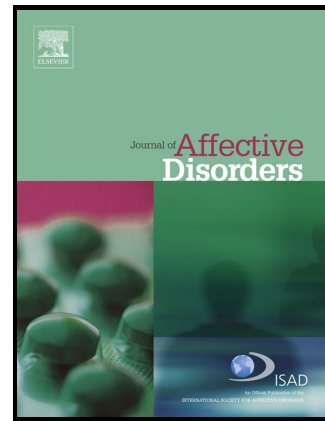


Author's Accepted Manuscript

“Depression Is who I am”: Mental illness identity, stigma and wellbeing

Tegan Cruwys, Sathiavaani Gunaseelan



PII: S0165-0327(15)30367-0
DOI: <http://dx.doi.org/10.1016/j.jad.2015.09.012>
Reference: JAD7694

To appear in: *Journal of Affective Disorders*

Received date: 4 June 2015
Revised date: 23 August 2015
Accepted date: 5 September 2015

Cite this article as: Tegan Cruwys and Sathiavaani Gunaseelan, “Depression Is who I am”: Mental illness identity, stigma and wellbeing, *Journal of Affective Disorders*, <http://dx.doi.org/10.1016/j.jad.2015.09.012>

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting galley proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

“Depression is who I am”: Mental illness identity, stigma and wellbeing.

Tegan Cruwys

Sathiavaani Gunaseelan

University of Queensland

Corresponding author: Dr Tegan Cruwys, School of Psychology, University of Queensland,
St Lucia QLD 4072 AUSTRALIA. email: t.cruwys@uq.edu.au ; Fax: +61 7 3365 4466.

ACCEPTED MANUSCRIPT

Abstract

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

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

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

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

Keywords: mood disorders, mental health, social identity, discrimination, normative influence, health behavior.

ACCEPTED MANUSCRIPT

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

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

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

ACCEPTED MANUSCRIPT

social and political structure, but also substantial and long-lasting consequences for health (Pascoe & Smart Richman, 2009; Schmitt, Branscombe, Postmes, & Garcia, 2014)

The rejection identification model (RIM; Branscombe, Schmitt, & Harvey, 1999) brought attention to the fact that being subject to discrimination due to one's membership of a social group increases the salience of the social identity associated with that social group. For example, a woman who experiences workplace discrimination because of her gender is more likely to think of herself as a woman, particularly when at work. This *social identification*, or subjective self-definition in terms of a social category, has a number of well-established consequences, including for wellbeing. RIM brought attention to the fact that when discrimination encourages and enables social identification with a stigmatized group, some of the harms of discrimination may be ameliorated. That is, social identifications *buffers* individuals against the negative consequences of stigma. RIM has been investigated in the context of ethnic minority identities (Branscombe et al., 1999; Latrofa, Vaes, Pastore, & Cadinu, 2009; Schmitt, Spears, & Branscombe, 2003), older people (Garstka, Schmitt, Branscombe, & Hummert, 2004), women (Schmitt, Branscombe, Kobrynowicz, & Owen, 2002) and people with physical disabilities (Fernández, Branscombe, Gómez, & Morales, 2012), but not, to our knowledge, in the context of mental illness groups.

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

ACCEPTED MANUSCRIPT

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

People with depression are part of a social category that is both a) subject to stigma and discrimination, and b) associated with specific normative thoughts (e.g., hopelessness, negativity) and behaviors (e.g., self-harm) that, if internalized by group members, are likely to worsen mental health. Therefore this social category represents an ideal test case for the theoretical question of whether there are social categories where social identification is negatively associated with wellbeing. Furthermore, depression identity differs from the social categories where the RIM has typically been investigated in at least three important ways. First, being a “depressed person” is usually *concealable*, and many people choose not to

ACCEPTED MANUSCRIPT

disclose their diagnosis to others. Previous research has suggested that concealing stigmatized identities can be associated with reduced wellbeing (Barretto, Ellemers & Banal, 2006). Second, the boundaries between mental illness and mental health are *permeable*, in that it is possible for a person to leave the stigmatized group via recovery— although perhaps not easily or quickly. Permeable group boundaries may reduce social identification (Ellemers et al. 1990). Third, and perhaps most importantly, depression identity describes a person's *lack of* wellbeing. That is, perhaps more so than any other social category, what it means to be a member of the “depressed” group is to experience poor wellbeing. Thus, even if wellbeing is operationalized in terms of constructs distinct from depression (such as life satisfaction, anxiety, stress), it seems likely that seeing depression as central to one's identity is incompatible with wellbeing.

The current study

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

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

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

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

ACCEPTED MANUSCRIPT

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

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

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

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

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

Method

Participants

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

The final sample included 250 depressed persons, 61.6% of which reported that they had received a formal mood disorder diagnosis from a health professional, while the

ACCEPTED MANUSCRIPT

remaining participants reported current depression symptoms of at least moderate severity (according to published cut-off criteria; Lovibond & Lovibond, 1995). Participants without a formal diagnosis whose current symptoms were mild or subclinical were excluded from the survey (an additional $N=60$). This was a conservative approach in order to increase our confidence that all participants had experienced, or were experiencing, clinical depression symptoms. The mean age was 27.37 years ($SD=11.64$; range 17-70). Participants were 64% female and recruited from across the world, with the most common nationalities being United States (38.8%), Australia (36.8%), and India (5.6%), with small numbers of participants from 20 other countries.

Measures

Wellbeing

Wellbeing was assessed using four overlapping but distinct constructs: depression, anxiety, stress and life satisfaction. This was to address the potential restriction of range that may have resulted from using depression symptoms as both a criteria for eligibility as well as a dependent variable. However, as can be seen from Table 1, almost the full range of the scale was utilized for all four wellbeing variables.

Depression Anxiety Stress Scales (DASS-21). The DASS-21 is a well-validated short form of the Depression Anxiety Stress Scales (Lovibond & Lovibond 1995). The measure includes three seven-item subscales, assessing depression, anxiety, and stress symptoms respectively. The DASS has excellent validity in both clinical and non-clinical samples and reliability of at least $\alpha=.88$ (Crawford et al., 2009; Henry & Crawford, 2005). For instance, one study with a clinical sample found that the DASS-21 accurately distinguishes between individuals with mood disorder, panic disorder or obsessive-compulsive disorder (Page, Hooke, & Morrison, 2007). Participants were asked to indicate how frequently in the preceding week they had experienced symptoms such as “I felt like I wasn’t worth much as a person”, (depression subscale, $\alpha=.88$), “I felt I was close to panic” (anxiety subscale, $\alpha=.81$) and “I tended to over-react to situations” (stress subscale, $\alpha=.84$)

ACCEPTED MANUSCRIPT

from 0 “Did not apply to me at all” to 3 “Applied to me very much, or most of the time”. For each subscale, responses were summed and multiplied by two in accordance with recommended practice (Lovibond & Lovibond, 1995). The mean scores were in “severe” range for depression ($M=24.92$; $SD=9.82$), the “severe” range for anxiety ($M=16.50$; $SD=9.31$) and the “moderate” range for stress ($M=23.45$; $SD=9.02$).

Life satisfaction. Life satisfaction was measured using the well-validated Satisfaction with Life Scale (Diener et al. 1985). Participant rated five items such as “If I could live my life over, I would change almost nothing” on a seven-point scale from “Strong Disagree” to “Strong Agree” ($\alpha=.90$). This sample reported low wellbeing on average ($M=15.83$, $SD=7.03$), approximately equivalent to a clinical outpatient sample at intake (Pavot & Diener 1993).

Social identification

In recent years, there has been a divergence between the measurement of social identification in terms of simple, one-item scales (e.g., “I identify as a depressed person”, Postmes, Haslam & Jans, 2012) or in terms of complex, multidimensional constructs (Leach et al., 2008). Our view is that, while a single construct is likely to capture social identity phenomena in many contexts, it is less appropriate for social categories that have negative and stigmatized content (see also Mlicki & Ellemers, 1996; Ouwerkerk, Ellemers, & Kortekaas, 1999). More specifically, we hypothesize that the *identity centrality* dimension (“Being depressed is an important part of how I see myself”) might best approximate the theoretical component of self-definition, or self-categorization, that is relevant to the hypotheses of the present study. Therefore we measured all five dimensions of social identification in accordance with the recommendations of Leach and colleagues (2008) and made a tentative hypothesis that our hypothesized effects would be most apparent for identity centrality.

Participants responded to 11 items such as “I feel a bond with other people who have depression” (identity solidarity, $\alpha=.86$), “Being part of a group of people who have depression

ACCEPTED MANUSCRIPT

gives me a good feeling” (identity satisfaction, one item only), “The fact that I have depression is an important part of my identity” (identity centrality, $\alpha=.83$), “I am similar to the average person who has depression” (identity self-stereotyping, $r=.78$), and “People who have depression have a lot in common with each other” (identity homogeneity, $r=.83$) on a seven-point scale from “Strongly Disagree” to “Strongly Agree”). Only one item from the satisfaction subscale was included in the survey as the other items were judged to have poor fit with the depression category (e.g. “It is pleasant to be a depressed person”).¹

Participants were also given the opportunity to provide an optional open-ended response to the question “Is depression part of how you see yourself as a person?”

Perceived discrimination

Personal experience with discrimination as a depressed person was measured using an adapted version of the Perceptions of Discrimination Scale (Schmitt & Branscombe, 2002). Participants responded to six items such as “I regularly encounter discrimination against people with depression” on seven-point scale from “Strongly disagree” to “Strongly agree” ($\alpha=.91$).

Symptom norms

The measure of symptom norms consisted of 4 items adapted from various sources (e.g., Cruwys, Haslam, Fox, & McMahon, 2015; Smith & Louis, 2008) that asked participants to rate how likely it would be for other people with depression to engage in four kinds of symptom-related cognitions (e.g. “Keep thinking negative and unhelpful thoughts”) and behaviors (e.g. “Engage in self harm behaviors”) on a seven-point scale from “Very unlikely” to “Very likely”. Items were chosen to map directly onto diagnostic criteria. Norms for emotional symptoms, such as guilt and sadness, were not directly assessed for this scale, in order to minimize conceptual overlap with the wellbeing items. The reliability of the items was good ($\alpha=.82$).

ACCEPTED MANUSCRIPT

Results

Descriptive statistics and correlations are outlined in Table 1.

Qualitative responses

121 participants (48.4%) chose to provide comments in response to the open-ended optional question “Is depression part of how you see yourself as a person?” Some participants (15.4% of those who provided a valid response) rejected the notion that depression was – or should – form part of their self-definition. Often, this included an explicit comparison to a physical health condition (e.g., a headache), or an emphasis on the possibility of change or recovery. Some examples are:

“Not at all... I strongly disagree with that phrase, depression should not be used as a identity. It is a mental illness but doesn't define who a person is. Associating it with who you are would only make it that much difficult to overcome it.” (Female, age 26)

“Depression is an illness not a definition of who I am...I am not my illness no more than someone with cancer or heart problems are defined by their illness.” (F, 22)

“No, I still see myself as a unique individual who is going through a tough time at the moment but it is not me in reality.” (F, 57)

Contrary to this view, however, a much larger group of participants (49% of those who provided a valid response) endorsed the notion that depression informed their identity. Often, this included reference to the idea that depression shaped their behavior and was preoccupying, or an emphasis that depression provided a cogent explanation for their subjective experience. Some examples are:

“Unfortunately depression is now so firmly rooted with me that it is an indelible part of my persona. I wouldn't know how to act without depression.” (M, 58)

“[Depression] has control over every thing I do, each day. It determines what I will and will not do...” (F, 22)

ACCEPTED MANUSCRIPT

“Yes, I always see myself as a generally depressed and unhappy person. I can't imagine myself any other way.” (F, 43)

“Depression becomes all I can think about myself. Depression becomes all-consuming.” (M, 42)

Approximately one third (35.6%) of participants who provided a valid response felt ambivalent about identifying as a depressed person, for example:

“It's hard to see myself without depression, however I don't feel that it defines me.” (F, 20)

“Depression permeates virtually every aspect of my life. At the same time, I don't want depression to define how I see myself as a person. I deal with it. It is a part of me, but it is not all that I am. I want to be defined more by the things that give me a reason to live and bring fulfillment into my life not by the things that make life hard.” (F, 43)

Evaluation of the hypotheses

The primary quantitative results are summarized in Figure 1. To assess the first hypothesis, concerning a negative relationship between discrimination and wellbeing, four separate regression analyses were conducted (one for each dependent variable). Personal experience of discrimination predicted lower life satisfaction, $F(1,248)=7.76, p=.006, R^2=.03$, more depression symptoms, $F(1,248)=17.50, p<.001, R^2=.07$, more anxiety symptoms, $F(1,248)=18.95, p<.001, R^2=.07$, and greater stress, $F(1,248)=10.86, p=.001, R^2=.04$. Therefore H1 was confirmed: the experience of discrimination as a depressed person was associated with poorer wellbeing.

Similarly, to assess the second hypothesis, concerned a positive relationship between discrimination and identification, five separate regression analyses were conducted (one for each component of identification). Personal experience of discrimination predicted greater identity centrality, $F(1,248)=51.07, p<.001, R^2=.17$, greater identity solidarity,

ACCEPTED MANUSCRIPT

$F(1,248)=22.70, p<.001, R^2=.08$, greater identity satisfaction, $F(1, 247)=12.53, p<.001, R^2=.05$, greater perceived identity homogeneity, $F(1,248)=12.99, p<.001, R^2=.05$, and greater identity self-stereotyping, $F(1,248)=16.54, p<.001, R^2=.06$. Therefore H2 was confirmed: the experience of discrimination as a depressed person was associated with stronger identification as a depressed person. Discrimination was a particularly strong predictor of the *centrality* of depression identity.

In order to assess the third and fourth hypothesis, Hayes PROCESS (2012, model 4) was used. The model included discrimination as the independent variable, the five components of identification as mediating variables, and a global wellbeing measure (created from the mean of the z-scores of the four separate wellbeing variables, such that high scores indicated greater wellbeing) as the dependent variable.² There was no significant indirect effect for ingroup homogeneity, ingroup self-stereotyping, identity satisfaction or identity solidarity. That is, for these subscales, neither H3 nor H4 were supported; these measures of identification were independent of wellbeing. However, identity centrality was a significant indirect mediator of the relationship between discrimination and wellbeing. The direction of this relationship was consistent with H4, such that identification as a depressed person was associated with *reduced* wellbeing ($\beta = -.26, p<.001$) and indirectly mediated the negative relationship between discrimination and wellbeing ($\beta = -.11, CI: -.18, -.05$).

A sensitivity analysis was conducted to investigate the most plausible alternative model, specifically that people with more severe depression symptoms perceive themselves to more prototypical of the group (ingroup self-stereotyping) and subsequently come to identify more strongly as depressed. However, this model was not supported by the data: depression severity did not predict ingroup self-stereotyping ($\beta=.01, p=.254$) and ingroup self-stereotyping did not mediate the relationship between depression severity and identification ($\beta=.00, CI: -.01, .01$).

Hypothesis five, concerning the moderating role of symptom norms, was tested using Hayes PROCESS (2012, model 14). The interaction between identity centrality and symptom

ACCEPTED MANUSCRIPT

norms in predicting wellbeing was significant, $t(245)=3.19, p=.002, \beta=.16$. Specifically, among those who were below the median (and the mid-point of the scale) in their identification as depressed, there was no relationship between symptom norms and one's own wellbeing ($t(100)=.79, p=.430$). That is, people who did not identify as depressed were not influenced by the symptom norms of depressed people. Among those above the median, however, there was a significant relationship between symptom norms and wellbeing ($t(146)=4.47, p < .001$). This was such that among people who identified as depressed, there was an association such that the more they characterized depressed people in terms of depression symptomatology, the poorer their own wellbeing. Therefore, H5 was confirmed – identifying as depressed was harmful to wellbeing because it facilitated convergence towards norms of depressogenic thoughts and behaviors.

Discussion

This study is the first to quantitatively demonstrate that social identification as mentally ill is associated with the experience of discrimination and poorer wellbeing. Furthermore, out of dozens of extant studies of social identity and wellbeing (for reviews, see Cruwys et al., 2014b; Jetten, Haslam, Haslam, Dingle, & Jones, 2014), this is the first to find a direct negative relationship between these two variables. It has previously been theorized, however, that there are conditions under which social identification could harm wellbeing (Cruwys et al., 2014b), specifically in the context of stigmatized group membership or group norms that proscribe activities harmful to wellbeing. Therefore, rather than being a disconfirmation of the social identity approach to health (including the rejection identification model), we see these results as providing evidence for boundary conditions under which the psychological resources provided by social identity become toxic to health.

These data also have implications for the way in which we conceptualize social relationships and group membership. That is, it is the subjective psychological connection with a group – social identification – and not one's official category membership that matters for mental health. All of the participants in the current study were, objectively speaking, part

ACCEPTED MANUSCRIPT

of the social category “depressed people”, and yet it was only those who self-defined as such who were subject to potentially harmful social influence processes from fellow depressed persons. This was borne out by the qualitative results, where those who accepted the depression identity label emphasized how this identity shaped their behavior. Relatedly, these data provide further evidence for the importance of identity *content*. In a recent related study, Cruwys and colleagues (2014a) found that depressed people who socially identified with recreational groups or psychotherapy groups experienced reduced depression symptoms over time. While this might, on the surface, appear to be a comparable sample with contrary results to those reported here, the norms of recreational or psychotherapy groups are critically different from those of “depressed people”, and thus their consequences for mental health diverge.

It is interesting to note that the reverse pathway, whereby the experience of depression symptoms leads to self-stereotyping and subsequent self-definition, was not supported by these data. This pathway does, however, remain a plausible means through which a depression identity might develop over time in a sub-clinical sample. This might have historically occurred in the present sample, however, this could not explain the observed differences in wellbeing. It is worth noting also that previous research investigating the role of ingroup self-stereotyping also concluded that it follows from, rather than precedes, identification and wellbeing (Latrofa et al. 2009). Nevertheless, a limitation of this study is its correlational nature, and no reverse causal pathway can be confidently ruled out here.

These data are relevant to the ongoing debate regarding the clinical impact of diagnosis. We do not dispute the benefits of diagnosis for guiding formulation and treatment. Nevertheless, these findings suggest that diagnosis, to the extent that it contributes to patients’ self-definition in terms of their mental illness, may have harmful consequences for wellbeing. Going beyond our data somewhat, but in keeping with social-psychological theory, we posit that when a mental illness diagnosis is disclosed to a patient, it ought to be accompanied by information that a) challenges the legitimacy of stigma towards people with mental illness,

ACCEPTED MANUSCRIPT

and b) encourages patients to see mental illness as a temporary state, rather than a permanent condition. This combination may limit negative effects and enable patients to engage in strategies of *individual mobility*, that is, recovery efforts.

A further implication for clinical practice is that, while interventions to boost social engagement are very much indicated, attention is needed to the normative content of these groups. Illness support groups, including online communities, have the potential to be harmful if they encourage patients to adopt an illness identity that is framed in permanent, biochemical terms, or to engage in collective rumination (see also Howard, 2006; Kvaale et al., 2013). Instead, clinicians should seek to provide alternative, positive sources of self-definition around which social identities might cohere, which might include recreational or community groups (e.g. Cruwys et al., 2014a; Gleibs, Haslam, Haslam, & Jones, 2011; Gleibs, Haslam, Jones, et al., 2011).

In sum, these data are the first to show, in a large international sample of depressed persons, that identifying as mentally ill is related to the experience of stigma and with poorer wellbeing. These data are also the first to provide evidence of a theorized, but to date hypothetical, boundary condition for the benefits of social identification for wellbeing. Identifying as depressed enables a process of social influence, whereby people are more likely to converge upon the norms of the in-group: in this case, thoughts and behavior that are depressogenic. In this way, the stigma of depression poses a double burden – not only through its direct harm to health, but also by bolstering mental illness identity and its associated ills. New directions in depression treatment should ideally establish methods of empowering people to recover from depression without the need to accept or enact an illness label.

ACCEPTED MANUSCRIPT

References

- Boardman, F. et al., 2011. Resilience as a response to the stigma of depression: A mixed methods analysis. *Journal of Affective Disorders*, 135, pp.267–276.
- Branscombe, N.R., Schmitt, M.T. & Harvey, R.D., 1999. Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*, 77(1), pp.135–149.
- Cornford, C.S., Hill, A. & Reilly, J., 2007. How patients with depressive symptoms view their condition: A qualitative study. *Family Practice*, 24, pp.358–364.
- Corrigan, P.W., Druss, B.G. & Perlick, D. A., 2014. The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15(2), pp.37–70.
- Crabtree, J.W. et al., 2010. Mental health support groups, stigma, and self-esteem: Positive and negative implications of group identification. *Journal of Social Issues*, 66(3), pp.553–569.
- Crawford, J.R. et al., 2009. A convenient method of obtaining percentile norms and accompanying interval estimates for self-report mood scales (DASS, DASS-21, HADS, PANAS, and sAD). *British Journal of Clinical Psychology*, 48(2), pp.163–80.
- Cruwys, T., Haslam, S.A., et al., 2014a. Depression and social identity : An integrative review. *Personality and Social Psychology Review*, 18(3), pp.215–238.
- Cruwys, T., Haslam, S.A., Dingle, G.A., et al., 2014b. Feeling connected again: Interventions that increase social identification reduce depression symptoms in community and clinical settings. *Journal of Affective Disorders*, 159, pp.139–146.
- Cruwys, T. et al., 2015. “That’s not what we do”: Evidence that normative change is a mechanism of action in group interventions. *Behaviour Research and Therapy*, 65, pp.11–17.
- Diener, E. et al., 1985. The Satisfaction With Life Scale. *Journal of personality assessment*, 49(1), pp.71–5. A
- Dingle, G.A. et al., 2014. Breaking good: Breaking ties with social groups may be good for recovery from substance misuse. *British Journal of Social Psychology*, pp.1–19.
- Ellemers, N., van Knippenberg, A. & Wilke, H., 1990. The influence of permeability of group boundaries and stability of group status on strategies of individual mobility and social change. *British Journal of Social Psychology*, 29(3), pp.233–246.
- Ellemers, N., Wilke, H. & Van Knippenberg, A., 1993. Effects of the legitimacy of low group or individual status on individual and collective status-enhancement strategies. *Journal of Personality and Social Psychology*, 64(5), pp.766–778.
- Fernández, S. et al., 2012. Influence of the social context on use of surgical-lengthening and group-empowering coping strategies among people with dwarfism. *Rehabilitation psychology*, 57(3), pp.224–35.

ACCEPTED MANUSCRIPT

- Garstka, T. A et al., 2004. How young and older adults differ in their responses to perceived age discrimination. *Psychology and aging*, 19(2), pp.326–35.
- Gleibs, I.H., Haslam, C., Jones, J.M., et al., 2011. No country for old men? The role of a “Gentlemen”’s Club’ in promoting social engagement and psychological well-being in residential care. *Aging & mental health*, 15(4), pp.456–66.
- Gleibs, I.H., Haslam, C., Haslam, S.A., et al., 2011. Water clubs in residential care: is it the water or the club that enhances health and well-being? *Psychology & health*, 26(10), pp.1361–77. A
- Goldman, L.S., Nielsen, N.H. & Champion, H.C., 1999. Awareness, diagnosis, and treatment of depression. *Journal of general internal medicine*, 14(9), pp.569–80.
- Hansen, N. & Sassenberg, K., 2011. Exploring the self-directed anger of the stigmatized: The interplay between perceived legitimacy and social identification. *Group Processes & Intergroup Relations*, 14, pp.807–818.
- Hayes, A.F. & Preacher, K.J., 2013. Statistical mediation analysis with a multicategorical independent variable. *The British journal of mathematical and statistical psychology*, pp.1–20.
- Henry, J.D. & Crawford, J.R., 2005. The short-form version of the Depression Anxiety Stress Scales (DASS-21): construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, 44(2), pp.227–39.
- Howard, J., 2006. Expecting and accepting: The temporal ambiguity of recovery identities. *Social Psychology Quarterly*, 69(4), pp.307–324.
- Howard, J., 2008. Negotiating an exit: Existential, interactional, and cultural obstacles to disorder disidentification. *Social Psychology Quarterly*, 71, pp.177–192.
- Jetten, J. et al., 2014. How groups affect our health and well-being: The path from theory to policy. *Social Issues and Policy Review*, 8(1), pp.103–130.
- Jones, J.M. et al., 2011. That which doesn’t kill us can make us stronger (and more satisfied with life): the contribution of personal and social changes to well-being after acquired brain injury. *Psychology & health*, 26(3), pp.353–69.
- Karp, D.A., 1994. Living with depression: Illness and identity turning points. *Qualitative health research*, 4(1), pp.6–30.
- Kvaale, E.P., Haslam, N. & Gottdiener, W.H., 2013. The “side effects” of medicalization: a meta-analytic review of how biogenetic explanations affect stigma. *Clinical psychology review*, 33(6), pp.782–94.
- Latrofa, M. et al., 2009. “United we stand, divided we fall”! The protective function of self-stereotyping for stigmatised members’ psychological well-being. *Applied Psychology*, 58(1), pp.84–104.
- Lebowitz, M.S., Ahn, W.-K. & Nolen-Hoeksema, S., 2013. Fixable or fate? Perceptions of the biology of depression. *Journal of consulting and clinical psychology*, 81(3), pp.518–27.

ACCEPTED MANUSCRIPT

- Link, B.G. et al., 1997. On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of health and social behavior*, 38(2), pp.177–90.
- Link, B.G. et al., 1999. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American journal of public health*, 89(9), pp.1328–33.
- Lovibond, P.F. & Lovibond, S.H., 1995. The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, 33(3), pp.335–343.
- Mlicki, P.P. & Ellemers, N., 1996. Being different or being better? National stereotypes and identifications of Polish and Dutch students. *European Journal of Social Psychology*, 26(November 1994), pp.97–114.
- Ouwerkerk, J.W., Ellemers, N. & Kortekaas, P., 1999. Self-categorisation, commitment to the group and group self-esteem as related but distinct aspects of social identity. *European Journal of Social Psychology*, 29, pp.371–389.
- Page, A.C., Hooke, G.R. & Morrison, D.L., 2007. Psychometric properties of the Depression Anxiety Stress Scales (DASS) in depressed clinical samples. *British journal of clinical psychology*, 46(3), pp.283–97.
- Pascoe, E. A & Smart Richman, L., 2009. Perceived discrimination and health: a meta-analytic review. *Psychological Bulletin*, 135(4), pp.531–554.
- Pavot, W. & Diener, E., 1993. Review of the Satisfaction With Life Scale. *Psychological Assessment*, 5(2), pp.164–172.
- Rüsch, N. et al., 2014. Does the stigma of mental illness contribute to suicidality? *British journal of psychiatry*, 205(4), pp.257–9.
- Saxena, S. et al., 2007. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*, 370, pp.878–889.
- Schmitt, M.T. et al., 2002. Perceiving discrimination against one's gender group has different implications for well-being in women and men. *Personality and Social Psychology Bulletin*, 28(2), pp.197–210.
- Schmitt, M.T. et al., 2014. The consequences of perceived discrimination for psychological well-being: A meta-analytic review. *Psychological bulletin*, 140(4), pp.921–48.
- Schmitt, M.T. & Branscombe, N.R., 2002. The meaning and consequences of perceived discrimination in disadvantaged and privileged social groups. *European Review of Social Psychology*, 12, pp.167–199.
- Schmitt, M.T., Spears, R. & Branscombe, N.R., 2003. Constructing a minority group identity out of shared rejection: the case of international students. *European Journal of Social Psychology*, 33(1), pp.1–12.
- Smith, J.R. & Louis, W.R., 2008. Do as we say and as we do: The interplay of descriptive and injunctive group norms in the attitude-behaviour relationship. *British Journal of Social Psychology*, 47, pp.647–666.

ACCEPTED MANUSCRIPT

- Tajfel, H. & Turner, J.C., 1979. An integrative theory of intergroup conflict. In W. G. Austin & S. Worehel, eds. *The social psychology of intergroup relations*. Monterey: Brooks/Cole., pp. 33–47.
- Tewari, S. et al., 2012. Participation in mass gatherings can benefit well-being: longitudinal and control data from a North Indian Hindu pilgrimage event. *PloS one*, 7(10), p.e47291.
- Turner, I. et al., 2014. Well-being, school climate, and the social identity process: A latent growth model study of bullying perpetration and peer victimization. *School Psychology Quarterly*, 29(3), pp.320–335.
- Turner, J.C., 1991. *Social influence*, Milton Keynes: Open University press.
- Wakefield, J.R.H., Bickley, S. & Sani, F., 2013. The effects of identification with a support group on the mental health of people with multiple sclerosis. *Journal of psychosomatic research*, 74(5), pp.420–6.
- Yanos, P.T., Roe, D. & Lysaker, P.H., 2010. The impact of illness identity on recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 13(2), pp.73–93.

ACCEPTED MANUSCRIPT

Table 1. *Descriptive statistics and correlations.*

	<i>M</i>	<i>SD</i>	Range	<i>Correlations</i>											
				1.	2.	3.	4.	5.	6.	7.	8.	9.	10.		
1. Depression	24.92	9.82	2-42	-											
2. Anxiety	16.50	9.31	0-42	.48*	-										
3. Stress	23.45	9.02	0-42	.57*	.61*	-									
4. Life satisfaction	15.83	7.03	5-32	-.47*	-.12	-.24*	-								
5. Identity solidarity	4.36	1.34	1-7	.15	.24*	.18*	.01	-							
6. Identity satisfaction	3.61	1.67	1-7	.08	.28*	.14*	.03	.66*	-						
7. Identity centrality	4.23	1.44	1-7	.29*	.25*	.30*	-.18*	.40*	.34*	-					
8. Identity self-stereotyping	4.24	1.38	1-7	.07	.14*	.10	-.05	.40*	.33*	.37*	-				
9. Identity homogeneity	4.04	1.39	1-7	.07	.12	.02	-.04	.40*	.39*	.31*	.69*	-			
10. Discrimination	3.71	1.55	1-7	.26*	.27*	.21*	-.17*	.29*	.22*	.41*	.25*	.22*	-		
11. Symptom norms	5.56	0.99	1-7	.24*	.12	.11	-.19*	.20*	.01	.16*	.11	.14*	.08	-	

N = 250.

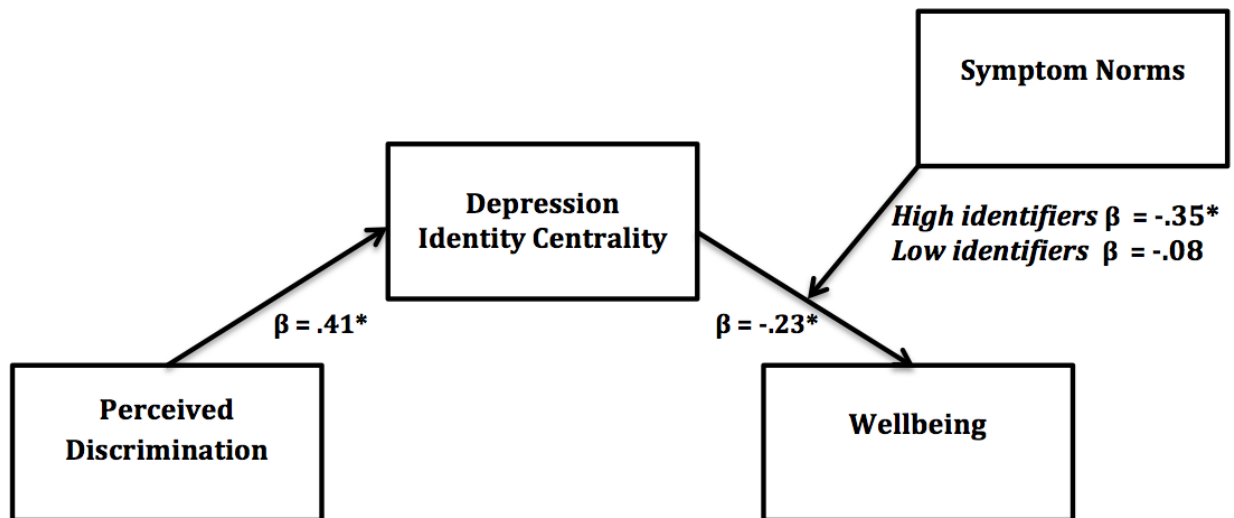


Figure 1. The centrality of depression to one's identity was associated with poorer wellbeing, particularly along those who thought that depression symptoms characterized people with depression.

NB. Standardized beta values are included in the figure and in text to aid interpretability, however, significance levels were calculated using unstandardized values in Hayes PROCESS models 4 and 14, in accordance with recommendations (Hayes & Preacher 2013).

ACCEPTED MANUSCRIPT

Footnotes

¹ Factor analysis indicated a three-factor solution of social identification was the best fit for these data. The first factor corresponded to the centrality subscale; the second factor consisted of an 'entitativity' dimension made up of self-stereotyping and homogeneity; and the third factor was made up of solidarity plus satisfaction. Given that our results focus on the identity centrality subscale, the coherence of which is supported by both the factor analysis and the extant literature, we retained the five-factor model for our analyses in keeping with published recommendations (Leach et al., 2008).

² Note that these findings also held when the wellbeing measures were assessed separately, such that for depression, stress and life satisfaction the results were identical. For anxiety, identity satisfaction, rather than identity centrality, was the significant mediator.

Highlights

- Identification with a group, even a stigmatized group, is protective for wellbeing
- These relationships have not been tested in the context of mental illness identity
- We surveyed 250 people with depression from 23 countries
- Identifying as depressed predicted lower wellbeing
- Identifying as depressed predicted conforming to the norms of depressed people