

## **Mental Health Support Groups, Stigma, and Self-Esteem: Positive and Negative Implications of Group Identification**

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*Research into the relationship between stigmatization and well-being suggests that identification with a stigmatized group can buffer individuals from the adverse effects of stigma. In part, this is because social identification is hypothesized to provide a basis for social support which increases resistance to stigma and rejection of negative in-group stereotypes. The present research tests this model among individuals with mental health problems. As hypothesized, group identification predicted increased social support, stereotype rejection, and stigma resistance. These self-protective mechanisms were in turn found to predict higher levels of self-esteem. However, the general effect of these associations was to suppress a negative relationship between social identification and self-esteem. This confirms that the positive impact of identification lies in its capacity to provide access to stress-buffering mechanisms but also indicates that the impact of identification with a severely stigmatized group is not necessarily positive. Implications for theory and practice are discussed.*

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### *Mental Health and Stigma*

Individuals are typically stigmatized as a result of attributes that set them apart from others and which mark them out as in some sense inferior—having what Goffman (1963) referred to as a “spoiled identity.” The mentally ill are one group among many others (e.g., ethnic minorities, homosexuals, individuals with physical and learning disabilities), who are stigmatized in contemporary society (Crocker, Major, & Steele, 1998; Goffman, 1963). Stigmatization is routinely manifested in the form of negative attitudes, discrimination, exclusion, and inequality of treatment. In this way, individuals with mental illness are often excluded from employment, independent living, and other significant life experiences (Farina, 1998; Phelan, Link, Stueve, & Pescosolido, 2000). Accordingly, the reduction of stigmatization in individuals with mental health problems is considered central to the promotion of mental health (Gale, Crepaz-Keay, & Farmer, 2004; World Psychiatric Association, 2000).

There is a considerable amount of research that documents the prejudices against individuals with mental health problems. They are disliked, derogated, negatively stereotyped, and discriminated against (Farina, 1982). Moreover, they are often portrayed as fundamentally different from “normal” people and as being less competent and more violent (Wahl, 1995). Nevertheless, relatively little research has explored the personal (and collective) experiences of stigma among people with mental illness (Dinos, Stevens, Serfaty, Weich, & King, 2004). It is this lacuna that the present study addresses.

Research has demonstrated that individuals with mental illness are aware of the stigma that their group faces and frequently have first-person experiences of stigma. For example, Dinos et al. (2004) interviewed individuals with psychiatric diagnoses who participated in mental health support groups, day centers, crisis centers, and hospitals and found that stigma about mental illness was pervasive and a serious concern. Similarly, Dunn (1999) reported that people with mental illness consistently identified stigma, discrimination, and exclusion as major barriers to health, welfare, and quality of life. Others have also observed that mentally ill and formerly mentally ill individuals routinely experience prejudice similar to that experienced by racial and ethnic minority groups (e.g., Farina, 1998).

### *The Impact of Stigma on Self-Esteem*

The stigma-related experiences of individuals with mental illness are likely to have significant implications for their self-esteem. Taking into account the role of social context in the development of self-esteem, Mead (1934) argued from a symbolic interactionist perspective, that the self cannot be separated from the society in which it is located, and moreover, that society structures and regulates the perceptions and behavior of all the individuals within it. As a result, individuals’

self-esteem is a direct consequence of the views that others hold of them. Particularly important in this respect are the views of people in relevant reference groups (Leach & Smith, 2006). Along related lines, Gergen's (1977) social constructionist theory proposes that a person's self-esteem is formed socially on the basis of others' views. According to both perspectives, if others' reflected appraisals of one's self are negative, as would often be the case for individuals with mental illness, then the internalization of these should result in low self-esteem.

Link's (1987) survey research with psychiatric patients appears to support suggestions that such processes do indeed reduce self-esteem. He concludes that individuals in this group "suffer the lower self-esteem and hopelessness associated with demoralization" (p. 111). This has been widely cited by many authors as evidence that individuals with mental illness have low self-esteem (e.g., Rosenfield, 1997). Tellingly, though, Link did not include a "pure" measure of self-esteem in his own research. Instead he based his conclusions on a measure of demoralization which combined items assessing specific components of self-esteem, hopelessness, pessimism, dysphoria, thought confusion, and sadness (Camp, Finlay, & Lyons, 2002). On this basis, it is clearly problematic to conclude that individuals with mental illness necessarily have low self-esteem as a result of being stigmatized.

Furthermore, contrary to symbolic interactionist and social constructionist perspectives, research has found that the self-esteem of members of different stigmatized groups tends to be similar to that of individuals who do not belong to stigmatized groups (e.g., based on studies of ethnic minorities, Verkuyten, 1994; and people with physical or learning disabilities, Crabtree & Rutland, 2001). In relation to individuals with mental health problems, Hayward and Bright (1997) concluded that previous studies provided no clear evidence that their self-esteem was lower than that of healthy controls. Such individuals were aware of the stigma surrounding their condition, but their self-esteem did not directly reflect the stigmatized view that others held of them. On this basis, Camp et al. (2002) conclude that "it seems too crude to suggest that merely being in a stigmatized group leads to low self-esteem" (p. 824; see also Ashburn-Nardo, this issue).

Moreover, not only do individuals with mental health problems often fail to internalize the stigmatized views that society holds about them, but they also sometimes explicitly reject these views in the process of evincing higher self-esteem (Corrigan & Watson, 2002). Indeed, the fact that it is common for individuals with mental illness to display positive self-esteem has been referred to by Corrigan and Watson (2002, pp. 35–36) as "the paradox of self-stigma and mental illness." Elaborating on this point, Corrigan and Watson (2002) observe that, to date, there is limited understanding of exactly why the self-esteem of those with mental health problems is so variable, noting that "few models have emerged for explaining self-stigma in mental illness or for developing strategies to change it" (pp. 35–36). In part this seems to reflect the fact that the relationship between

stigma and self-esteem is more complex than simple models suggest and is moderated by a range of group-related factors that have been the focus of considerable recent debate.

### *Group Membership and Self-Esteem*

An alternative approach to understanding self-esteem is provided by social identity theory (Tajfel & Turner, 1979). Among other things, this argues that group membership—and, more specifically, the social identity that this furnishes individuals with (e.g., as a member of an ethnic minority group, as an individual with mental health problems)—often plays a key role in determining individuals' self-esteem. This theory postulates that individuals generally strive to maintain a positive self-concept and that in many social contexts people derive their self-esteem from their social group membership. Tajfel and Turner (1979) hypothesize that the evaluations individuals make regarding their social group are essentially relative in nature. This means that positive self-esteem can be achieved when favorable comparisons are made between the individual's social group and relevant out-groups (e.g., because the in-group is perceived to be superior). In contrast, if an individual belongs to a group that is negatively valued (i.e., stigmatized), any comparisons they make with other groups will tend to result in negative self-esteem (Major & O'Brien, 2005). Where this threat exists, individuals are hypothesized to strive to achieve positive self-esteem by pursuing a number of other strategies (Tajfel & Turner, 1979; see also Ellemers, 1993).

One strategy open to members of groups that are perceived to have permeable boundaries is to seek personal mobility—attempting to pass from a stigmatized group to a more valued group. However, because individual mobility is typically not an option for individuals diagnosed with mental health problems, it would appear that members of this group are likely to employ alternative strategies to maintain their self-esteem. In particular, if boundaries between groups are impermeable and intergroup relations are seen to be insecure (i.e., perceived to be unstable and/or illegitimate), members of stigmatized groups are more likely to favor social competition with the high-status out-group, thereby engaging in activity designed to challenge the status quo.

In this vein, Branscombe, Schmitt, and Harvey's (1999) rejection-identification model points to ways in which members of disadvantaged groups can deal with the experience of prejudice through processes of stigma resistance and stereotype rejection. In line with principles of self-categorization theory (Turner, Oakes, Haslam, & McGarty, 1994), it is suggested that the shared identity of members of stigmatized groups provides a basis for giving, receiving, and benefiting from social support that provides individuals with the emotional, intellectual, and material resources to resist (i.e., question, challenge, and oppose) the stigma, discrimination, and prejudice that they experience. In this it also provides a basis for

challenging and rejecting the stereotypic views that other groups within society hold about one's in-group. Among other things, this is because stigmatized groups often develop an agenda of social change that explicitly challenges negative societal stereotypes and labels them as illegitimate (Reynolds, Oakes, Haslam, Nolan, & Dolnik, 2000). Accordingly, to the extent that they identify with a stigmatized group, individual group members should have more access to this support (as found by Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005), and hence should resist stigma and reject negative in-group stereotypes more strongly.

Consistent with these ideas, a number of studies have shown that group identification is an important factor in predicting individuals' willingness to engage in resistance on behalf of their in-group (Van Zomeren, Postmes, & Spears, 2008; Veenstra & Haslam, 2000). Studies by Schmitt and Branscombe (2002) and Reynolds et al. (2000) have also found that group identification enhances individuals' willingness to challenge the legitimacy of an out-group's views and actions. As Tajfel (1978) argued, enhancing individuals' sense of collective self-efficacy and their perceived ability to bring about social change has, in its own right, the capacity to increase psychological well-being. This analysis is also consistent with evidence that identification with a stigmatized group can have positive implications for well-being because it is a basis for self-stereotyping that creates a positive sense of "oneness" with other in-group members (Latrofa, Vaes, Pastore, & Cadinu, 2009).

### *The Present Study*

In the United Kingdom there exists a network of mental health support groups designed to provide individuals who have mental health problems with opportunities for social support and positive social interaction. Such groups also provide an opportunity for individuals to identify with groups whose members share mental health problems. To test the above ideas, the present research used these groups to examine the relationships between identification with a stigmatized group and the adoption of coping strategies that should have positive implications for self-esteem.

To this end, individuals who were attending mental health support groups completed questionnaires designed to measure (1) support group identification, (2) the adoption of particular coping strategies, and (3) self-esteem. On the basis of the arguments above, it was predicted that, to the extent that individuals with mental health problems identified with such groups, they would be likely to provide each other with social support that (1) increases their resistance to the stigma of mental illness and (2) reduces their endorsement of negative in-group stereotypes (H1; see also Luhtanen, 2003; Major & O'Brien, 2005). In line with Branscombe et al.'s (1999) rejection-identification model, these processes were in turn predicted to increase group members' self-esteem (H2).

## Method

### *Participants*

Participants were 73 members of mental health support groups (34 men, 39 women) in the southwest of England. Participants were recruited at regular informal drop-in sessions organized by the support groups over a 12-month period. Their ages ranged from 18 to 73 years, with a mean age of 45. Of the 71 participants responding to the question about mental illness diagnosis, 65 people reported that they had received a formal clinical diagnosis. These included anxiety, bipolar disorder, borderline personality disorder, depression, obsessive-compulsive disorder, psychosis, and schizophrenia.

### *Measures and Procedure*

After participants gave their informed consent to take part in the study, they completed the research questionnaire. In addition to relevant demographic information, this contained measures of (1) group identification (10 items,  $\alpha = .81$ ; typical item "I am a person who sees myself as belonging to [name of support group]"); (2) self-esteem (Rosenberg, 1965) (10 items,  $\alpha = .88$ ; typical item "At times I think I am no good at all"); (3) stereotype rejection (7 items,  $\alpha = .73$ : "Mentally ill people tend to be violent"; "Mentally ill people shouldn't get married"; "People with mental illness cannot live a good, rewarding life"; "People can tell that I have a mental illness by the way I look"; "Because I have a mental illness, I need others to make most decisions for me"; "I can't contribute anything to society because I have a mental illness"; "Stereotypes about the mentally ill apply to me" (all reverse-scored); (4) stigma resistance (5 items,  $\alpha = .51$ : "People with mental illness make important contributions to society"; "I feel comfortable being seen in public with an obviously mentally ill person"; "Living with mental illness has made me a tough survivor"; "In general, I am able to live my life the way I want to"; "I can have a good, fulfilling life, despite my mental illness"; and (5) perceived social support (Zimet, Dahlem, Zimet, & Farley, 1988; 12 items,  $\alpha = .88$ ); comprising three subscales (1) support from family (4 items,  $\alpha = .88$ ; typical item "My family really tries to help me"); (2) support from friends (4 items,  $\alpha = .89$ ; typical item "I can count on my friends when things go wrong"); and (3) support from others (4 items,  $\alpha = .96$ ; typical item "There is a special person who is around when I am in need."). Following the procedure adopted in other studies, a measure of "external social support" (representing the perceived level of social support individuals received from people other than their family) was created by subtracting the support from family subscale score from the sum of the support from friends and support from others subscale score.

Participants responded to all items using 5-point Likert-type scales with appropriately labeled end points, 1 (*strongly disagree*) to 5 (*strongly agree*). After completing the questionnaire, they were debriefed and thanked for their participation.

## Results

### *Missing Data and Screening*

There were 88 instances of missing data (<1.5% of responses), with no more than three missing values on each item. Missing data were substituted with the median value on that item. Assumptions of normality were tested and satisfied.

### *Analytic Strategy*

A first phase of analysis examined the simple correlations between the various measures administered in the study. These relationships were then analyzed by means of structural equation modeling. The theoretical model incorporated hypotheses that individual's level of mental health support group identification would predict the extent to which they resisted stigma associated with mental illness, rejected stereotypes of mental illness, and reported receiving external social support (H1), and that these factors would in turn predict self-esteem (H2).

### *Bivariate Correlations*

As predicted, and as can be seen from Table 1, group identification was significantly correlated with stereotype rejection, stigma resistance, and perceived external social support ( $r$ 's = .34, .32, .31, respectively; all  $p$ 's < .05). Also as predicted, these three coping dynamics were in turn each positively correlated with

**Table 1.** Means, Standard Deviations, and Correlations between Variables

	Mean	<i>SD</i>	Stereotype Rejection	Stigma Resistance	External Social Support	Self-esteem
Group identification	4.42	.54	.34**	.32**	.31**	-.01
Stereotype rejection	3.84	.71		.23*	.17	.33**
Stigma resistance	3.58	.70			.33**	.32**
External social support	4.38	1.95				.27*
Self-esteem	2.96	.88				

*Note.*  $N = 73$ ; \* $p < .05$ , \*\* $p < .01$  (two-tailed).

self-esteem ( $r$ 's = .33, .32, .27, respectively, all  $p$ 's < .05). In addition, stigma resistance was significantly correlated with both stereotype rejection and external social support ( $r$ 's = .23, .33, respectively, both  $p$ 's < .05). Interestingly, though, the simple correlation between group identification and self-esteem was very close to zero ( $r = -.01, p = .95$ ).

### *Structural Equation Modeling*

The fit of the data to the theoretically predicted model of relationships between variables was analyzed using structural equation modeling (EQS Version 6.1 for Windows; Bentler, 1995). The models generated are conventionally evaluated for statistical significance using the chi-square Goodness-of-Fit Index. A nonsignificant chi-square suggests that the model fits the data. Other Goodness-of-Fit indices that are not as dependent on sample size provide further information regarding the fit of a model. Commonly used indices include the Comparative Fit Index and the Bentler–Bonnett Normed Fit Index (see Bentler & Bonnett, 1980). These indices range from 0 to 1, with values exceeding .90 indicating a good fit. We also report the root mean square error of approximation (RMSEA; see Steiger, 1990), which is based on the proportion of variance not explained in the model. Values above .10 indicate poor fit, and values below .05 excellent fit to the data. In addition to fit indices, the adequacy of models can be determined by evaluating the statistical significance of hypothesized relationships.

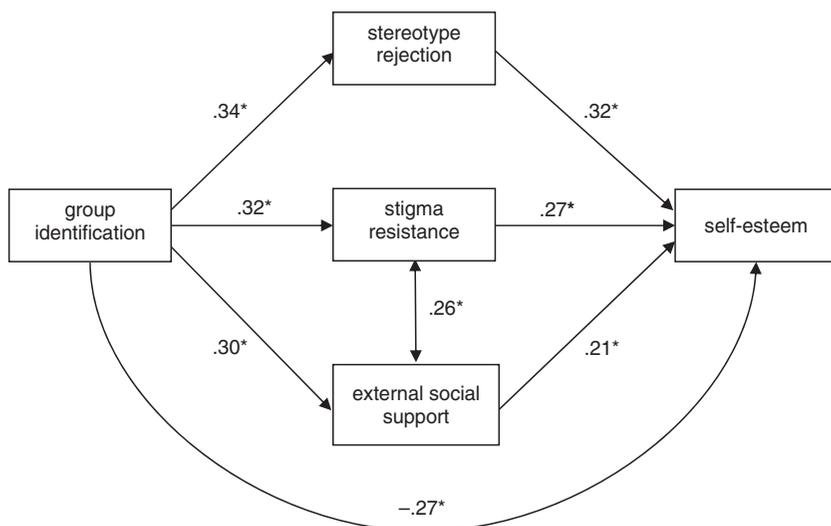
Our analysis began by testing a null model, where all parameters were set to zero. The null-model tests the assumption that no covariation exists among the variables that make up the model and provides a baseline to compare the theoretical model against. As anticipated, the null model did not fit the data well, with a highly significant chi-square indicating a significant difference between the observed and estimated covariance matrices,  $\chi^2(10) = 50.78, p < .001$ .

The hypothesized model was then tested by examining whether the more individuals with mental health problems identify with their support group the more they perceive themselves as receiving external social support (i.e., from others apart from their family) and resist stigma and reject stereotypes associated with mental illness (H1) and whether to the extent that these aspects of coping are in place individuals report higher self-esteem (H2). This model was found to fit the data better than the null model. However, the chi-square statistic still suggested a significant difference between the observed and estimated covariance matrices,  $\chi^2(4) = 11.54, p < .05$ .

There are two common techniques for identifying how the fit of a model can be improved (Ullman, 1996). These include inspecting the standardized residual matrix for highly correlated error terms and then allowing these to correlate in the model. In addition, a Lagrange multiplier test can be conducted to assess whether removing or adding parameters to the model improves model fit. From

inspection of the standardized residual matrix a high proportion of unexplained variance remained between relative social support and stigma resistance ( $r = .23$ ). Accordingly, it was decided to allow the disturbances of these variables to covary, as this disturbance is unlikely to be explained by variations in group identification. Furthermore, the Lagrange multiplier test indicated that one additional path—a direct relation between group identification and self-esteem—could be added to the model and provide a significant improvement in fit,  $\chi^2(1) = 5.28, p < .05$ . These two amendments to the hypothesized model produced a good fit,  $\chi^2(2) = 1.46, p = .48$ . The amended model is displayed in Figure 1. Goodness-of-Fit indices, reported in Table 2, also indicate a good match between the observed and estimated covariance matrices. All of the estimated parameters were reliable, and the direction of relationships was consistent with the hypothesized model.

Comparing this model to others with plausible alternative causal sequences it is clearly superior. When testing an alternative model (Model A in Table 2) in which self-esteem predicts identification, which in turn predicts external support/stereotype rejection/stigma resistance (also modeling the covariance between support and stigma resistance, as above), fit is significantly poorer compared to the initial and improved theoretical model,  $\chi^2(5) = 21.99, p < .001$ . Adding the direct effects between self-esteem and support, stereotype rejection, and stigma resistance significantly improves fit, but crucially this reduces the path from self-esteem to identification to 0.01, *ns*—indicating that this causal sequence does not



Note.  $*p < .05$ .

Fig. 1. Structural equation solution for the amended social identity based coping model.

**Table 2.** Goodness-of-Fit Measures for the Models Tested

	$\chi^2$	<i>Df</i>	<i>p</i>	CFI	BBNFI	RMSEA
Null model	50.78	10	<.001	<.001	<.001	.24
Theoretical model	11.54	4	.02	.82	.77	.16
Amended theoretical model	1.46	2	.48	1.00	.97	.00
Alternative theoretical Model A	21.99	5	<.001	.58	.57	.22
Alternative theoretical Model B	27.08	5	<.001	.46	.47	.25
Alternative theoretical Model C	25.25	5	<.001	.50	.50	.24

*Note.* *N* for chi-square is 73. CFI = Comparative Fit Index; BBNFI = Bentler–Bonnett Normed Fit Index; RMSEA = root mean square error of approximation.

adequately describe the data. A further alternative model (Model B) in which external support/stereotype rejection/stigma resistance predict self-esteem, and self-esteem predicts identification fits even more poorly,  $\chi^2(5) = 27.08, p < .001$ . And the model with all the direct effects included also fits less well than the best theoretical model,  $\chi^2(2) = 4.74, p = .07, RMSEA = .14$ . A final alternative model (Model C) which is similar to Model B but which reverses the final two variables so that identification leads to self-esteem fits almost equally badly,  $\chi^2(5) = 25.25, p < .001$ . Here, too, adding the direct effects does still not produce very good fit,  $\chi^2(2) = 4.72, p = .09, RMSEA = .14$ . In sum, all alternative models fit less well than the amended theoretical model presented in Figure 1. This fact, together with its consistency with previous research (notably Branscombe et al., 1999; Latrofa et al., 2009) increases our confidence in the validity of this model.

## Discussion

Consistent with H1, identification with a mental health support group predicted increased resistance to the stigma associated with mental illness, rejection of mental illness stereotypes, and increased perceived social support from nonfamily friends and others. Consistent with H2, individuals' external social support, stigma resistance, and rejection of stereotypes of mental illness also predicted enhanced self-esteem. These findings are consistent with principles derived from a social identity approach to health (e.g., Branscombe et al., 1999; Haslam et al., 2005; Haslam, Jetten, Postmes, & Haslam, 2009). Among other things, this approach suggests that social identification (in this case with a mental health support group) promotes strategies that increase individuals' ability to challenge (and thereby cope with) the stigma of illness and thereby has positive implications for self-esteem.

However, in addition to support for these hypotheses, the model suggested by our data points to the importance of a further parameter. For group identification also directly predicted lower levels of self-esteem. Intriguingly, this finding

suggests that social identification with a stigmatized group has, simultaneously, both direct negative and indirect positive consequences for self-esteem. More specifically, the optimal data model (Figure 1) suggests that identification with a stigmatized group can have negative implications for self-esteem (in ways suggested by McCoy & Major, 2003) but that these are suppressed because such identification also serves as a basis for collective coping strategies (i.e., rejection of stigma, rejection of stereotypes, provision of social support) that protect individuals from the negative implications of their group membership.

As an aside, it is worth noting that with suppression effects, as with mediation in general, there is always the possibility that sampling fluctuations or measurement error contribute to spurious effects (although these are unlikely to be statistically significant; Shrout & Bolger, 2002, p. 432). In the case of suppression, this is referred to as empirical suppression. If this occurs, then the constellation of associations between independent variable, dependent variable, and mediator fluctuates randomly in such a way that a pattern of suppression is revealed. In this case, we show evidence of suppression by conceptually related but relatively independent mediators. This allows us to test for suppression with each mediator separately. Indeed, there was evidence of (near) significant suppression for all variables independently: for stereotype rejection, Sobel's  $Z = 2.18$ ,  $p = .03$ ; stigma resistance,  $Z = 2.09$ ,  $p = .04$ ; social support,  $Z = 1.84$ ,  $p = .07$ . This increases confidence that the combined suppression effect observed in the structural equation model is robust and nonspurious.

In the first instance, then, the present results are consistent with symbolic interactionist perspectives that suggest that people's sense of self is likely to be structured by the views that others have of them (Gergen, 1977; Mead, 1934). To the extent that a group is stigmatized in society, it is therefore the case that membership of that group will tend to have negative implications for a person's self-esteem (Bourguignon, Seron, Yzerbyt, & Herman, 2006). At the same time, though, while membership of stigmatized groups can threaten self-esteem, the present data also suggest that the group itself can be a means for coping with, and suppressing, this threat. Evidence that this is the case fits with social identity models of stress resistance (e.g., Haslam & Reicher, 2006) in showing that identification with a support group can protect individuals with mental health problems from the stigma of mental illness by providing them with a number of coping strategies. In particular, as Branscombe et al. (1999) suggest, the shared identity of members of stigmatized groups provides a basis for receiving social support and engaging in collective action to resist the perceived injustice of discrimination and prejudice (see also Haslam et al., 2005). In this regard, the present study supports aspects of the rejection-identification model in identifying a clear relationship between social support and other coping strategies and self-esteem. Nevertheless, whereas in the rejection-identification model these processes serve to elevate an otherwise weak relationship between social identity and self-esteem, in the

present case they serve to suppress an otherwise negative relationship between these variables.

For this reason, the present results suggest that it may be too simplistic to conclude that in-group identification only ever has positive consequences for self-esteem. For, in the mental health context at least, controlling for the positive consequences of group identification reveals an underlying negative association between identification and self-esteem—so that the more individuals identify with their mental health support group, the worse they feel about themselves. This makes good sense we would suggest, because if all that identification with a stigmatized group offers a person is a stronger association with a devalued identity, then this is likely to compromise rather than enhance self-esteem in ways anticipated by a social constructionist perspective (Gergen, 1977; Mead, 1934). Nevertheless, it appears that this negative association can be counteracted through the dynamics of group membership itself. For just as association with a devalued group brings with it stigma that threatens members' self-esteem, so too that association provides a basis for resources that can be marshaled to collectively resist that stigma and its implications for perceived self-worth (Haslam & Reicher, 2006; Reynolds et al., 2000; see also Chaudoir & Quinn, this issue).

### *Policy Implications*

Consistent with previous research, the results of the present study suggest that support groups may offer an alternative (or at the very least a helpful adjunct) to traditional drug and therapeutic interventions in reducing the impact of mental health problems. This is important as the incidence of mental illness is projected to continue to increase, so that depression alone will rise from the fourth leading contributor to the global burden of disease to the second by 2020 (WHO, 2006). Furthermore, many traditional drug and therapeutic interventions are very costly, and have limited efficacy (e.g., Moncrieff, 2002). They are also disempowering to service users, making them more dependent on others and reducing their sense of control over their lives (Fitzsimons & Fuller, 2002). For all these reasons community-based support groups appear to offer a realistic and cost-effective solution to traditional approaches and to have the potential to support and empower large numbers of people and provide them with a greater sense of control over their lives. Such a conclusion is clearly consonant with the general goals of community psychology, which aims to overcome the individualistic bias of psychology by exploring the potential for creative forms of collective empowerment in traditionally disempowered groups (Orford, 1992).

At the same time, though, the present findings suggest that some caution is needed, lest it be thought that the very existence of support groups itself provides a path to enhanced psychological outcomes. For the present data suggest that if (or when) identification with stigmatized groups does not increase access to

social support and stigma-resistance strategies, then it can actually be associated with negative outcomes (in the form of reduced self-esteem). Accordingly, across our sample as a whole the association between support group identification and self-esteem was close to zero.

### *Limitations and Future Research*

Although key findings of this study were consistent with previous theorizing, it remains the case that further research is needed to explore the causal sequence of relationships between the variables identified here. Not least, this is because alternative causal pathways between these variables are both possible and plausible. In particular, group identification may moderate the effects of stigma on relevant outcomes in ways that the design of the present study was ill suited to reveal (Hansen & Sassenberg, 2006; McCoy & Major, 2003).

To address such issues, future research could involve experimentally manipulating levels of group identification and also use quasi-experimental designs that include control groups comprising individuals with mental health problems who are not members of support groups (e.g., see Haslam et al., 2010). It would also be helpful for such work to include more direct measures of willingness to participate in collective action, not least because the present study's examination of the collective dimensions of the processes in which we were interested was limited. Relatedly too, there is scope for measures of social support to be improved to assess directly the impact of the support provided by a relevant support group (which was here only approximated by our measure of external social support).

Replication would also serve to increase confidence in the stability of the modeling solution generated here. It needs to be noted, though, that ethical, practical, and logistic difficulties meant that it took a full year to collect the present data. Accordingly, any more elaborate research program would be extremely time consuming and expensive to conduct. Having said that, there is potentially a role for smaller-scale qualitative research that could help to provide more fine-grained insight into the nuanced identity-based dynamics that are assumed to be at play here (Haslam & Reicher, 2006).

### *Conclusion*

The current research provides important insights into the implications of social identification for individuals who are members of mental health support groups. Consistent with symbolic interactionist views there was evidence of a direct association between identification with a mental health support group and with reduced self-esteem. However, as anticipated on the basis of previous work in the social identity tradition, group identification also predicted individuals' use of strategies for coping with, and resisting, the stigma of this group membership and

use of these coping strategies in turn predicted higher levels of self-esteem. The overall effect of these identity-based strategies was therefore to buffer individuals from the negative implications of their group membership.

Considered together, these findings suggest that identification with mental health support groups has both threatening and remedial effects. At the outset, the membership itself is something of a curse—after all, this is not a group that individuals are routinely proud or happy to be members of. At the same time, though, the group also serves as a basis for support and resistance, and in this it offers a path to self-enhancement and collective reempowerment. A key challenge, therefore, is to ensure that mental health support groups do more than merely confirm to those who identify with them that they are members of a problematic group that is stigmatized by others. Instead they need to ensure that they use this knowledge as a basis for practical, political activities that not only envision social and personal change but also help to bring it about.

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