. According to Corrigan and Penn (1999), these flawed beliefs often lead to stereotypes, which when acted upon become discrimination or stigmatization.

Link and Phelan (2001) view stigma as a concept that consists of a number of components, which include: labeling, stereotyping, separation, loss of status, and discrimination. When these points converge, and power is applied, stigma occurs.

According to Link and Phelan (2001), when a label is applied to a person, a negative stereotype is then connected to that person. For example, when a consumer is first given the label of “mentally ill,” many people tie it to the negative stereotypes they have been socialized to believe. Scheff (1966) suggests that these stereotypes become applied in early childhood as children play being “crazy” or the “boogie man.” Unfortunately, most of the
information about mental illness is learned through other children.

After labeling and stereotypes, the third component of stigma is separation. Link and Phelan (2001) believe it is the "rationale for believing that negatively labeled persons are fundamentally different...types of people" (p. 370). This results in the reaction of separating "us" from "them." The attitude of separation can be seen in the way consumers are referred to by their illness. When people have other illnesses, it is properly stated that they have a particular condition, such as cancer. One would never say a person is cancerous. Yet, Link and Phelan (2001) point out that many times consumers are no longer referred to as persons but as labels; he or she is a schizophrenic, rather than he or she has schizophrenia. The stigmatized become another class of persons.

Link and Phelan (2001) go on to state that the consequence of separating "us" from "them" is discrimination and a loss of status for those with a mental illness. In addition to rejection, harassment and disapproval, consumers face the likely prospect of fewer chances in life as well.

In Link and Phelan's (2001) conceptualization of stigma, they emphasize that for stigma to occur "social,
economic, and political power” must be in place (p. 375). For example, patients in a psychiatric hospital may have derogatory labels for some of the psychiatrists or nurses, and apply negative stereotypes to the labels, explain Link and Phelan. They may even go so far as to avoid and make disparaging remarks about them so that all of the components of stigma are in play, but due to the power differential, stigma would still not result. They contend “stigma is dependent on power” (p. 375).

It seems appropriate to end this section on stigma and begin the next section on self-esteem by including the words of a consumer who expresses the emotions that a study cannot.

Looking back, my biggest struggle was not with the illness itself, but with being tossed aside by the normally functioning world and made an outcast of society…. Nothing compares with being rejected over and over, and treated as if one were a freak, unworthy of respect. No, the psychotic symptoms were not the cause of my despair. It was realizing that, because there is no cure for schizophrenia, I must wear this label for the rest of my life, and as a result of it, be considered different and treated as an inferior being. (Murphy, 1998, p. 185)
Self-esteem

Rosenberg, well known for developing a widely used self-esteem scale, defines self-concept as a "picture of the self" (1979, p. 7). In other words, a self-concept is all of one's thoughts and emotions that are connected to the observations of oneself. For the purpose of this study, self-esteem and self-concept (Rosenberg's term) will be used interchangeably.

Rosenberg (1979) developed four principles which explain the formation of self-concept. The first one, reflected appraisals, refers to how a person actually views himself, how he believes he is viewed by others, and the attitude of the community toward him (p. 63).

The second principle, social comparisons, expresses the idea that self-concept is formed in comparison to others; a person sees himself as either "superior or inferior" or the "same or different" from others (p. 68). Interestingly, where a person stands in comparison to others in a social setting can change drastically depending upon the group. For instance, a person with mental illness may experience feeling inferior in a workplace setting, but then superior in a support group setting of consumers where he has fewer symptoms than they.
Self-attribution is the third principle, which simply stated is the process by which a person attributes certain characteristics to himself. Rosenberg believes that when a person observes his own behavior he has the ability to then draw conclusions about his "inner motives, states, or traits..." (1979, p. 71). From these conclusions a person can assign certain characteristics to himself. Rosenberg (1979) provides the example of a child who concludes that he is a good speller when he does well on spelling tests.

The final principle in the formation of self-concept according to Rosenberg (1979) is psychological centrality. While it has been stated that self-concept is affected by the view of others, the significance of it will depend on how central it is to that person's identity. For instance, if a woman greatly values her identity as a mother and people told her she was not fit to be a mother, this would affect her self-concept more than criticism about something less important to her. In other words, the value a person places on a particular characteristic indicates how the reflections of others will affect their self-concept.

Along the same line, self-concept is affected more by the reflections of valued relationships in life than by those that are less important (Rosenberg, 1979). It stands
to reason that a child’s self-concept is affected more by his parents than by someone in line at the grocery store.

Rosenberg’s (1979) scale is a global self-esteem instrument and measures the positive and negative attitudes toward the self. When a person has a high self-esteem, Rosenberg explains, he has respect for himself and feels he is a worth while person. On the other hand, if a person has low self-esteem, he “lacks respect for himself, considers himself unworthy, inadequate, or otherwise seriously deficient as a person” (p. 54).

Wright et al. (2000) and Owens (1994) split Rosenberg’s scale into positive and negative aspects, making it a bidimensional scale. The positive aspect is referred to as self-worth by Wright, which is expressed in feelings of valuing self and satisfaction in life. Self-deprecation, on the other hand, is the negative side of self-esteem.

Impact of Stigma

Mental illness is one of the most stigmatized human conditions and it is “clustered” with the status of drug addict or prostitute instead of with other illnesses, such as diabetes (Albrecht, Walker, & Levy, 1982, as cited in Link et al., 1989, p. 401). Even though the term “mental
illness" implies that a person has a condition that occurred through no fault of his own, some people treat consumers as though they could control their illness (Goffman, 1963). These individuals do not feel compassion for a consumer; rather they are angry and think they do not deserve the help they receive (Corrigan & Penn, 1999).

In research conducted by Dickerson et al. (2002) 73 of the 74 participants recounted experiences of being stigmatized. The study was performed in an outpatient setting among consumers who were diagnosed with schizophrenia. Revealing their illness to others was of great concern and many reported hearing others say derogatory statements in their presence. Not being treated with "kindness and sympathy" by law enforcement was a common response, as was reporting that employers or supervisors were a "source of stigma" (p. 151). Surprisingly, 20 percent of the participants reported mental health caregivers as being another source of stigma.

In England a study of 778 consumers revealed similar results with 47 percent reporting physical or verbal harassment (Read & Baker, 1996, as cited in Sayce, 1998). Another 14 percent of consumers reported being attacked with eggs, having dog feces put in their mailbox, or being
the object of similar pranks. In addition to the general public, 62 percent of family and friends and 50 percent of health care workers were also reported treating the consumers badly.

Much of the misinformation that comes to the public about mental illness comes through the media. Overall the media is guilty of misusing psychiatric terms and presenting a poor depiction of mental illness, which further develops negative stereotypes (Wahl, 1995). Often mental illness is joked about, which might not be hurtful if consumers were an accepted part of society. But, Wahl states it is "quite another when your group is not respected or valued" (p. 32). He goes on to say that this produces insensitivity and communicates to those who are the brunt of the joke that their illness is a "trivial" matter and they are not worthy of respect (p. 35).

According to Wahl (1995), it is not surprising that the public expresses fear toward a person with severe mental illness. The media continually produces movies, television shows, and books that depict people with schizophrenia as violent. Gerbner produced a summary that reviewed 17 years of daytime television (as cited in Wahl, p. 66). He found that 72.1 percent of characters with a
mental illness were portrayed as violent and 21.6 percent of that number killed someone on screen.

The truth of the matter is that some individuals with schizophrenia do become violent in the confusion of their psychosis; however, it is a very small number. The majority of people who suffer with schizophrenia are not violent. Cutcliffe and Hannigan (2001) cite two empirical studies that indicate the number of homicides committed by consumers have dropped significantly over the last 40 years. They report that currently homicides are committed by less that one percent of those with a psychiatric disorder (p. 318). The depiction in the media of violence among this population reinforces the notion of separation, and that consumers are fundamentally different from others.

Wright et al. (2000) followed 88 patients in a longitudinal study who were deinstitutionalized due to the closing of their psychiatric hospital. The research lasted two years during which time the individuals were surveyed face to face upon discharge, then one year, and two years later. Stigma was measured by asking the respondents questions about their defenses against being stigmatized and their actual experiences with it. A bidimensional view of self-esteem was used. This enabled the researchers to
measure both for self-worth (respect, satisfaction, value of self) and for self-deprecation (critical, devaluing, hating of self).

Wright et al. (2000) found, for those respondents who did not experience stigma, their global self-esteem remained stable over the two years. However, for other respondents the effect of experiencing stigma had a significant impact on negative self-esteem (self-deprecating views of self). As Wright et al. explain, "while the absence of rejection did not improve self-image, its presence certainly hurt it" (p. 80).

Another important finding was that the consumers, who developed negative self-esteem in the first year, remained at that level after two years (Wright et al., 2000). Even though the respondents had a history of psychiatric hospitalization, the experience of stigmatization after discharge increased their feelings of self-deprecation. This study not only confirmed that stigma has powerful impact on self-esteem, but also that the impact seems to remain stable over time.

Link, Struening, Rahav, Phelan, and Nuttbrock (1997) conducted a longitudinal study that was a year in length and involved 84 men who were in a model treatment facility. The researchers wanted to see if the benefits of
treatment would counteract the effects of stigma over the course of a year. It was found that while the respondent's symptoms improved, the effect of stigma remained the same. The men's perception of being devalued and discriminated against and their "reports of discrimination experiences" continued to cause poor outcomes (p. 186). This again demonstrates that stigma has long-term effects on those with mental illness, even when their symptoms subside.

Theory Guiding Conceptualization

Link et al. (1989) explains that the labeling theory developed by Scheff in 1966 was composed of four steps, the first of which was giving the label of "mentally ill" to an individual. As a result of that label, the person experiences the negative responses of others, which cause the individual to take on the identity of a mentally ill person. Finally, as this identity becomes stronger, the mental illness becomes entrenched causing a "vulnerability to future disorder" (Link et al., 1989, p. 403).

In this research, Link et al. (1989) developed the modified labeling theory which softened Scheff's model. Even though people with mental illness will experience negative responses from others, the modified theory stated that they will react to stigma in various degrees. Link et
al. also placed an emphasis on how the labeled individuals will cope with other people knowing about their illness; some will be secretive, others will withdraw, or they may try to educate people around them. Finally, Scheff believed that labeling caused mental illness. The modified labeling theory posits that the disorders are not caused by the label but may cause "negative outcomes that may place mental patients at risk for the recurrence...of disorders" (Link et al., 1989, p. 404).

This 1989 research tested the modified labeling theory by taking five groups of people and evaluating them according to each of the theory's steps (Link et al.). The five groups were: patients in first time treatment; patients in repeated treatment; formerly treated patients now in the community; and individuals from the community without pathology. The results of the study showed that society in general is socialized with certain negative beliefs about mentally ill persons. When a person becomes ill and the label is applied to them, they develop a coping strategy of "secrecy, withdrawal, or education" (Link et al., p. 419). In time their means of coping will effect their social connections. They believe that those with the greatest fear of being stigmatized will insulate themselves from the general population which will produce
a negative outcome. Overall the findings supported the modified labeling theory.

The study conducted by Rosenfield (1997) was interested in the claims of the modified labeling theorists. By controlling for self-esteem and self-mastery, she compared the perception of stigma versus treatment services for quality of life. The study was conducted at Club Habilitation Services, which is patterned after Fountain House, a model program giving optimum treatment. Rosenfield reported that the results showed both stigma and services received affected quality of life; stigma in a negative way and services in a positive manner. However, because it was cross-sectional data she was unable to determine causal direction. It could be that increased life satisfaction decreases the perception of stigma or that lower perceptions of stigma increase quality of life measures.

Another longitudinal study tested the affects of stigma on psychological well-being and life satisfaction in two groups of consumers; those in self-help groups and in outpatient clinics (Markowitz, 1998). Some believe that it is the behavior of those with a mental illness that causes the rejection and stigma from others. Markowitz wanted to test this by measuring the relationship between
stigma and psychotic symptoms as well as depression and anxiety. He believed that if the critics were correct, then the experience of stigma should be stronger in those with psychotic symptoms. Life satisfaction was operationalized through self-esteem and self-efficacy measures. Markowitz hypothesized that the expectation of rejection and experience of rejection (stigma measures) will affect symptoms of mental illness, self-esteem, self-efficacy, and life satisfaction unfavorably. A total of 610 individuals were surveyed.

In the results, Markowitz (1998) reported that the relationship between stigma and depressive symptoms was stronger than between stigma and psychotic symptoms. This does not support the view that the behavior of consumers causes the rejection of others. However, he questioned whether stigma may be the result of the mentally ill person's poor self-esteem and lack of opportunities instead of stigma causing it. According to Markowitz (1998), more research is needed to gain an "understanding of how stigma both affects and is affected by psychological and social variables" (p. 344).
Summary

Stigma has been defined as a concept with a number of components: labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). Experiencing stigma relates significantly to self-esteem since the view of others is important in defining oneself. The thoughts and feelings one has toward the observation of oneself and how one perceives others to view oneself is a simple definition of self-esteem. Stigma has been shown to correlate with a lowered self-esteem that endures over a long period of time in mental health consumers. The modified labeling theory (Link et al., 1989) shows how this correlation operates.
CHAPTER THREE

METHODS

Introduction

The purpose of this project was to measure correlations between stigma and self-esteem among individuals who are receiving treatment for a mental illness. As such, it was a quantitative study using instruments for stigma and self-esteem. The survey was administered twice to a group of individuals who take part in a transitional program. Statistical analysis was performed using SPSS computer software. The study expected to find a negative correlation between stigma and self-esteem. That is to say, the higher the measure of stigmatization, the lower the measure of self-esteem is likely to be.

Study Design

This research project was exploratory and quantitative in nature to investigate the correlation between stigma and self-esteem in mental health consumers through a cross-sectional survey. The study was built on a foundation of knowledge already established through previous research. As an exploratory design, it may
stimulate additional research with more complex designs (Grinnell, 2001).

This study was limited in that being exploratory it was only able to give a description of the participants at a particular point in time (Grinnell, 2001). Therefore, this project was unable to determine causality; that is, if stigma affects self-esteem. Despite the limitation, it provided information to add to the knowledge base, furthering the understanding of this issue. The research questions were: Is there a correlation between stigma and self-esteem in mental health consumers? If so, what is the strength of that correlation?

Sampling

Data was obtained from 30 individuals who were receiving services from agencies that provide help in gaining skills for employment, socialization, and supported living programs. Two similar mental health agencies in Southern California were used; one which provided 18 respondents and the second which provided 12. These individuals have a mental illness as classified in the DSM-IV and were sufficiently stabilized to understand the consent and complete the questionnaire accurately. Many of the individuals had a dual-diagnosis; a mental
illness and a substance abuse problem. Since past research on the consequences of stigma included both types of persons, this did not affect the results.

This was a convenience and purposive sampling design. As stated, the questionnaire was administered at two locations where the respondents were receiving treatment. Many prior studies on stigma and self-esteem were conducted in similar settings; therefore, this sample and setting provides the opportunity to come closer to replicating prior research.

Data Collection and Instruments

In order to operationalize stigma and self-esteem, two instruments were administered. To measure stigma, the Consumer Experiences of Stigma Questionnaire (CESQ) was used, which was developed by Wahl with input from members of the National Association of the Mentally Ill (Dickerson et al., 2002; Wahl, 1999). The scale was comprised of questions that asked about interpersonal experiences with stigma and discrimination (see Appendix A for entire questionnaire). A 5-point Likert scale was used in scoring going from never (1) to very often (5). The Consumer Experiences of Stigma Questionnaire was modified by excluding two questions that had to do with being denied
psychiatric services because of inadequate insurance. Due to the severe nature of their illness, the participants in this study are on Medicare disability and their health care needs are covered. Another set of questions that were removed asked if the consumer had ever been excluded from volunteer work, denied a passport, driver’s license, or educational opportunities. These questions were removed because the participants are in a setting where they are trying to gain employment and as such, it is unlikely that they can either afford an automobile or travel outside the country. In the same way, they are not involved in volunteer activities or formal education. Another motivation for shortening this questionnaire was to make it more manageable for the participants; with the modifications there were a total of only 15 items for this section. While the Consumer Experiences of Stigma Questionnaire has not been standardized yet, it has been used in research (Dickerson et al., 2002).

The self-esteem scale, a standardized instrument developed by Rosenberg, is a 10-item questionnaire that measures global self-esteem (Rosenberg, 1979). The questions focus on feelings, thoughts, and attitudes of a person toward himself or herself (see Appendix A for entire scale). Both positive and negative self-esteem is
assessed, for example, “I feel that I have a number of good qualities” measures positive self-esteem. On the other hand, “At times I think I am no good at all” quantifies negative self-esteem (Rosenberg, 1979, p. 291).

Respondents were asked to indicate their answers to the questions on a four-point Likert scale from strongly agree (1) to strongly disagree (4). Three measurements were obtained from this scale: global self-esteem, self-worth (positive), and self-deprecation (negative). All three measures were correlated to stigma.

The dependent variables were stigma and self-esteem; the independent variables were age, gender, diagnosis, number of hospitalizations, and length of time since last hospitalization. The stigma and self-esteem scale, age, number of times hospitalized, and time since last hospitalization are continuous levels of statistical measurement, while gender and diagnosis are categorical.

Procedures

After receiving approval from the Institutional Review Board of California State University, San Bernardino, permission was obtained from the county research board, the program manager and chief executive officer of the agencies where the surveys were
administered. On the days that the surveys were given, employees at the agencies made an announcement and asked for volunteers. A room was provided at each agency to provide privacy and small groups of two to four individuals completed the written survey at a time.

Before the instrument was given, an informed consent from each consumer was acquired (see Appendix B). Each location required that the consent be handled in a different manner. At one agency the respondents marked the consent with an "X" and the forms were kept by the investigator (Consent Form A). The second agency required the respondents to sign the consent form with their name and place it immediately in an envelope (Consent Form B). The envelopes were given to the county research board where they will be kept unopened.

After consent was given, the questionnaire was handed to the participant in a manila envelope. When it was completed, the consumer sealed the envelope and turned it in to the investigator. At that time the participant received the debriefing statement and monetary token (see Appendix C for debriefing statement).

In the event that a participant decompensated during or after completing the survey, emergency help was brokered by Karen Mahan a third year Master in Social Work
student. She served as an assistant during data collection so that if an emergency arose, she could call one of the telephone numbers listed on the consent to ensure that the participant received the help they needed. Fortunately, no such emergency presented itself.

Protection of Human Subjects

Anonymity was ensured by two different methods, according to the way the consent was handled. In one group informed consent forms were not signed but affirmed by a mark. In this manner, it was not known who participated in the study. In the second group, where they were required to sign the consent, it was placed immediately in a blank envelope and sealed so that the names of the participants were not known. Additionally, there was no identifying information on the questionnaire or numbers on the manila envelope. Assigning numbers to each case for data entry took place at a later time.

When the participant finished their survey, they were asked to place it in the unmarked manila envelope and seal it. In this way, the investigator had no knowledge of who completed which questionnaire and anonymity and confidentiality was maintained.
As stated, this research project was approved by the Institutional Review Board of California State University, San Bernardino (see Appendix D). As a requirement of the Institutional Review Board, the surveys will be kept for three years and then destroyed.

Data Analysis

All the data was entered into the SPSS program to determine correlations between stigma and self-esteem. To begin with, a Cronbach alpha was used to assess the reliability of the survey instruments. Then the following descriptive statistics were performed on each question with a continuous variable measurement: mean, standard deviation, range of scores, skewness and kurtosis, normality, and outliers. The purpose of these statistical tests was to see if there was a normal distribution in the variables.

A bivariate analysis was run to determine the correlation between stigma and self-esteem and its strength. Pearson’s product-moment correlation gave the direction and strength of a relationship between variables as well as the significance level.
Summary

This quantitative research project used a single group design to measure stigma and self-esteem among mental health consumers. A cross-sectional survey was administered to 30 individuals at two agencies with socialization and employment programs. Survey instruments were used to measure stigma and self-esteem, the dependent variables. The independent variables were age, gender, diagnosis, number of hospitalizations, and the amount of time since the last hospitalization. Procedures were set in place to protect anonymity and confidentiality of the participants. Data analysis was done through the SPSS program to determine the correlation between stigma and self-esteem.
CHAPTER FOUR

RESULTS

Introduction

Included in this chapter will be a presentation of the demographic characteristics of the respondents to the survey. It will also include a summary of the results by giving the frequencies of each of the items on the questionnaires; correlations between various questions; and finally the correlation between the total stigma and self-esteem scores.

Presentation of the Findings

The survey was administered on two different occasions. In November 2003, 18 participants completed the questionnaire at the first location and in February 2004 the remaining 12 consumers answered the survey at the second location for a total of 30 participants.

The participants ranged in age from 21 to 60 years of age, with the average being 38. Approximately 40% were males (n = 12) and 60% were females (n = 16).

Clinically the consumers presented a range of diagnoses; most stated they suffered from Major Depressive Disorder (30%, followed by Schizophrenia (24%). Bipolar Disorder (20%) and Schizoaffective Disorder (20%) were
also common. Half of the respondents stated that they were dealing with a substance abuse diagnosis as well as a mental illness (dual diagnosis).

Of the participants in the survey, only 20% have never been hospitalized. Of the remaining, there was a wide range in the number of times they have been an in-patient, from one to seventeen, with the average at four. Over half have been in the hospital within the last year, while 20% stated that it has been three years or longer since they have been hospitalized.

The modified Consumers Experiences with Stigma Questionnaire had good internal consistency in this project, with a Cronbach alpha coefficient of .81.

The responses to the items measuring stigma are listed in Table 1, with some modification in the wording of the question to accommodate space. The majority of respondents (60%) sometimes or often avoided telling others that they were receiving psychiatric treatment. Likewise, 63% admitted that others treated them as less capable when it was learned that they received psychiatric care. Yet up to 83% felt that their friends were understanding and supportive at least some of the time.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response choices</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you avoided telling others that you receive psychiatric treatment?</td>
<td>Never</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>46.7</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>0</td>
</tr>
<tr>
<td>Have others treated you less capable because you receive psychiatric</td>
<td>Never</td>
<td>16.7</td>
</tr>
<tr>
<td>treatment?</td>
<td>Seldom</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>46.7</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>6.7</td>
</tr>
<tr>
<td>Were friends understanding after learning that you receive psychiatric</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>treatment?</td>
<td>Seldom</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>20.0</td>
</tr>
<tr>
<td>Have you been shunned or avoided by others because you receive psychiatric treatment?</td>
<td>Never</td>
<td>43.3</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>0</td>
</tr>
<tr>
<td>Have you heard others say offensive things about persons and psychiatric treatment?</td>
<td>Never</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>6.7</td>
</tr>
<tr>
<td>Have you been given advice to lower your expectations for accomplishments in life because you are a consumer?</td>
<td>Never</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>6.7</td>
</tr>
<tr>
<td>Have you been treated fairly by others who knew you received psychiatric treatment?</td>
<td>Never</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>13.3</td>
</tr>
<tr>
<td>Have you seen things in the mass media about people receiving psychiatric treatment that you found offensive?</td>
<td>Never</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>3.3</td>
</tr>
<tr>
<td>Question</td>
<td>Response choices</td>
<td>Response (%)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Have you worried others will view you unfavorably because you receive psychiatric treatment?</td>
<td>Never</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>10.0</td>
</tr>
<tr>
<td>Have you been turned down for a job when it was learned you received psychiatric treatment? (n = 29)</td>
<td>Never</td>
<td>56.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>0</td>
</tr>
<tr>
<td>Have you had difficulty in finding housing because your psychiatric disorder was known? (n = 29)</td>
<td>Never</td>
<td>56.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>0</td>
</tr>
<tr>
<td>Have co-workers or supervisors been supportive? (n = 29)</td>
<td>Never</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>20.0</td>
</tr>
<tr>
<td>Was the fact that you received psychiatric treatment used against you in legal proceedings?</td>
<td>Never</td>
<td>70.0</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>3.3</td>
</tr>
<tr>
<td>Have law enforcement officers treated you with kindness and sympathy? (n = 29)</td>
<td>Never</td>
<td>46.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>23.3</td>
</tr>
<tr>
<td>Have you avoided indicating that you received psychiatric treatment on written applications? (n = 29)</td>
<td>Never</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Often</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>20.0</td>
</tr>
</tbody>
</table>

A substantial number (57%) have experienced being shunned or avoided by others when it was learned that they were receiving psychiatric treatment. Not surprisingly, 77% of the respondents have been in situations where they
heard others say offensive things and 33% said that they heard these things often to very often.

When asked if they have seen or read things in the mass media about psychiatric disorders that were hurtful, 73% gave positive responses but 53% said it was only seldom or sometimes. The majority of the participants (73%) stated that they worried that others would view them unfavorably sometimes to very often. Likewise, 60% avoided indicating on written applications that they receive psychiatric care from sometimes to very often.

The Rosenberg Self-esteem Scale also showed good internal consistency in this project, with a Cronbach alpha coefficient of .93.

Frequencies of responses to each question on the scale are reported in Table 2. Five of the survey questions measured positive self-esteem (item 1, 3, 4, 7, and 10). Over half of the respondents (60%) agreed with the statement that they are satisfied with themselves and 70% stated that they have a number of good qualities. A large majority (77%) believed that they are able to do things as well as most people. In a similar manner, 70% of the participants feel that they are people of worth and take a positive attitude toward themselves.
The other five questions measured negative self-esteem or self-deprecation (items 2, 5, 6, 8, and 9). Half of the respondents agreed that at times they think they are no good at all, while 43% believed that they do not have much to be proud of and feel useless at times.

Table 2. Responses to Survey Self-esteem Items

<table>
<thead>
<tr>
<th>Question</th>
<th>Response choices</th>
<th>Responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>On the whole, I am satisfied with myself.</td>
<td>Strongly agree</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>16.7</td>
</tr>
<tr>
<td>At times I think I am no good at all.</td>
<td>Strongly agree</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>16.7</td>
</tr>
<tr>
<td>I feel that I have a number of good qualities.</td>
<td>Strongly agree</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>3.3</td>
</tr>
<tr>
<td>I am able to do things as well as most other people.</td>
<td>Strongly agree</td>
<td>40.0</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>0</td>
</tr>
<tr>
<td>I feel I do not have much to be proud of.</td>
<td>Strongly agree</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>23.3</td>
</tr>
<tr>
<td>I certainly feel useless at times.</td>
<td>Strongly agree</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>40.0</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>16.7</td>
</tr>
<tr>
<td>I feel that I'm a person of worth, at least on an equal plane with others.</td>
<td>Strongly agree</td>
<td>46.7</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>3.3</td>
</tr>
<tr>
<td>I wish I could have more respect for myself.</td>
<td>Strongly agree</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>13.3</td>
</tr>
</tbody>
</table>
The majority (60%) answered that they wished they could have more respect for themselves. A significant number (40%) were inclined to believe that they were a failure.

Additional descriptive statistics were run on the total score for the stigma questionnaire and a total score for global self-esteem. The range of possible points for stigma was 15 to 70 points with a mean of 37.19 and standard deviation of 9.56. The range of possible points for global self-esteem was 10 to 40 points with a mean of 22.17 and standard deviation of 7.46.

A scatterplot was generated to check for violation of the assumptions of linearity and homoscedasticity. The results indicated a linear relationship with a fair degree of correlation in a negative direction.

The relationship between variables on the questionnaires was investigated using Pearson product-moment correlation coefficient. The more
significant results are presented in Table 3 with only those variables shown that indicated a moderate to high degree of correlation due to space limitations.

Finally, the relationship between stigma experiences, global self-esteem, and positive and negative self-esteem was investigated. The Pearson product-moment correlation coefficient indicated a strong negative relationship between stigma and global self-esteem ($r = -.550$, $n = 27$, $p = .003$). It also indicated a strong negative relationship between stigma and negative self-esteem ($r = -.565$, $n = 27$, $p = .002$). There was a moderate negative correlation between stigma and positive self-esteem ($r = -.475$, $n = 27$, $p = .012$).

Table 3. Correlations: Stigma and Self-esteem Items

<table>
<thead>
<tr>
<th></th>
<th>Self-Esteem Item 1</th>
<th>Self-Esteem Item 2</th>
<th>Self-Esteem Item 3</th>
<th>Self-Esteem Item 6</th>
<th>Self-Esteem Item 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stigma Item 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$r$</td>
<td>-.493**</td>
<td>-.667**</td>
<td>.381**</td>
<td>-.509**</td>
<td>-.365*</td>
</tr>
<tr>
<td>$p$</td>
<td>.006</td>
<td>.000</td>
<td>.038</td>
<td>.004</td>
<td>.047</td>
</tr>
<tr>
<td><strong>Stigma Item 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$r$</td>
<td>-.377*</td>
<td>-.475**</td>
<td>-.406*</td>
<td>-.466**</td>
<td>-.459*</td>
</tr>
<tr>
<td>$p$</td>
<td>.040</td>
<td>.008</td>
<td>.026</td>
<td>.009</td>
<td>.011</td>
</tr>
<tr>
<td><strong>Stigma Item 5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$r$</td>
<td>-.468**</td>
<td>-.535**</td>
<td>-.381*</td>
<td>-.399*</td>
<td>-.365*</td>
</tr>
<tr>
<td>$p$</td>
<td>.009</td>
<td>.002</td>
<td>.038</td>
<td>.029</td>
<td>.047</td>
</tr>
<tr>
<td><strong>Stigma Item 10</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$r$</td>
<td>-.380*</td>
<td>-.540**</td>
<td>-.473**</td>
<td>-.536**</td>
<td>-.268</td>
</tr>
<tr>
<td>$p$</td>
<td>.042</td>
<td>.002</td>
<td>.010</td>
<td>.003</td>
<td>.159</td>
</tr>
</tbody>
</table>
Summary

Chapter Four reviewed the results of the statistical data drawn from the project questionnaires. Demographic information indicated good variability in the respondents, in the area of age, gender, and diagnosis. Analysis of frequencies and descriptive statistics were presented, as well as correlations between items on the surveys, and the correlations between the total stigma and self-esteem scores.
CHAPTER FIVE

DISCUSSION

Introduction

This chapter presents the conclusions drawn as a result of examining the responses of consumers to the questionnaire and reflecting on their meaning. Observations on reported stigma and self-esteem measures are noted and the correlations between the two are considered. Limitations that apply to this project are addressed and, finally, recommendations derived from this research are presented.

Discussion

The results of the survey are encouraging in many ways. A substantial majority (67%) indicated that they have seldom or never been given advice to lower their expectations on life due to the fact they were receiving psychiatric treatment. This differs from the results obtained by Wahl (1999), in which only 41% answered the same way to the same question. The reason for this difference may be a result of program outcomes. The respondents are a part of a program that is working toward improvement in socialization and employment, which may be expressing hope rather than limitations to the consumer.
Another positive response was that consumers felt encouraged and understood by their friends. This response may also be reflective of the population sample. It could be that many respondents have made friendships in the program with other consumers, who may tend to be more encouraging and understanding than the general population.

A notable difference from Wahl's (1999) results was to the question about being shunned. In his sample, 38% indicated that they had never or seldom experienced being shunned or avoided while 63% made the same indication in this sample.

While it is promising to see that 63% of the respondents do not experience much avoidance from others, it still means that 37% have experienced shunning from sometimes to often, which is an alarming level. Not only is the experience on a directly personal level, but a substantial majority stated that they have heard others say offensive things about people receiving psychiatric treatment in general. Even if others are not directing their hurtful remarks to the individual, it is still demeaning and communicates a less than acceptable status to that person. This indicates that a meaningful number of individuals from this sample sense that others identify
them with the label of their illness and as such treat them or talk about them as being inferior.

It is not surprising then, that the majority of the consumers surveyed were also worried that others would view them unfavorably or less capable. It seems the protective response was to avoid letting others know that they receive psychiatric care both in everyday communication and on written applications.

The results measuring positive self-esteem indicated that this group of consumers by-and-large believed they were capable people with a number of good qualities. Most consumers in this survey were positive in their outlook and felt worthwhile as a person. This would reflect that 60% to 70% of the sample believed in their innate worth as a person and, in general, were confident of their capabilities.

However, there were a number of disturbing points that were brought out in the questions measuring negative self-esteem. Half of the respondents have times where they believe they are no good at all and 60% wish they could have more respect for themselves. These are highly self-derogatory statements, which mean that many of the respondents have times where they feel a sense of shame and see themselves as deficient.
While not a majority, two out of every five expressed that they did not have much to be proud of, felt useless, and were inclined to believe that they were failures. These are comparative statements in which the respondent is measuring himself or herself to someone else or a certain standard. When a person thinks they are a failure, they have in mind a picture of what a successful person is like. Therefore a significant number of these respondents feel as though they do not measure up to others in some way. As a result they devalue their own accomplishments and usefulness.

While it seems incongruous, individuals can be confident of their abilities yet simultaneously be critical of themselves (Owens, 1994). This would seem to be the case for a considerable number of the respondents. Negative self-esteem seems to abandon the good and worthwhile features of the self and replace it with self-criticism that discredits the worth and capabilities of a person (Wright, Gronfein, & Owens, 2000).

Rosenberg’s (1979) principle of reflected appraisals seems to explain the correlations found in the self-denigrating statement of being “no good at all” on the questionnaire. There were strong negative correlations between that statement and being treated as less capable
and hearing people say offensive things. Therefore, the respondents seem to be saying, the more people treat me as incapable and say offensive things about others like myself, the less I will tend to think of myself. It supports Rosenberg’s view that how a person believes they are viewed by others affects their self-esteem.

The results of a strong negative correlation between stigma and global self-esteem were consistent with previous studies. An even stronger connection between stigma and self-denigration was reported. This would suggest that when a consumer experiences rejection from others due to their mental illness, it may lower their global self-esteem and specifically target an increase in self-devaluation. This could mean that the way that consumers are treated and the way they look at themselves are interrelated. It may also indicate that when faced with stigma, a person’s belief in their capabilities is unable to override their self-criticism and doubt.

The findings of this study provide further support for the modified labeling theory by showing a relationship between stigma and negative outcomes. Additionally, the idea that secrecy is a way to cope with the label is supported through the high frequency of responses that indicated they avoided telling others of their condition.
Limitations

A number of limitations in this project need to be acknowledged. The size of the sample was small with only 30 consumers participating. Some would argue that statistical significance is hindered by the low number. Another problem in the sample was the fact that these consumers were in a treatment program that was providing social skills and employment development training, both of which would tend to increase a person's self-esteem. While there was a variance in the types of diagnoses represented, all of the individuals in the sample were high functioning, which also may have skewed the results. Because of these limitations, it cannot be said that the answers given represented the typical mental health consumer.

In the Modified Consumer Experiences Questionnaire, an answer of “not applicable” was not given as an option to choose from when answering the survey, which affected the outcome of a number of questions. As an example, for the question asking if law enforcement officers have treated them with kindness, 47% chose never and no one chose seldom. It is more than likely these individuals have never had an experience with law enforcement. The same situation probably applies to the question asking if
receiving psychiatric treatment was used against them in legal proceedings, in which 70% answered never. A good many of those individuals have probably not been involved in legal matters.

A final limitation is that there was no comparison between these consumers and individuals in the general population. This project did not measure the self-esteem of those who do not receive psychiatric treatment so it could be that it was commensurate with consumers.

Recommendations for Social Work Practice, Policy and Research

Social workers comprise the largest proportion of practitioners in the mental health community, which makes it vital that they be involved in changing the way society views and treats consumers. Both policymakers and advocates should not only become more aware of this problem, but develop strategies to counter stigma in the community. Public education from mass media to programs beginning in grade school could make people aware of their own attitudes, educate them on the truth of mental illness, and challenge them to change.

On a program development and direct practice level, social workers need to find ways to specifically reduce self-deprecation in mental health consumers. This study
and others suggest that hearing others say offensive things plays a part in self-criticism for the consumer. It is important to find ways to counter this negative influence and help people develop ways to cope. Therapists could also be advised to help their clients focus on who they are as a whole person so that their mental illness does not become their centralized identity.

In addition, caseworkers need to be aware of the impact of stigma in their placement of consumers in group homes or other community facilities. If these individuals are discharged into surroundings that are antagonistic or even unsympathetic, it could influence their self-concept and their adjustment into the community.

Although there is a growing body of knowledge in the area of stigma and its effects on individuals with a mental illness, additional research needs to continue. Participants in many of the studies have been affiliated with a treatment program or with the National Alliance of the Mentally Ill. This leaves out consumers who are not yet stabilized, who may be homeless, or simply living in isolation with family members. Future research should seek to broaden the population tested by taping in to these areas.
Mental health research also needs to further address the specific issue of stigma and its affect on self-deprecation or the negative aspect of self-esteem. The development and standardization of instruments to measure this mechanism would give a clearer picture of how to counter the effect in therapeutic intervention.

Conclusions

This project supports many previous studies that state that stigma has an affect on the well-being of consumers, especially in the area of self-concept. While a causal relationship cannot be identified in this study alone, it adds to the growing body of knowledge that stigma is a powerful experience and that it adversely affects those who come in contact with it.
APPENDIX A

QUESTIONNAIRE
MCESQ*

Please circle the number that best fits your experience to the following questions:

**HOW OFTEN:**

1. Have you avoided telling others outside of your immediate family that you have received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

2. Have others treated you as less capable when they learned you had received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

3. Were friends understanding and supportive after learning that you receive psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

4. Have you been shunned or avoided by others when they learned you received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

5. Have you been in situations where you heard others say unfavorable or offensive things about persons and their psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

6. Have you been given advice to lower your expectations for accomplishments in life because you receive psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

7. Have you been treated fairly by others who knew you received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

8. Have you seen or read things in the mass media about persons receiving psychiatric treatment and their psychiatric disorders that you found hurtful or offensive?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

9. Have you worried that others will view you unfavorably because you receive psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often
10. Have you been turned down for a job, for which you were qualified, when it was learned you received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

11. Have you had difficulty renting an apartment or finding other housing when your psychiatric disorder was known?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

12. Have co-workers or supervisors at work been supportive and accommodating when they learned that you have received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

13. Have you had the fact that you received psychiatric treatment used against you in legal proceedings?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

14. Have law enforcement officers treated you with kindness and sympathy when they learned you had received psychiatric treatment?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often

15. Have you avoided indicating on written applications that you received psychiatric treatment for fear that information would be used against you?
   1 = never  2 = seldom  3 = sometimes  4 = often  5 = very often


RSE*

Please circle the number that best fits your response to the following statements:

1. On the whole, I am satisfied with myself.
   1 = strongly agree  2 = agree  3 = disagree  4 = strongly disagree

2. At times I think I am no good at all.
   1 = strongly agree  2 = agree  3 = disagree  4 = strongly disagree

3. I feel that I have a number of good qualities.
   1 = strongly agree  2 = agree  3 = disagree  4 = strongly disagree
4. I am able to do things as well as most other people.
   1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree

5. I feel I do not have much to be proud of.
   1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree

6. I certainly feel useless at times.
   1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree

7. I feel that I’m a person of worth, at least on an equal plane with others.
   1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree

8. I wish I could have more respect for myself.
   1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree

9. All in all, I am inclined to feel that I am a failure.
   1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree

10. I take a positive attitude toward myself.
    1 = strongly agree   2 = agree   3 = disagree   4 = strongly disagree


Please answer the following questions:

Age: _______   Gender: (circle) Male   Female

Psychiatric diagnosis, if known: _________________________________________________

__________________________________________________________

Dual diagnosis? Yes _____ No _____

Total number of psychiatric hospitalizations you have had: _______

How long has it been since your LAST psychiatric hospitalization?

____ 0-6 months ago   ____ 6-12 months ago   ____ 1-3 years ago   ____ 3 years and over

Thank you for completing this survey.
Please place it in the manila envelope and return to Marilyn Pitts.
APPENDIX B

INFORMED CONSENT
Informed Consent  
(Form A)

You are invited to participate in a research project being conducted by Marilyn Pitts, Master of Social Work student at California State University, San Bernardino (CSUSB). If you would like to be a part of it, you will be given a survey that will ask you some questions about your experiences with people who are not consumers and how you feel about yourself.

If you think you would like to participate, let me explain the procedure. First of all, you will need to give your consent, which can be done by marking this form. After you have given your consent, I will give you a survey and a manila envelope. As you are completing the survey, if there is something you don’t understand, please ask me so I can make it clearer. When you finish, place the survey in the envelope, and seal it. In this way, no one will know which survey is yours and your answers will be anonymous. It is unlikely that this survey will take longer than 30 minutes and probably much less.

In participating in this study there is a risk that thinking about your experiences may be upsetting to you. If this happens, I will let you know people who can speak with you. There is no other foreseeable short term or long term risk to you in taking this survey and the research project has been approved by the Institutional Review Board of CSUSB. In addition to risks, there are benefits in being a part of academic research. As consumers you are in the unique position to let your experiences be known and heard by others.

Your participation is completely voluntary, you are free to not answer any question, and you can stop at any time. Also, as a token of appreciation you will be given $10 in cash even if you don’t finish the survey. Whether you decide to participate or not will have no effect on the services you receive from Jefferson Transitional Programs. The agency will not know who participated. If you have any questions or concerns about this research project, please contact my faculty supervisor, Tom Davis, Ph.D. at (909) 880-5000, extension 3839.

If you agree to be in this study, I will ask you to make a mark (X) in place of your signature on this consent form. It is not necessary to know your name in order to participate. To protect your privacy, this survey needs to be anonymous. You will be given a copy of this information to keep for your records.

I am over 18 years of age. I agree to participate in this study.  
Make mark (X) here (DO NOT sign with your name)

Mark (X) ___________________________ Date ___________________________
Informed Consent  
(Form B)

You are invited to participate in a research project being conducted by Marilyn Pitts, Master of Social Work student at California State University, San Bernardino (CSUSB). If you would like to be a part of it, you will be given a survey that will ask you some questions about your experiences with people who are not consumers and how you feel about yourself.

If you think you would like to participate, let me explain the procedure. First of all, you will need to give your consent, which can be done by signing this form and placing it in the attached envelope. After you have given your consent, I will give you a survey and another envelope. As you are completing the survey, if there is something you don’t understand, please ask me so I can make it clearer. When you finish, place the survey in the envelope and seal it. In this way, no one will know which survey is yours and your answers will be anonymous. It is unlikely that this survey will take longer than 30 minutes and probably much less.

In participating in this study there is a risk that thinking about your experiences may be upsetting to you. If this happens, I will let you know people who can speak with you. There is no other foreseeable short term or long term risk to you in taking this survey and the research project has been approved by the Institutional Review Board of CSUSB. In addition to risks, there are benefits in being a part of academic research. As consumers you are in the unique position to let your experiences be known and heard by others.

Your participation is completely voluntary, you are free to not answer any question, and you can stop at any time. Also, as a token of appreciation you will be given $10 in cash even if you don’t finish the survey. Whether you decide to participate or not will have no effect on services you receive. If you have any questions or concerns about this research project, please contact my faculty supervisor, Tom Davis, Ph.D. at (909) 880-5000, extension 3839.

If you agree to be in this study, please sign this consent form below. You will be given a copy of this information to keep for your records.

I am over 18 years of age. I agree to participate in this study.

______________________________  ______________________
Signature                                Date
APPENDIX C
DEBRIEFING STATEMENT
Debriefing Statement

Thank you for participating in this study that is concerned with how people who are not consumers behave toward consumers and how that makes consumers feel. Your participation is contributing to the academic knowledge base of this issue, which in time will affect future intervention and policy.

Please do not discuss the contents of the survey until the survey is completed. Otherwise, it may alter their perception and they may be influenced by your point of view.

You were advised that there was a risk in being a part of this survey. If thinking about your experience was emotionally upsetting to you and you would like to talk about it, please get in touch with your personal therapist/counselor. If you do not have a personal therapist, you may contact Riverside County Mental Health Crisis Outpatient at (909) 358-4705 for immediate treatment or Riverside County Mental Health Treatment Services (ETS) at (909) 358-4881.

If you have any questions or concerns about the study, please contact Tom Davis, Ph.D., MSW at (909) 880-5000, extension 3839. A copy of the group results of this study will be sent to your agency when complete, probably by the end of summer 2004.
APPENDIX D

INSTITUTIONAL REVIEW BOARD
February 20, 2004

Ms. Marilyn Pitts
c/o: Prof. Tom Davis
Department of Social Work
California State University
5500 University Parkway
San Bernardino, California 92407

Dear Ms. Pitts:

Your protocol change in your application to use human subjects, titled, "Correlations Between Stigma and Self-Esteem in Mental Health Consumers" has been reviewed and approved by the Chair of the Institutional Review Board (IRB). A change in your informed consent requires resubmission of your protocol as amended.

You are required to notify the IRB if any future substantive changes are made in your research prospectus/protocol, if any unanticipated adverse events are experienced by subjects during your research, and when your project has ended. If your project lasts longer than one year, you (the investigator/researcher) are required to notify the IRB by email or correspondence of Notice of Project Ending or Request for Continuation at the end of each year. Failure to notify the IRB of the above may result in disciplinary action. You are required to keep copies of the informed consent forms and data for at least three years.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, IRB Secretary. Mr. Gillespie can be reached by phone at (909) 880-5027, by fax at (909) 880-7028, or by email at mgillesp@csusb.edu. Please include your application identification number (above) in all correspondence.

Best of luck with your research.

Sincerely,

Joseph Lovett, Chair
Institutional Review Board

JL/mg

cc: Prof. Tom Davis, Department of Social Work
REFERENCES


