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Resisting the Stigma of Mental Illness

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Abstract

The relationship between stigmatization and the self-regard of patients/consumers with mental disorder is negative but only moderate in strength, probably because a subset of persons with mental illness resists devaluation and discrimination by others. Resistance has seldom been discussed in the stigma and labeling literatures, and thus conditions under which individuals are resistant have not been identified. I define resistance as opposition to the imposition of mental illness stereotypes by others and distinguish between deflecting ("that's not me") and challenging resistance strategies. Individuals should be more likely to employ resistance strategies when they have: past experience with stigma resistance; past familiarity with an ill family member or friend; symptoms that are non-severe or controlled; treatment experience in settings run by consumers; initially high levels of psychosocial coping resources; and multiple role-identities. Incorporating resistance into classic and modified labeling theories of mental illness highlights the personal agency of labeled individuals, missing especially in classic labeling theory.

Keywords

stigma, mental illness, resistance, coping

People who have been labeled mentally ill have acquired a stigma—an attribute that is "deeply discrediting" (Goffman 1963:3), accompanied by stereotyping, rejection, status loss, discrimination, and low power (Link and Phelan 2001). Most theorists assume that stigmatization almost inevitably results in self-devaluation or low self-esteem, but unexpectedly, the evidence for this presumption is contradictory (Crocker and Major 1989; Crocker, Major, and Steele 1998; Major and O'Brien 2005). I will argue that an appreciable percentage of labeled individuals resist stigma and stereotyping rather than accept or adapt to it. Surprisingly little theoretical attention has been paid in the stigma and labeling literatures to the forms that stigma resistance can take or the conditions under which it is probable. My purpose is to delineate two types of resistance and identify contingencies that make resistance to stigma more likely, with mental illness as my case in point (although these concepts and contingencies also may apply more broadly to other types of stigma).

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THEORETICAL BACKGROUND: SYMBOLIC INTERACTIONISM AND LABELING

Symbolic interactionism in general and labeling theories in particular clearly suggest that *social* devaluation will produce *self*-devaluation. The key process linking society and the self in this approach is "taking the role of the other" (Cooley 1902; Mead 1934): we see ourselves as meaningful social objects (who we are) and appraise our goodness, worthiness, and competence (how good we are) through the eyes of significant others and from the standpoint of the wider community. Because the meanings of social objects and social acts are culturally shared (Blumer 1969; Mead 1934), an undesirable category or label applied by others to the self becomes an undesirable social identity. That identity in turn results in self-devaluation (Goffman 1963), or, in more contemporary terms, produces "self-stigmatization" (Corrigan and Watson 2002; Corrigan and Calabrese 2005) or "internalized stigma."

Grounded in symbolic interactionist thought, classic labeling theory arrives at the same prediction. Classic labeling theory holds that individuals who have been categorized by other people as deviant come to view themselves as deviant (Becker 1963; Kitsuse 1962; Scheff 1966; Schur 1971), especially when they are formally classified by powerful agents of social control. Accepting a deviant identity occurs because labeled individuals take the perspective of others and define themselves as others do (Goffman 1963), or, more complexly, because labeling sets off a self-fulfilling prophecy that results in identity adoption. According to Scheff (1966) once individuals have been classified as mentally ill, stereotypes about mental illness become activated in the imaginations of other people. These stereotypes are learned early in life and are reinforced over time in ordinary interaction and by caricatures in the media. Stereotyped expectations lead "normals" (Goffman 1963) to block labeled individuals from returning to conventional activities and to reward them for behaviors that conform to the mental patient role (Goffman 1961). Observing themselves acting in accordance with stereotyped expectations, and highly sensitive when in crisis to the cues provided by others, labeled persons conclude that they must be mentally ill and accept the mental patient role as an identity. Subsequent episodes of stress further impair labeled individuals' ability to control their behavior, repeatedly validating their own and others' views of their illness and incompetence. In short, labeling and differential treatment by other people produces a "mentally ill" identity and self-devaluation.

Link's modified labeling theory (Link 1987; Link et al. 1989) elaborates and extends this traditional approach. In this argument, labeled individuals themselves can inadvertently start a self-fulfilling process. Like Scheff, Link holds that societal members learn and are fully aware of the stigma of mental illness, know the stereotyped ways in which "crazy" people are thought to behave, and understand that most people are likely to devalue, reject, and discriminate against persons with mental illness on these grounds. When individuals enter mental health treatment, they become labeled as "mental patients." At that point, mental illness stigma and stereotypes become personally relevant and threatening; these attitudes and beliefs might easily be applied to themselves. Fearing devaluation and rejection, patients/consumers attempt to ward off such consequences by using one or more of three coping strategies: secrecy

about their patient history ("passing" as normal [Goffman 1963]), withdrawal from interactions with all but close family or friends, and educating others about mental illness. Negative consequences follow. The label itself creates a sense of differentness and shame, diminishing self-esteem and making social encounters tense. Coping efforts, particularly withdrawal, can backfire, increasing social isolation, discouraging pursuit of employment, and increasing demoralization. These stressors in turn make labeled individuals more vulnerable to recurrences of disorder. In short, attempts to avoid devaluation and discrimination generate problematic social and economic circumstances that perpetuate the risk of disordered episodes, which in turn may further undermine self-worth.

Unlike traditional labeling theory, modified labeling theory does not assume that persons with mental illness accept their official categorizations as self-descriptive. As Goffman (1963) points out, stigmatized persons may not identify with a social label personally but still must deal with the interpersonal difficulties created by a discrediting public identity conferred by other people. Interpersonal encounters with normals are fraught with risk and anxiety; stigmatized persons almost inevitably discover limits to normals' acceptance, reminded that they are different, undesirable, and unworthy (Goffman 1963). Hence, damage to self-esteem should follow from the acquisition of a stigmatizing label, regardless of whether that label has been internalized or simply bestowed.

EVIDENCE FOR THE LINK BETWEEN STIGMA AND SELF-ESTEEM

Numerous studies have documented negative beliefs held by the American public about persons with mental illness. "The mentally ill" are believed to be unpredictable, irrational, dangerous, bizarre, incompetent, and unkempt, and these stereotypes have persisted and even strengthened from the 1950s to the present, along with a steady desire to keep social distance from such people, despite educational campaigns (Link et al. 1999; Martin, Pescosolido, and Tuch 2000; Pescosolido et al. 1999, 2010; Phelan et al. 2000; Rabkin 1980; Stout, Villegas, and Jennings 2004; Wahl 1995). In laboratory studies, desire for social distance is evident in awkward interactions and negative ratings of persons believed to have had mental health problems (Crocker et al. 1998; Link and Phelan 2010). High percentages of former and current patients in mental hospitals—from 50 to 95 percent—are aware of the stigma attached to psychiatric disorder and expect devaluation and discrimination on this basis (Link 1987; Link et al. 1989; Link et al. 1997; Rosenfield 1997; Wahl 1999b; Wright, Gronfein, and Owens 2000). Similar percentages report actual experiences of discrimination (Jenkins and Carpenter-Song 2005; Link et al. 1997; Wahl 1999b; Wright et al. 2000). Independent of patients' psychiatric symptoms, having a label and perceiving stigma are associated with several negative outcomes: smaller and less supportive social networks (Link et al. 1989; Perlick et al. 2001); less income and higher unemployment (Link 1982, 1987; Link, Mirotznik, and Cullen 1991); greater demoralization and depressive symptoms (Link 1987; Link et al. 1991, 1997); and lower subjective quality of life and overall satisfaction (Rosenfield 1997; Markowitz 1998). In short, an abundance of evidence shows that a stigmatized label and expectations and/or experiences of social rejection significantly diminish the life quality and life chances of consumers, countering earlier assertions that stigma has only

minor or short-lived negative consequences for patients' lives compared to the influence of their symptoms (e.g., Gove 1980, 1982). Importantly, studies consistently show that low self-esteem and self-efficacy are the central mechanisms through which devaluation and discrimination are tied to negative outcomes (Kleim et al. 2008; Markowitz 1998; Rosenfield 1997; Wright et al. 2000; Yanos et al. 2002).

Given the predictions of labeling theories and the well-documented negative consequences of stigma, one would expect sharp differences in self-esteem between persons with and without serious disorders as well as strong correlations between perceived/experienced discrimination and low self-regard. But this is not what studies show (Corrigan and Watson 2002; Corrigan, Watson, and Barr 2006; Hayward and Bright 1997; Hayward et al. 2002; Kleim et al. 2008; Link et al. 2001, 2002; Link, Castille, and Stuber 2008; Markowitz 1998, 2001; Rosenfield 1997; Wright et al. 2000; Yanos et al. 2002). To be sure, virtually all studies report a significant negative association between perceived or experienced stigmatization and patients' self-esteem and/or generalized self-efficacy, even when prior levels of these factors and the severity of respondents' symptoms have been controlled. But the inverse relationships between stigma and self-regard are surprisingly modest in strength. For example, in a sample of Clubhouse[1] participants with serious disorders, perceived devaluation-discrimination was correlated −.25 with global self-esteem (Link et al. 2008). Among members of a self-help group for persons with manic-depression, perceptions of devaluation-discrimination and self-esteem were correlated −.34 (Hayward et al. 2002). Among patients in private and outpatient psychiatric treatment for schizophrenia, perceived stigmatization was correlated −.28 with general self-efficacy (Kleim et al. 2008; Vauth et al. 2007). These modest correlations indicate that some individuals who perceive high levels of societal rejection nevertheless have high self-worth while others who see little societal rejection have low self-regard anyway. Corrigan and Watson (2002) have called this "the paradox of self-stigma": although a majority of consumers of mental health services suffer self-derogation as a consequence of perceived or experienced discrimination, a subset instead reacts energetically and with righteous anger, while still others remain indifferent.

This paradox differs from another discussed in the broader stigma literature. Most studies show stigmatized individuals *do not differ* from non-stigmatized persons in self-esteem, while other investigations find stigmatized persons have significantly *higher* self-esteem than normals do, contrary to intuition and theoretical arguments (Crocker and Major 1993; Crocker et al. 1998; Major and O'Brien 2005). The vast bulk of this broader literature, however, examines persons with visible stigmas (e.g., skin color, physical and learning disabilities, developmental delays). In contrast, people with histories of mental disorder have an invisible stigma (except when their symptoms are florid, or an institutional setting gives their status away). Mental illness is also considered a "moral" stigma (Goffman 1963), indicating a blemish of character or failure of self-control (although with medicalization and geneticization, this

[1]A Clubhouse is a community mental health program focused on recovery, run by current and former consumers. It provides work and social opportunities to persons with severe or persistent mental illness, and is modeled on Fountain House in New York.

view of disorder may be softening). Moral stigmas are more discrediting than bodily or membership (e.g., ethnic, religious) stigmas (Corrigan 2000; Crocker et al. 1998; Goffman 1963; Jones et al. 1984; Weiner, Perry, and Magnusson 1988). In contrast to persons with observable marks that are not their responsibility, individuals known to be previously or currently hospitalized for disorder are at greater risk of devaluation and rejection and thereby at higher risk of self-derogation. The nature of mental illness stigma, then, may explain why there is a consistent, modest inverse relationship between perceived prejudice/discrimination and self-esteem in consumer studies, in contrast to findings in the broader stigma literature.[2]

EVIDENCE FOR RESISTANCE TO STIGMA

How common is resistance to mental illness stigmatization and stereotyping? Frequencies are difficult to find in the literature; most studies report mean scores on scales, which are parsimonious but less informative for my purposes. A handful of articles offer suggestive percentages: in interviews with National Alliance for the Mentally Ill consumers, Wahl (1999a) found that 21 percent took some corrective action in response to stigma experiences, including attempts to educate persons who made disparaging remarks about mental illness, filing appeals against discrimination, and persisting in efforts to gain work or insurance despite barriers. Eighteen percent of Wahl's sample said that directly challenging stigma raised their self-esteem or sense of empowerment. In other studies, when patients with major depression and schizophrenic disorders were asked what they would do in the face of others' discomfort, from 65 to 85 percent endorsed educating others about mental illness/psychiatric treatment (Link et al. 1989, 2002), and 81 percent of Clubhouse respondents with serious disorders agreed that it was better to confront stigmatizing behavior than to ignore it (Link et al. 2002). Thus, appreciable percentages of current or former consumers of services indicated actual resistance to or willingness to resist derogation and discrimination by other people. Despite the enormous percentage gaps in these studies between what people said they did and what people said they were prepared to do, Link and colleagues (2002) found that willingness to challenge stigma was significantly and positively associated with respondents' self-esteem ($r = .22$, $p < .05$), consistent with the effects of challenging mentioned by Wahl's respondents.

There are other, more subtle hints of resistance found in the mental illness literature. About 50 percent of hospitalized patients with severe disorders did not characterize themselves as mentally ill at an initial interview (Doherty 1975; Estroff et al. 1991; Warner et al. 1989; see also Weinstein 1983). Between 35 and 45 percent of Clubhouse respondents disagreed that they felt different or ashamed because of their illness or hospitalization (Link et al. 2002). About 40 percent of Clubhouse members distanced themselves from other people

[2]Crocker, Major, and their colleagues focus on self-esteem contrasts between stigmatized and non-stigmatized groups (women versus men, blacks versus whites, etc.), while mental illness studies usually scrutinize the association between social rejection and self-esteem *within* patient groups. Mental illness researchers seem to presume (rather than demonstrate) that patients/consumers have lower self-esteem than "normals."

with mental illness, endorsing the view that their problems were different from those of most mental patients (Link et al. 2002; Quadagno and Antonio 1975). About 25 percent of an outpatient Veterans Administration sample with serious mental illness showed high levels of stigma-resisting beliefs (e.g., "I can have a good, fulfilling life, despite my mental illness") (Ritsher and Phelan 2004). So there are indications that subsets of individuals resist internalizing stigma, which in turn helps preserve or even enhance self-esteem and a sense of personal control. The degree of internalized stigma is moderately to strongly correlated with low self-esteem and/or self-efficacy, with *r*'s ranging from .42 to .59 across studies (Corrigan et al. 2006; Link et al. 2002; Ritsher and Phelan 2004; Ritsher, Otilingam, and Grajales 2003; Yanos et al. 2008). Conversely, then, the relative *lack* of internalization is linked to *higher* self-evaluations.

In sum, there are definite hints in the empirical literature that some individuals reject others' damaging remarks and behaviors or refuse to see themselves in the ways that the public or acquaintances do. Despite wide variations in samples and measures across studies, there are also intimations that resistance can be self-protective, perhaps even self-enhancing. Thus, it seems sensible to consider types of stigma resistance and the conditions under which resistance might be employed by persons with histories of mental disorder.

TWO FORMS OF RESISTANCE: CHALLENGING AND DEFLECTING

What is resistance? In general, resistance refers to opposition to a harmful force or influence. There are two senses in which resistance or opposition are commonly used: challenging, confronting, or fighting a harmful force or influence, and deflecting, impeding, or refusing to yield to the penetration of a harmful force or influence.[3] These are intentional, agentic responses to possible harm; the first involves pushing back with a force of one's own while the second involves deliberately blocking an outside force so that it glances away or falls back—one guards or hardens the self rather than engaging in conflict.[4] To distinguish between the two, I refer to them as challenging and deflecting types of resistance (sometimes with other synonyms, for variability). I propose that both forms of resistance serve to protect the self against devaluation, but challenging opens possibilities for victory in changing others' negative views or actions, while deflecting does not. Even when efforts are unsuccessful, the courage and initiative required for confrontation may reinforce an individual's sense of personal control or empowerment. Thus, confrontational resistance may raise self-esteem, while blocking may simply maintain a person's self-esteem at its current level.

Some preconditions seem necessary for the use of resistance strategies (as well as other coping strategies). Because resistance is an agentic response to devaluation and stereotyping, individuals first must have acknowledged to themselves that they have had a mental health problem and/

[3]In psychology, the term "resilience" is often used to refer to the ability to withstand harm (e.g., Bonanno 2004). I view resilience—maintaining a stable equilibrium in functioning in the face of adversity—as an *outcome* of the use of resistance strategies.

[4]The term "resistance" is used in psychology and psychiatry to describe an unconscious defense mechanism, but in this article I focus on conscious blocking and confronting.

or that they have been in mental health treatment. In other words, they must acknowledge that the label of "mentally ill" or "mental patient" is potentially applicable to themselves, regardless of whether they accept this categorization as a personal identity or not. They must also understand that it is or could become a public identity if their mental health status were revealed or discovered—that is, others have or could define them as mentally ill or as mental patients (Link et al. 1989). Finally, individuals must have knowledge of the cultural meanings commonly attached to the mental illness/mental patient label, again regardless of whether they endorse those meanings or not. Meanings include the label's pejorative character, stereotyped behavioral expectations, and the possibility that discrimination will be directed at its carrier. Corrigan et al. (2006) call this "stereotype awareness." These three preconditions distinguish people who use resistance (and other coping strategies) from individuals who are in denial or unaware of their illness or of cultural stereotypes, often because of the illness itself (Corrigan and Watson 2002).[5] These preconditions make the possibility of experiencing devaluation and discrimination "personally relevant," in modified labeling theory terms (Link et al. 1989).

I propose that there are five groups of individuals who differ in the stances they take toward the applicability and threat of cultural stereotypes (setting aside persons who are in denial or are unaware of their labeled status or of cultural stereotypes). At one extreme, individuals who agree with broad cultural conceptions of mental illness and endorse those conceptions as self-descriptive are "self-stigmatized"—they have accepted and internalized the public's views (Corrigan et al. 2006). At the other extreme, persons who disagree strongly with public stereotypes of mental illness and reject those images not only as characterizations of themselves but of consumers in general are those who will "challenge" or confront stigmatization. The three groups that fall in between reject mental illness stereotypes as self-descriptive, even though they may (or may not) agree with broad cultural beliefs about persons with disorder. Individuals who resist with "deflection" believe that public stereotypes simply "do not characterize me—I'm not like that." In this group, the potential for harm due to stereotyping is recognized but dismissed outright as a viable threat to the self. Another set anticipates possible devaluation in interpersonal interaction and averts it with "avoidance": they pragmatically keep their treatment history secret, dodge or withdraw from interactions with people who might be prejudiced, or socialize primarily with others who share the same stigma. Finally, persons who have directly experienced the hurt of rejection and devaluation engage in "self-restoration," shifting their social comparisons to other persons with mental disorder or disinvesting themselves from endeavors at which they may fail, among other esteem-restoring strategies (see Crocker and Major 1989). The underlying battle imagery involves retreats from threat of attack (for those who avoid) or attempts to repair the damage caused by attack (for those who restore), in contrast to resistance strategies of fighting back (for those who challenge) and guarding the fort (for those who deflect).

[5]Persons who deny that they have a mental health problem are resisting the imposition of a negative *label* ("there's nothing wrong with me!"). My focus here is on persons who resist the *stigma* attached to a label that they understand could be successfully applied to them.

In sum, I am suggesting that patients/consumers cope differently with the threat of stigma through self-stigmatizing, deflecting, avoiding, self-restoring, and challenging. Individuals undoubtedly use a range of coping strategies, but their repertoire is likely to be typified by one of these orientations. In what follows, I focus on those who deflect and challenge, given that tactics of stigma resistance and the conditions under which resistance is probable have been generally neglected in the literature, as many commentators have noted (e.g., Howarth 2006; Prus 1975; Quadagno and Antonio 1975; Rogers and Buffalo 1974; Shih 2004).

Deflecting Strategies

Stigma deflection strategies are usually cognitive in nature. As discussed above, individuals who use these blocking strategies understand that they have a disorder and/or they have been in treatment, that other people have identified (or could identify them) in these terms, and that broad cultural stereotypes have been (or could be) applied to them. But they view those stereotypes as inapplicable to themselves—as "not me" (McCall 2003; Snow and Anderson 1987). There are at least three ways to decide "that's not me."

First, mental illness stereotypes are extremely negative in content and imagery: "crazy people" are bizarre, unpredictable, dangerous, incompetent, and out of touch with reality. These attributes capture the public's imagination of the most severe types of disorder, especially schizophrenia (Estroff et al. 1991). However, the symptoms of most psychiatric disorders, even the most severe, do not typically match these images (Gove 2004; Quadagno and Antonio 1975) or, if symptoms match in one respect (e.g., irrational thoughts), they usually do not in others. Perceiving the obvious misfit between one's own symptoms and public images makes it straightforward to conclude that "I'm not like that—that's not me," or "I'm different from most mental patients" (Estroff et al. 1991; see also Snow and Anderson 1987). In self-categorization theory terms (Turner et al. 1994), there is a lack of "normative fit" between one's own characteristics and the category of "mentally ill persons."

A related strategy of resistance is to maintain that one's history of mental disorder is "only one part of me—it doesn't define who I really am" (Howard 2006). In identity theory terms (Stryker 1980), a mental illness–related identity, because of its discrediting character, should rank low in the individual's salience hierarchy; it is unlikely to be invoked in one's self-presentation to strangers or to guide one's choice of activities in free time (Stryker and Serpe 1982; Wright et al. 2000). Because the identity yields few intrinsic or extrinsic rewards, entails greater costs, and garners little support from other people, its rank should be low in the prominence hierarchy of ideal selves (McCall and Simmons 1978). In this deflection strategy, one's mental illness is "not me" because it is "a small, unimportant part of me."

A third strategy is to define the nature of one's problem in terms that are less discrediting and stereotyped than mental illness: "I'm not mentally ill; I've simply had a nervous breakdown/am suffering nervous exhaustion/am anxious/am depressed." The person acknowledges that he or she has a mental health problem, but in contrast to mental illness, it is a temporary, less serious, more understandable, and socially more acceptable response to stressful life circumstances (Barke, Fribush, and Stearns 2000; Estroff

et al. 1991; Gove 2004; Quadagno and Antonio 1975; Rogers and Buffalo 1974). In essence, individuals assert that "my *problem* is not like that," instead of "*I* am not like that." Public stereotypes are therefore not applicable to the self because those stereotypes pertain to mental illness, not to nervous breakdown or emotional distress.

When individuals block the applicability of mental illness stigma and stereotypes to themselves in one or more of these ways, they dramatically reduce, if not eliminate, potential threats to their self-regard. Moreover, when they encounter explicit devaluation or discrimination in interpersonal interaction, they can attribute these acts to others' prejudice or ignorance (an external cause) and not to some defect in themselves (Crocker and Major 1989; Crocker et al. 1998; Prus 1975; Shih 2004). Deflection renders the person fairly impervious to stereotype threat. Although self-esteem is not likely to rise with the use of blocking strategies, it should not shift substantially from the level that existed prior to labeling.

Challenging Strategies

Challenging differs in both obvious and more subtle ways from deflecting. The manifest difference is that challenging involves attempting to change other people's views or behaviors instead of blocking their incursions on self-regard. To confront is to engage with the biased attitudes and actions of others rather than dismiss them. More subtly, challengers share deflectors' beliefs that mental illness stereotypes are "not me," but they add a further qualification by arguing that those stereotypes are "not me because they're wrong." Some (perhaps most) challengers may go a step further: Those stereotypes are wrong "not only about me but about most patients with mental illness." Those who make the latter generalization are likely to have or to develop identification with other patients/consumers as a collectivity (Corrigan and Watson 2002; Watson and River 2005), a topic to which I return below.

Given that the goal of challenging is to highlight and change prejudice and discrimination, challenging strategies tend to be behavioral rather than cognitive in nature. There are several ways to contest others' attitudes and acts, varying in their levels of directness and assertiveness. I should note that these strategies can have their desired effects only if the person's history of mental illness is known to others and he or she has shifted from being "discreditable" to being "discredited" (Goffman 1963). In contrast, deflection strategies can be used by individuals whose stigma is hidden *or* known.

Perhaps the most indirect form of contestation is to behave in ways that contradict normals' stereotyped expectations. Some theorists describe this strategy as compensation or overcompensation because it involves working hard to excel at skills or tasks thought to be difficult to impossible for persons with particular kinds of stigma to handle (Crocker et al. 1998; Goffman 1963; Major and Eccleston 2005; Shih 2004). Behavior that conforms to or even exceeds conventional standards prevents normals' expectations of failure or continued deviance from coming true (Sato 2001). Invalidating others' beliefs about persons with mental illness and winning their respect can be gratifying and can uplift self-regard and a sense of personal control. (A potential drawback, however, is that normals might see the successful individual as an exception to the rule, undermining the goal of this strategy.)

A more direct and assertive form of resistance is educating other people

about the nature of mental illness and psychiatric treatment (Link et al. 1989). The risks attached to this strategy probably depend on whom the person attempts to teach in his or her social network. Close family and friends are less likely to reject one on the basis of one's status or to take offense from efforts to counter their misapprehensions. Disclosing to and educating relationally distant others is more risky, exposing one to possible devaluation or defensively hostile reactions to one's efforts. Because educating others may be successful with intimates but backfire with non-intimates, it may produce an overall "no effect" on self-regard or other quality of life outcomes, a finding reported in some studies (Link et al. 1991, 2002). Separating out the targets of individuals' educative efforts would clarify whether and when this strategy has beneficial consequences for self-esteem.

"Confronting" is more direct and assertive than educating. In this strategy, rather than tactfully enlightening, one actively contests others' erroneous beliefs and unjust acts. Examples include disagreeing with a biased statement, objecting to a thoughtless remark, or reproving a tasteless joke about oneself or people with mental illness in general. One might challenge the legitimacy of a claim made about oneself or one's category, question the legitimacy or expertise of the claimant making judgments, point out others' biases or discriminatory acts, or lodge complaints and bring legal suit, among other actions (Corrigan and Calabrese 2005; Prus 1975; Rogers and Buffalo 1974; Wahl 1999a). Direct confrontation can antagonize others, creating or escalating interpersonal tensions, increasing the threat of reprisal, and possibly rupturing important social ties (Kaiser 2006). The perceived balance of benefits and costs may determine whether or not confrontation enhances self-esteem and a sense of control; the more positive the outcome of the challenge, the more positive for self-regard. On the other hand, pride in courageously standing up for oneself or one's group may enhance self-esteem, regardless of the outcome—one has done the right thing at real risk to oneself.

Up to this point, challenging strategies employed by individuals have been the focus. But challenging can also occur collectively, in the form of advocacy and activism by consumer groups aimed at changing societal beliefs and system-level discriminatory practices. Corrigan and Lundin (2001) discuss three strategies of collective action: contact, education, and protest. Contact is an educative strategy; consumers tell personal stories of struggle with mental illness, the hurtful impacts of stigma, and the process of recovery to relevant audiences (e.g., school classes, religious groups, agency administrators), with opportunities for questions and answers. Contact with persons living successfully with or recovering from disorder undermines stereotypes about mental illness (Couture and Penn 2003). Education refers to presentations and other communications (media campaigns, newsletters, advertisements) about types of mental illness, its prevalence, causes, and effective treatments as well as information that counters mental illness myths. Group protest directly confronts public statements made by opinion leaders, representations in the media, or social or industry policies that are prejudicial in content or discriminatory in practice.

Participation in collective resistance offers a number of advantages for persons with histories of mental illness, including legitimized anger at injustice; ingroup support and understanding; shared social and political goals;

opportunities to act on convictions; decreased individual risks; and exercise of agency. These advantages should promote members' self-esteem, self-efficacy, and optimism (a combination of orientations to the self, the world, and the future often termed "empowerment") (Corrigan and Calabrese 2005; Corrigan and Lundin 2001).

Conditions for the Use of Deflecting and Challenging Resistance Strategies

When rejection or discrimination occur in face-to-face interaction, it may be difficult to take or sustain a resistant stance. When the individual is altercast by other people as mentally ill or as a mental patient, he or she experiences pressure to respond in expected ways, lacks support for his or her preferred identity in the situation, and must struggle to negotiate shared, mutually acceptable definitions of self and other in the encounter—a struggle that the other party may win due to status or power imbalances (McCall and Simmons 1978; Link and Phelan 2001). With such pressures, deflecting beliefs that "that's not me" may be hard to maintain. Educating others about mental illness stigma and confronting negative attitudes and behaviors may be even more difficult, given risks of intensified scrutiny and sanctions, losing credibility and face, and alienating interaction partners, among other costs (Prus 1975; Kaiser 2006). Five factors, however, may increase the likelihood of using deflecting and challenging resistance strategies in stigmatizing interpersonal encounters, despite these pressures and risks.

Past experience with stigma resistance. Individuals may have already had experience with stigma prior to the emergence of their mental health problems. For example, they may possess a devalued racial, ethnic, religious, or sexual identity, have a physical impairment, or are an ex-addict or ex-con. Deflecting or challenging strategies that were developed previously to cope with an existing attribute can be generalized and applied to the stigma of mental disorder. In essence, one transfers learned coping skills from one discrediting attribute to the next. Prior resistance experience thus should heighten the person's likelihood of blocking or confronting mental illness stereotypes.[6]

Past familiarity with mental illness in family or friends. Many individuals have had personal experience with a significant other—a partner, family member, or friend—who is grappling with mental health problems. Through interactions with this significant other over time, individuals realize that his or her symptoms simply do not match widespread stereotypes about "crazy people." Information countering erroneous public beliefs is also acquired. Given greater familiarity and knowledge about mental illness from such experiences, persons who then develop mental health problems of their own should be quicker to recognize that their symptoms do not fit stereotypes, predisposing them to deflection strategies of resistance. Additionally, if they have generalized from their own or their significant other's stigma experiences to most patients/consumers, they should be more inclined to challenge other people's disparaging attitudes and behaviors. Of course, I am assuming here that the

[6]It is possible, however, that individuals' abilities to resist rejection and discrimination may be overtaxed by the acquisition of an additional devalued characteristic; if so, prior experience instead will undermine the probability of responding with resistance.

initial relationship with the ill significant other was close and caring. If the relationship had been strained or difficult, especially if disruptive symptoms and relapses caused further strains, persons might instead have distanced themselves from the family member or friend. In short, the moderating effects of familiarity with mental illness probably also depend on the quality of the relationship with the significant other.

Characteristics of the illness, illness career, and treatment setting. The characteristics of the individual's disorder and his/her history of treatment and recovery should influence whether he/she resists stigmatization in interpersonal interaction. The less serious and more time-limited one's disorder, the greater one's success in symptom management, or the more complete one's recovery,[7] the more probable the perception that public images simply "don't fit me." Conversely, the longer the person has been ill, the greater the impairment, or the more frequent his or her relapses, the less plausible this belief will be. The individual's actual symptoms may not match public stereotypes of insanity, but an inability to sustain conventional social roles will signal unreliability or incompetence to the self as well as to other people.

However, if stigma-deflection strategies become less probable with prolonged or recurrent impairment, the structure of the individual's treatment setting may foster willingness to challenge stigmatization. Treatment programs that bring patients together (e.g., group therapy, inpatient wards, skills training classes, lodges, clubhouses) allow group members to compare personal incidents of rejection and stereotyping. Sharing such stories could increase a sense of alienation and helplessness among participants, of course. But if treatment programs are run substantially or entirely by consumers who are dedicated to promoting recovery, a collective identity might emerge from views and experiences held in common. Identifying with other patients/consumers legitimizes righteous anger in response to stigmatization (Corrigan and Watson 2002), which in turn can motivate the personal use of challenging types of stigma resistance. Commitment to the welfare of patients/consumers as a group may also inspire participation in group-devised resistance strategies for social change (Corrigan and Lundin 2001; Estroff, Penn, and Toporek 2004; Tajfel and Turner 1986; Taylor and Moghaddam 1994).

In sum, people who have time-limited, less severe, manageable, and/or recoverable disorders should be more likely to resist stigmatizing encounters with deflection strategies. Those with severe, persistent mental health problems who are involved in consumer-run treatment settings should be predisposed to employ confrontation tactics in interpersonal encounters and to participate in group-sponsored challenges to prejudice and discrimination.

An additional note is required. It might seem obvious that people with non-severe disorders should more often resist stigma with deflection compared to people with severe disorders. But to my knowledge this hypothesis has not been examined. Virtually all studies of coping with mental illness stigma focus on convenience samples of patients with serious disorders who have long histories of treatment and multiple hospitalizations, and who are in outpatient therapy, organized community mental

[7]The meaning of "recovery" differs among clinicians, researchers, and consumers (Bellack 2006). I use it to refer to independent living in the community with symptoms under stable control or in remission.

health programs, or advocacy groups of consumers. Such samples are fully defensible on practical grounds; it is expensive and time-consuming to generate representative samples of persons with moderate and severe disorders who are former or current patients (as in the National Comorbidity Surveys). But when samples are composed only of persons with severe mental illness, variability in stigmatization experiences and coping responses is attenuated dramatically. Individuals who suffer from moderately serious disorders (e.g., generalized anxiety, dysthymia, agoraphobia, obsessive-compulsive, or eating disorders) are at risk of devaluation, stereotyping, rejection, and discrimination, too, although those threats should be less extreme than the stigma directed at persons with severe disorders. Existing studies overlook a substantial proportion of persons who may be actively blocking the identity implications of their mental health problems, thus underestimating the extent to which stigma resistance in fact occurs.

High levels of psychosocial coping resources. As others have pointed out, devaluation and discrimination are stressors with which persons must cope (Major and Eccleston 2005; Miller and Kaiser 2001; Phelan, Link, and Dovidio 2008); they are situational demands that harm or threaten the self and prompt cognitive or behavioral efforts to readjust (Lazarus and Folkman 1984). Perceived prejudice is a persistent or recurrent strain, and discriminatory acts are acute negative events with identifiable onsets and offsets. Stress theory holds that people draw from their personal and social resources in order to cope with negative events and chronic strains (Pearlin 1999). Those with high levels of psychosocial resources are more adept at problem-focused and emotion-focused coping (Lazarus and Folkman 1984), and effective coping in turn reduces the physical and mental health consequences of stress exposure (Taylor and Aspinwall 1996). Psychosocial resources that have been studied most frequently as stress-buffers include self-esteem, a sense of control or mastery over life (generalized self-efficacy), and social support (Bonanno 2004; Taylor and Aspinwall 1996; Thoits 1995).

Stress theory clearly suggests that high levels of psychosocial resources will moderate the relationship between stressful demands and coping efforts, or in this case, between perceived or actual stigmatization and the use of resistance strategies. Those with greater resources prior to the onset or exacerbation of stigmatizing experiences should be more likely to employ resistance tactics. People with the least severe, most manageable disorders should have lower perceived or experienced stigma as well as greater psychosocial resources in the first place, a triple advantage which should produce an iterative, escalating process of recovery (Markowitz 1998, 2001). Conversely, those triply disadvantaged by severe illness, greater stigmatization, and fewer coping resources are likely to follow a downward trajectory.

Multiple role-identities. People who possess multiple roles should be more likely to employ resistance strategies when facing devaluation or discrimination in interpersonal encounters. The role-identity concept and theory about the structure of the self suggest three reasons for this.

Social roles are key sources of personal identity for most people—definitions of who we are in our own and others' eyes (Stryker 1980; Thoits 1992). Roles that individuals accept as

self-descriptive are often termed "role-identities" (McCall and Simmons 1978; Stryker 1980). Most people have multiple role-identities because they hold several positions in the social structure to which are attached sets of behavioral expectations (e.g., spouse/partner, parent, employee, student, volunteer, church member, friend). As mentioned earlier, theorists have described identities as organized into hierarchies of salience (Stryker 1980), prominence (McCall and Simmons 1978), psychological centrality (Rosenberg 1979), and subjective importance (Thoits 1992). The higher in such hierarchies, the greater the likelihood that a role-identity will be enacted (Stryker and Serpe 1982) and the more probable a successful identity performance will positively influence self-esteem (Rosenberg et al. 1995). Conversely, the less importance attached to a particular identity, the less influence poor role-identity performance will have on self-regard (Crocker et al. 1998).

Theoretically, as discussed earlier, devalued role-identities such as "mentally ill person" or "mental patient" should rank low in individuals' identity hierarchies. The more role-identities an individual holds, then, the smaller the percentage of the self the illness-related identity represents and the lower the identity should rank relative to other more valued aspects of the self. Recall that a strategy of deflection is to assert that the experience of mental illness is a "small, unimportant part of me." It follows that the more role-identities possessed, the more able one should be to deflect the stigmatizing remarks or behaviors of other people.

It is important to note that deliberately decreasing the salience/importance of a problematic role-identity is frequently described in the literature as a self-protective or self-restorative strategy (Crocker and Major 1989; Crocker et al. 1998; Major and O'Brien 2005; McCall and Simmons 1978; Miller and Kaiser 2001; Shih 2004; Thoits 2010; Wright et al. 2000). One disengages from a devalued, stressful identity and invests instead in other more rewarding identities. However, changing one's identity hierarchy is not a form of resistance as conceived here (as opposition). In reorganizing one's priorities, one *repairs* damage already done to the self rather than *parries or blocks* potential damage to the self at the outset. The distinction is subtle; to discriminate empirically between stigma-deflection and self-restoration, one would need repeated measures of individuals' role-identity structures and self-esteem scores over time. Despite the intricacies of disentangling these two strategies, the distinction seems important: a person who resists is relatively invulnerable to stigmatization while one who repairs has taken a "hit" to self-regard and struggles to recover.

Multiple roles can have a second, more indirect effect on the use of stigma-deflection strategies. The more conventional roles one holds, the more role partners there are in one's life who are invested in legitimizing and supporting one's performance of conventional behaviors (McCall and Simmons 1978). The more support for conventional role-identity enactments, the less one's mental illness–related identity receives validation, again making it "not an important part of me." However, if a person's symptoms are severe and disrupt conventional role enactments over time, role partners may instead drop their identity support, insist that the person is ill, and urge him or her (back) into treatment (Estroff et al. 1991; Thoits forthcoming).

Finally, multiple roles can strengthen the relationship between stigma exposure and the use of resistance strategies

through their positive effects on mental health. Role-identities promote mental health because they provide purpose and meaning in life (i.e., who I am), supply behavioral guidance through normative scripts (how I should behave), and influence self-evaluations based on the quality of one's role performance (how worthy and competent I am) (Thoits 1983, 1986, 2003). The more identities one holds, especially the more voluntary (as opposed to obligatory)[8] identities one holds, the greater one's self-esteem, sense of personal control, life satisfaction, and happiness, and the lower one's symptoms of psychological distress (Thoits 2003). The reverse is also true: individuals with higher self-esteem, greater personal control, and lower psychological distress acquire more role-identities over time, especially more voluntary identities (Thoits 2003). Role-identity accumulation reflects the exercise of personal agency—deliberate, intentional, goal-oriented action, enabled by actors' sense of confidence and competence, yielding further gains in confidence and competence. In essence, persons with multiple role-identities should have greater coping resources with which to resist the prejudice and discrimination they encounter in social relations.

It may seem implausible that individuals with serious mental disorders would possess multiple role-identities. Indeed, most studies show that the great majority of current or former patients with serious conditions are unmarried, and substantial percentages (30 to 50 percent) are unemployed, suggesting that a good proportion may not be actively parenting either (e.g., Corrigan et al. 2006; Estroff et al. 1991; Jenkins and Carpenter-Song 2005; Kleim et al. 2008; Link et al. 1989; Vauth et al. 2007; Wahl 1999a). Nevertheless, variability does exist in the distributions of marital and work roles. Many other roles that participants might hold simply are not canvassed in stigma studies (for example, parent, relative, friend, boyfriend/girlfriend, church member, neighbor, volunteer, student, caregiver). If more roles were assessed, we might discover that substantial percentages of patients with mental disorders hold multiple conventional role-identities. If study samples were broadened to include individuals who have moderately serious disorders, even greater variation in role-identity accumulation should be observed. Such designs would allow a better test of whether multiple role-identities moderate the link between stigmatization and the use of deflecting and challenging resistance strategies.

The Dynamics of Stigma Resistance

Up to this point, I have discussed types of stigma-resistance and the conditions under which they might be employed as though resistance were an individual's usual and sole response to reminders of stereotyping and discriminatory encounters. This was for expositional simplicity only. Like everyone else, persons with a history of disorder typically use *combinations* of coping strategies (e.g., Link et al. 1989, 2002) and *shift* strategies over time as situational contingencies change (e.g., Corrigan and Watson 2002; Estroff et al. 1991).

[8]Voluntary identities are shorter-term role relationships that are relatively easy to exit if their costs begin to exceed their rewards (e.g., neighbor, church member, club member). Obligatory identities are longer-term, more affectively intense, and have more demanding mutual rights and obligations (e.g., spouse, parent, employee), making these roles more difficult to exit.

Perhaps the most common combination might be private deflection along with secrecy (Goffman 1963; Link et al. 1989) and/or selective disclosure to trusted others (Goffman 1963). Here, one both blocks the self-esteem consequences of stigmatization and sidesteps exposure to devaluation that might require additional deflecting. Such combinations may be especially characteristic of individuals with mild to moderately serious disorders who previously were or are now in treatment. They know they are *not* mentally ill per se, but just in case others might impose that label, they keep their history secret or carefully guarded. Those whose mental health status is publically known might also combine deflecting resistance with subsequent avoidance of persons who have stereotyped them or might do so. Again blocking would be bolstered by limiting one's exposure to stigmatizing encounters.

Individuals who use challenging resistance strategies are "out"—it would be difficult to disconfirm others' stereotypes or educate/confront others effectively without self-disclosure. Thus, secrecy and selective disclosure are not options. Because challenging entails interpersonal costs, individuals might additionally engage in one or more avoidant or self-reparative strategies such as associating often with people who do not stereotype (especially other patients/consumers); comparing themselves to patients/consumers who are doing less well than they are (rather than comparing to normals); and attributing their failures to other people's biases against persons with mental illness rather than to their own shortcomings, among other strategies (see Crocker et al. 1998).

Some tactics should appear or disappear from the individual's coping repertoire as his or her illness career unfolds. As symptom control becomes effective and stable, or when full recovery is attained, individuals who previously internalized stigma or predominantly employed self-restoration strategies may embrace deflecting resistance tactics. Reminders of one's treatment history can be blocked with "that's not me now/that's an unimportant part of me now/I no longer have that problem." Persons who had moderately serious disorders should be most likely to make this change. In terms of social identity theory (Tajfel and Turner 1986; Taylor and Moghaddam 1994), this shift reflects an individual's "social mobility" from membership in a devalued, powerless social group to inclusion in a valued, dominant out-group—in this case, from "mentally ill" to "normal" persons.

With effective symptom management or recovery, individuals typically regain old or add new conventional role-identities as well as derive from role enactment an increasing sense of accomplishment and control. As argued earlier, the more role-identities one acquires, the less importance one's prior identity as "mental patient" will carry, allowing a shift from self-devaluation or self-restoration strategies to deflecting resistance.

Regular association with other consumers is another contingency that might add resistance to the individual's coping repertoire. If association were forced by commitment proceedings or court mandate, psychological reactance to coercion (Brehm 1966) could generate deflecting resistance: "I'm not like those other patients." When association with other patients/consumers is instead voluntary and regularized through participation in a treatment center or group program, social comparisons with fellow members may steer the individual in one of two directions:

perceiving one's dissimilarity from the majority of the group should inspire deflection, while observing staff members treating oneself and other patients in condescending or demeaning ways may foster challenges to mental illness stereotyping.

More generally, shifts from internalized stigma or self-restoration tactics to the use of challenging strategies may occur in response to a significant "encounter," similar to the turning point often posited in theories of racial identity development (see review in Phinney 1993). The encounter is an event or series of events that force the unaware or stigma-accepting individual to recognize the negative impacts of stereotypes and social rejection. Theoretically, once differential treatment and its injustices are realized, the person immerses him or herself in learning about the oppressed group's social and cultural situation, identifies with the oppressed group, and eventually develops a commitment to advancing its welfare. If such a developmental process occurs in the lives of patients with a mental disorder, the use of challenging strategies should emerge after a significant encounter. Entry into a consumer-run program or treatment setting might constitute one such encounter, as discussed earlier. This process has a number of elements in common with the "social change" response of devalued groups to discrimination, as described in social identity theory (Tajfel and Turner 1986; Taylor and Moghaddam 1994). When members of a devalued social category perceive that upward social mobility is blocked, that they share a collective fate, and that the discrimination directed at them as a group is illegitimate and unjustifiable, they will challenge the norms and social policies that have sustained group distinctions. Acceptance of the status quo is replaced by collective resistance.

The above contingencies concern the appearance of resistance strategies in the individual's coping repertoire. Resistance can also wane or vanish over time. This is most likely when a disorder worsens dramatically, frequently recurs, or becomes persistently disabling. It becomes increasingly difficult to sustain the belief that mental illness stereotypes do not apply to oneself, and symptoms can impair one's abilities to confront prejudice and discrimination effectively. The person may abandon resistance strategies and resort primarily to avoidance or self-restoration, or he or she may give up entirely and self-stigmatize. In sum, as symptom severity and situational contingencies change over time, individuals' propensities to employ deflecting or challenging resistance tactics are likely to change in tandem.

CONCLUDING REMARKS

I have used tentative and probabilistic language throughout this paper because I have (1) defined a concept that has not previously been defined in the mental illness labeling literature, (2) distinguished between two forms of resistance that were not delineated before, and (3) identified several conditions for resistance that are rarely discussed in the stigma-coping literature. Thus, much here is speculative, although there are hints in existing studies that at least some propositions would find support.

Because resistance was previously undefined, the concept was applied somewhat loosely by authors to a diverse array of coping strategies, some of which might be more specifically classified as avoidant or restorative in nature, such as shunning persons who are prejudiced

or maintaining that symptoms are not one's fault (e.g., Corrigan and Watson 2002; Doherty 1975; Prus 1975; Quadagno and Antonio 1975; Rogers and Buffalo 1974; Watson and River 2005). By conceptualizing resistance as *opposition* to the invasion of devaluation and discrimination, I have attempted to cast a boundary around the range of coping responses that might be characterized as resistant.

At the same time, I have elaborated the concept of resistance by distinguishing between blocking/deflecting and confronting/challenging forms—one primarily cognitive, the other primarily behavioral in manifestation, respectively. My goal was to add to the coping strategies that individuals use to ward off the consequences of perceived or experienced stigma, as outlined in modified labeling theory (Link 1987; Link et al. 1989). Recently, Link and colleagues (2002) themselves expanded their coping responses to include distancing and challenging, although they have not conceptualized these responses as resistance per se. Including resistance tactics helps to advance a key contribution of modified labeling theory: bringing personal agency "back in." In classic labeling theory, the individual is a passive victim, compelled by other people's stereotypes and constraining behaviors to accept a mental patient identity (Quadagno and Antonio 1975). In modified labeling theory, persons anticipate the negative consequences of labeling and attempt to forestall them by passing, withdrawing, or educating—acts that clearly reflect the exercise of agency. In my view, resistance to stigma is especially important to theorize in the modified labeling process because deflecting and challenging strategies offer the possibility of sustaining or even improving individuals' self-regard, in contrast to other acts, such as withdrawal, that have unfortunate consequences.

When focusing on resistance as a general category of responses to stigma, attention naturally turns to the issue of when individuals are more or less likely to resist, as opposed to internalize, avoid, or self-repair. There has been little work on this problem; Corrigan and Watson's model of stigma responses (Corrigan and Watson 2002; Watson and River 2005) is an exception. They argue—and I have drawn upon this argument—that righteous anger is generated when one both rejects cultural stereotypes as unjust and identifies with other patients/consumers, a combination that leads to collective action. However, I have proposed that challenging is not limited to actions by groups but includes confrontational tactics that individuals employ on their own. Furthermore, in addition to identifying with other patients/consumers in treatment settings, I have specified other circumstances in which the use of deflecting and challenging resistance strategies might be expected (past experience with resisting stigma, past familiarity with mental illness, characteristics of the illness and the treatment career, high levels of psychosocial resources, and multiple role-identity involvements). My intention was to elaborate classic and modified labeling theories, both of which have failed to consider resistance as an important category of stigma response and, as a byproduct, have neglected the range of conditions under which resistance might occur. Theorists will no doubt add other conditions that inspire resistance; these preliminary thoughts are intended to move theory in that direction.

There is a danger that in focusing on stigma resistance I have inadvertently implied that societal rejection is less of

a problem than it is, that stigma is easily managed, that resistance is the most common or healthiest strategy used by persons with mental illness, or that resistance always has neutral or positive consequences for self-esteem, interpersonal relationships, and life chances. None of these would be appropriate conclusions. Evidence is undeniable that derogation and discrimination are both expected and experienced by the vast majority of patients/consumers with a disorder and that stigma creates serious and persistent problems in their work and social lives. Data are simply too sparse and measures too diverse at this point to determine whether resistance is frequent or rare, or whether it is beneficial or harmful over the long run. I simply suggest three things: (1) resistance may help to explain why the tie between stigma exposure and low self-esteem is not tight, (2) attention to resistance illuminates the agency of persons with mental disorder instead of their passivity or defensive reactivity, and (3) the conditions promoting resistance as well as the consequences of such strategies should be studied in detail. Resistance tactics that are discovered to raise self-regard may become promising targets for future interventions. These preliminary thoughts perhaps will encourage others to elaborate the strategies and conditions that promote successful stigma resistance. It is possible that the strategies and conditions discussed here will apply not only to persons with mental illness but to a far wider range of individuals who must cope with "spoiled identities" (Goffman 1963).

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BIO

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