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"It's Part of Who I Am, But Not Really Who I Am": Mental Illness Identity Deflection Among Those With Serious Mental Illness

A Thesis submitted in partial satisfaction
of the requirements for the degree of

Master of Arts

in

Sociology

by

Lexi Sarah Harari

September 2018

Thesis Committee:
- Dr. Sharon S. Oselin, Chairperson
- Dr. Bruce G. Link
- Dr. Jan E. Stets

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The Thesis of Lexi Sarah Harari is approved:

Committee Chairperson

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I would like to thank those on my committee—Dr. Sharon S. Oselin, Dr. Bruce G. Link, and Dr. Jan E. Stets, for the invaluable guidance they have provided through all the phases of this project. I dedicate this thesis to both my family and friends.

ABSTRACT OF THE THESIS

“It’s Part of Who I Am, But Not Really Who I Am”: Mental Illness Identity Deflection Among Those With Serious Mental Illness

by

Lexi Sarah Harari

Master of Arts, Graduate Program in Sociology
University of California, Riverside, September 2018
Dr. Sharon S. Oselin, Chairperson

Although many clinicians believe serious mental illnesses are incurable, research shows that individuals with these diagnoses undergo a complex and multidimensional recovery that often encompasses a change in self-concept and identity. Drawing on this recovery-oriented approach, some individuals diagnosed with serious mental illness undergo mental illness identity deflection (MIID)—a process whereby the label of “mentally ill” or “mental patient” is relegated to a position of lower importance in one’s overall identity (e.g., the disorder is “only part of me—it doesn’t define who I really am”). Such a process has been conceptualized as a cognitive form of resistance to the stigma attached to mental illness. I show how particular sociocultural resources one can draw upon during recovery allow MIID to become possible for individuals with serious mental illness, and what consequences it has for their overall recovery. In this qualitative study, I draw on interviews ($N = 15$) with individuals formally diagnosed with serious mental illness to examine which sociocultural resources enhance one’s recovery through the initiation and maintenance of MIID, and what effect this may have for one's recovery from serious mental illness. The findings show that the majority of interviewees engage in MIID, and the sociocultural resources that make MIID possible have positive consequences for recovery.

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Introduction

In his seminal work on stigma, Goffman (1963) concluded individuals that have been diagnosed with illnesses face a stigma that is more “deeply discrediting” than stigmas associated with the body (e.g., race) or membership in certain groups (e.g., religious). Mental illness in particular is a topic that receives substantial social scrutiny, labeling those affected and conferring stigma unto them. In the time since Goffman reached this conclusion, a large literature has addressed the adverse outcomes associated with stigma for those diagnosed with mental illness, such as decreased self-esteem, lowered empowerment/mastery, reduced self-efficacy, hopelessness, and diminished overall quality of life (for a review, see Livingston and Boyd 2010). Recently, increasing amounts of scholarly attention is devoted to how affected individuals *resist* such stigma. Research illustrates the myriad ways in which individuals resist stigma, including educating others about mental illness, withdrawing from social interactions where discrimination/prejudice may be present, and challenging negative stereotypes (Link et al. 1989, 2002; Thoits 2011).

One such form of stigma resistance overlooked in the literature is mental illness identity deflection (MIID). MIID is a *cognitive* form of resistance to stigma attached to mental illness whereby an individual “rejects, rebuffs, or refutes the idea that one has a mental disorder or that one holds the identity of a ‘mental patient’” (Thoits 2016: 135; Thoits 2011). It is important to note, though, that although individuals may believe or say “I am not mentally ill” or “I’m not like other mentally ill people,” they are doing this in the face of being formally diagnosed and/or having undergone treatment for a mental illness. Put another way,

> "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/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" (Thoits 2011: 11-12).

Investigating MIID is especially important given its neglect in the stigma resistance literature, despite evidence suggesting a large number of individuals with mental illness engage in it in some capacity (Estroff et al. 1991; Link et al. 2002; Ritsher and Lucksted 2000; Thoits 2016).

Conceptualizations of MIID differ according to contrasting theoretical paradigms of mental illness. The more sociological approach, modified labeling theory (MLT), conceptualizes MIID as an effective method through which to resist the harsh stigma of mental illness, leading to positive outcomes for the individual, such as increased self-esteem (Link et al. 1989). Alternatively, psychiatric approaches to mental illness view MIID as a lack of "insight" into one's mental illness. Insight, then, refers to the awareness of one's symptoms, and the ability to appropriately attribute those symptoms to one's diagnosis (Amador et al. 1993). Lacking such insight, or engaging in MIID, constitutes a harmful denial of one's diagnosis that should have adverse consequences for recovery (Amador and Strauss 1993; Gove 1970, 1975; Gove and Fain 1973). Research investigating the link between MIID and its outcomes for individuals with mental illness is quite mixed, leading to inconsistent and sometimes contradictory results, suggesting the need for additional studies focusing on MIID and its antecedents and consequences.

Although the psychiatric approach claims that MIID would be counterintuitive to recovery from mental illness, dominant mental health recovery paradigms suggest MIID might actually play an important role in recovery. Although many serious mental illnesses (e.g., schizophrenia) are considered incurable by most clinicians (McGorry 1992), individuals diagnosed with these disorders *can* and *do* recover (Andresen, Oades, and Caputi 2003; Kruger 2000). Several studies note that recovery from serious mental illness is a "complex and multidimensional" process that involves a change in self-concept and identity (Andresen, Oades, and Caputi 2003; Markowitz 2001: 64; Spaniol, Gagne, and Koehler 1999), which is quite similar to the conceptualization of MIID. According to dominant mental health recovery paradigms that include identity transformation as an important component of recovery, it could be that MIID is an integral component of overall recovery.

Certain sociocultural resources that have been emphasized in the mental health recovery literature may be a useful lens through which to adjudicate the two opposing conceptualizations of MIID—modified labeling theory and the psychiatric approach. These resources include but are not limited to a positive self-concept, a living environment that promotes recovery, and recovery-oriented services and resources (William and Granfield 2004, 2008). If MIID is an important part of recovery like dominant mental health paradigms suggest, logic follows that particular recovery-oriented sociocultural resources may play an important role in one's ability to engage in MIID.

Through a qualitative investigation of 15 individuals formally diagnosed with a serious mental illness, I intend to (1) delineate which recovery-oriented sociocultural resources influence the process of MIID, and (2) explore whether these sociocultural resources influence overall recovery through MIID after being formally diagnosed with a mental illness. The primary purpose of this investigation is to discover which sociocultural resources, if any, help individuals with mental illness engage in this unique form of stigma resistance, and what impact this may have on their overall recovery from mental illness. In the following section, a more thorough discussion of the extant literature on MIID will be articulated. Although this literature is quite limited, MIID will be discussed within its two opposing conceptualizations, as well as its hypothesized antecedents and consequences.

Mental Illness Identity Deflection and Recovery from Mental Illness

To date, there are few studies that have explicitly examined MIID as a form of stigma resistance. Howard (2008) suggests this is largely due to sociology's lack of attention to the shedding of labels in favor of examining the acquisition of labels. Estroff (1981) notes this may be because there are few visible markers that indicate when someone has undergone significant strides in recovering from mental health issues, but many visible markers that indicate when someone acquires the disorder label (e.g., being hospitalized, receiving a formal diagnosis).

Still, there are notable exceptions in the stigma resistance literature that have investigated MIID. It was first explicitly examined as a form of stigma resistance with Thoits' (2011) important theoretical piece on the antecedents and forms of MIID. Because of the complexity inherent in a cognitive form of stigma resistance, Thoits (2011) contends that are three different ways in which MIID may manifest itself in individuals diagnosed with and/or treated for mental illness. The various ways in which MIID presents itself is as follows: 1) Affected individuals acknowledge and emphasize an obvious incongruence between negative stereotypical perceptions of symptoms and their own behavior—"I'm not like that," "I'm not as bad as the others"; 2) Affected individuals relegate the mental illness identity to a place of lesser importance when compared to other identities—"My mental illness doesn't define me"; 3) Affected individuals identify with less stigmatized and more socially acceptable mental health conditions (e.g., stress) rather than their official diagnosis—"I don't have schizophrenia, I merely have stress/anxiety/depression."

These manifestations of MIID, particularly the first two aforementioned methods which Thoits (2011) described, closely parallel what Snow and Anderson (1997) termed associational distancing. Because one's identity is partially shaped by others' identities who fall in the same group, those with stigmatized identities use this as a method in which to cognitively distance themselves from stigmatized others (Snow and Anderson 1997). By drawing a distinction between oneself and negatively evaluated others, self-worth and dignity can be protected and maintained in the face of stigma. While Snow and Anderson (1997) found this was frequent among those experiencing homelessness, qualitative research has highlighted how other stigmatized groups engage in associational distancing as well. For example, Barton's (2007) work shows how exotic dancers engage in a process of "othering" fellow dancers to cope with the negative stereotypes attached to their profession. Similarly, Oselin's (2018) research illustrates how street-based male sex workers use associational distancing to differentiate themselves from similar others.

Theoretical Frameworks

As mentioned earlier, conceptualizations of MIID differ according to various theoretical paradigms of mental illness. The more sociological approach, modified labeling theory (MLT), conceptualizes MIID as an effective method in which to resist the harsh stigma of mental illness, leading to positive outcomes for the individual, such as increased self-esteem (Link et al. 1989). The departure point for MLT is the awareness of widespread societal beliefs, attitudes, and stereotypes regarding mental illness. Indeed, seminal works on the stereotypes of mental illness (e.g., Nunnally 1961) find that popular conceptions of serious mental illness, particularly schizophrenia, include ideas of such people being "dangerous" and "unpredictable." Many studies since then corroborate these findings, indicating that these negative stereotypes of mental illness persist (Corrigan et al. 2000; Link et al. 1999; Pescosolido et al. 1999).

According to MLT, when an individual is formally diagnosed with or treated for a mental illness, these negative beliefs, attitudes, and stereotypes become personally relevant, and therefore constitute a threat to one's value and worth. However, those diagnosed with mental illness are not powerless victims to these negative perceptions; rather, they are agentic and often resist stigma in various ways. Although Link *et al*. (1989) articulated three ways in which individuals resist (secrecy, or what Goffman [1963] called "passing," withdrawal from society or social situations where stigma/discrimination might be present, and educating others), MIID may be conceptualized as an additional way in which individuals can express agency in resisting mental illness stigma (Thoits 2011, 2016; Thoits and Link 2016). Because stigma is considered a threat, logic follows that MIID, as a form of stigma resistance, may buffer against some of the negative outcomes associated with the stigmatization of mental illness, such as decreased self-esteem (Livingston and Boyd 2010). Several studies in the stigma resistance literature indicate that a large number of individuals diagnosed with mental illness do engage in MIID in various capacities (Estroff et al. 1991; Link et al. 2002; Ritsher and Lucksted 2000; Thoits 2016).

In stark opposition to MLT, psychiatric approaches to mental illness view MIID as a lack of "insight" into one's mental illness, or in other words, a harmful denial of one's diagnosis that should have adverse consequences for recovery (Amador and Strauss

2000; Gove 1970, 1975; Gove and Fain 1973). Thus, according to this perspective, MIID is counterproductive to one's recovery from mental illness. Psychiatric theories tend to downplay the significance of the label of mental illness and its accompanying stigma, viewing it as largely inconsequential for affected individuals and their recovery (Gove 1980, 1982). Indeed, scholars that favor psychiatric theories contend accepting one's diagnosis should, theoretically, lead to the receipt of treatment and the necessary resources to initiate and maintain recovery (Gove and Fain 1973; Linn 1963).

According to this psychiatric perspective, if one were to engage in MIID, one would be denying the reality of their mental illness and preventing themselves from getting the treatment they desperately need. The inevitable result is diagnosed individuals who embrace their diagnosis are given more credibility as someone who has "insight" into their mental illness, and they are thought to have a positive prognosis (Hasson-Ohayon et al. 2009; McEvoy 2004). Thus, the two conceptualizations of MIID put forward by MLT and the psychiatric perspective strongly oppose one another. In other words, its current framing in the two literatures indicates that one cannot use MIID as a stigma resistance strategy while also possessing insight into their mental illness. Rejecting one's diagnosis, or even making it a less salient feature of one's identity, is inherently at odds with acknowledging and agreeing with one's diagnosis while identifying symptoms.

The present study attempts to adjudicate these dichotomous theoretical perspectives—what role does stigma resistance, specifically MIID, play in recovery from mental illness? What helps individuals to engage in MIID, and what are the potential outcomes of this form of stigma resistance for recovery?

Predictors of MIID

Thoits (2011) delineated five conditions in which MIID is most likely to occur: 1) having past experience with stigma resistance, 2) having past familiarity with mental illness in family and friends, 3) having a short-lived, mild, manageable and/or "recoverable" diagnosis, 4) possessing high levels of psychosocial coping resources to help manage challenging emotional- and problem-oriented conflicts, and 5) having multiple role-identities. Thoits (2016), in an empirical test of these conditions as well as MIID's consequences, found strong support for the third and fifth conditions as predictors of MIID. That is, individuals with mild or moderate mental illnesses accompanied by low functional impairment were more likely to engage in MIID when compared to individuals with more serious disorders with high functional impairment. A similar finding indicated that those who had recently or ever undergone treatment for mental illness were less likely to report engaging in MIID (Thoits 1985, 2016). Additionally, individuals with multiple role-identities (e.g., husband or wife, employed person) were far more likely to engage in MIID, suggesting that their more conventional role-identities formed a more integral part of their identity than their diagnosis.

Consequences of MIID

The two opposing conceptualizations of MIID posit widely divergent claims about its consequences. Indeed, there is some indication that MIID is associated with positive outcomes, in line with modified labeling theory's conceptualization. For instance, MIID has been linked to lower distress, higher positive affect and self-esteem, as well as higher perceived quality of life when compared to individuals who accepted the mental illness identity or used other forms of stigma resistance (Firmin et al. 2016; Thoits 2016; Thoits and Link 2016). However, the findings about MIID and its associated outcomes for recovery remain mixed. While some studies do find positive associations between MIID and important recovery outcomes (e.g., self-esteem), other studies find no evidence of this association (Ritsher and Phelan 2004), and still other studies conclude that MIID has both positive and negative outcomes. For instance, Howard (2006, 2008) finds that while some "delabelers" experience an "identity void" where a major source of identity becomes forfeited, some who choose to remain identified with their mental illness used the label as a way to make sense of their symptoms.

Ultimately, the inconsistency of these findings points to a need for additional research on whether MIID is associated with positive or negative consequences for recovery, and the conditions that make MIID possible. Additionally, several limitations about the extant literature on MIID should be noted. First, although Thoits' (2011) theoretical work on the antecedents of MIID is important, her call for future research to empirically test her claims has gone largely unanswered. There is still a glaring omission in the stigma resistance literature of MIID, and consequently, we know little of whether MIID is harmful or beneficial for recovery, and what sociocultural conditions make MIID more or less likely to occur.

Second, the few studies that do examine MIID are limited in a number of ways. For instance, two studies that look at how individuals "delabel" and dissociate with their diagnosis use samples consisting only of individuals who have *formerly* self-identified as someone with a mental illness (Howard 2006, 2008). Although these studies provide important insights into what delabeling may have been like for these persons, the retrospective nature of the study provides little information regarding conditions that made it more or less likely to initiate the delabeling process. Additionally, these studies do not tap into the experiences of individuals who still identify with a diagnosis but deflect the mental illness identity in varying degrees, or those who have been formally diagnosed by a medical health professional. Thus, these studies miss a significant component of the labeling process—that is, receiving an official label from an authoritative figure (e.g., psychiatrist).

Thoits' (1985, 2011, 2016; Thoits and Link 2016) theoretical and empirical works are also invaluably important in increasing our understanding of MIID. However, in her empirical test of her own theoretical propositions, her quantitative study had an extremely limited measure of MIID as the (dis)agreement of having an emotional or mental "disability," which could be interpreted by respondents quite differently than a mental illness. And because her study did not include those diagnosed with the schizophrenia spectrum disorders, it is difficult to test her hypothesis that those with more serious mental illnesses are less likely to engage in MIID (Thoits 2016), leaving this claim largely unsubstantiated.

I argue that particular recovery-oriented sociocultural resources constitute a uniquely suitable method in which to investigate MIID. Since these sociocultural resources have been emphasized as particularly important for recovery (Jacobsen and Greenley 2001; Tew 2013, White and Cloud 2004, 2008), it is plausible that they play a significant role in the ability to engage in MIID, and stigma resistance strategies overall. Specifically, it should be those sociocultural resources that directly affect one's degree of association with mental illness that impacts their ability to engage in MIID. For instance, particular aspects of what Cloud and Granfield (2004, 2008) call "recovery capital" are hypothesized to be especially important for one's ability to use MIID as a form of stigma resistance since it pertains to how individuals see themselves in relation to larger society (e.g., a positive self-concept). Possessing a positive self-concept, for example, would likely decrease one's association with the stereotypes attached to serious mental illness, thereby making MIID a viable option to resist the stigma attached to one's diagnosis.

Therefore, it is important to identify any recovery-oriented sociocultural factors that promote MIID and what this interaction means for one's recovery from serious mental illness. Although serious mental illnesses are often considered incurable, there is evidence that individuals with these diagnoses make great strides in recovery and are able to live fulfilling lives (Kruger 2000). Additionally, MIID, as a process of identity formation and change, might hold significance for recovery from serious mental illness, which "[involves] negotiating major changes and transitions in relation to 'finding a new place in the world'" (Tew 2013: 361). This suggests that certain sociocultural resources can play a vital role in influencing identity through the MIID process. If this is the case, what resources contribute to overall recovery, and what role does MIID play?

Methods

Design

The aforementioned limitations point to very limited knowledge on how individuals diagnosed with (serious) mental illness engage in MIID. Theoretical and quantitative studies (and even the limited qualitative research, due to limited samples and operationalizations of mental illness) have been restricted in the information they can provide. Using in-depth interviews can help to overcome these shortcomings by examining how individuals with (serious) mental illness who use MIID interpret their diagnosis, the diagnostic label, and the stigma attached to mental illness; the myriad ways in which MIID manifests itself from individual to individual; what factors make MIID more likely to occur; and what role MIID plays in overall recovery from mental illness.

To overcome previous limitations in the literature, the present study employs a cross-sectional design with data collected through interviews with 15 individuals that have been formally diagnosed with a mental illness. All interviews were conducted with individuals who are currently enrolled, or have graduated, from an 18-month in-patient residential treatment program inside a psychiatric facility. The interviews were semi-structured. Some prior studies have utilized semi-structured interviews when analyzing the lived experiences and subjectivities of people diagnosed with mental illness (Estroff et al. 1991; Howard 2006, 2008). Using semi-structured interviews versus survey or other informal methodologies offered interviewees a comfortable environment in which to share sensitive information because they were provided the opportunity to talk through relevant issues, inquire about the purpose of the study, and be debriefed after the interview concludes (Fylan 2005). Additionally, the open-ended nature of such interviews offers the participants an opportunity to reflect and focus on the components of recovery capital and stigma resistance most significant to them and their identity.

Data

The interview consisted of three primary sections after demographic questions: (1) an open-ended, generative narrative about the participant's overall experience being formally diagnosed (2) specific questions about various sociocultural resources and how these components may have influenced their cognitive belief system about their diagnosis, and (3) questions about the salience of one's diagnosis to one's identity, and an opportunity to provide any additional thoughts before the interview concluded (refer to Appendix A for the interview protocol). The bulk of the interview was designed to elicit the ways in which varying sociocultural sources may have influenced the way in which they feel about the diagnosis and their efforts to engage in MIID as a coping technique.

Research Site

Summit Center is a psychiatric in-patient residential facility for serious mental illness with 15 beds, and serves individuals, whom they call "residents," ages 18-65. At the end of the 18 month-long program, residents discharge and graduate from the facility, with the goal to move to a "lower level of care" where individuals are afforded a greater degree of independence either out in the community or a different (less intensive) facility. This happens in 75% of cases. Typically, residents discharge to one of the surrounding "Co-ops," which are less intensive treatment centers within walking distance of Summit Center. Summit Center boasts 24-hour care, where at least one nurse and one mental health rehabilitation worker are constantly “on the floor,” or working inside the facility. It is contracted by the county in which it is located, and is a licensed facility under the Department of Health Services.

Sample

The regional director of Summit Center expressed interest and support for my study. While discussing my study with the regional director and program director at Summit Center, I informed them both that I would like to examine the sociocultural factors that affect the lived experiences of individuals that have been formally diagnosed with mental illness. They were also told about the process of obtaining approval from the university’s Institutional Review Board (IRB) as well as the confidential and voluntary nature of the study. As an incentive and a method to build rapport with residents at the facility, I offered to volunteer during the months in which I conducted interviews and assist in whatever tasks may be needed around the facility. As a result, I helped staff with small activities when necessary, such as unlocking and locking doors, transporting food, and assisting in some recreational outings.

After I obtained IRB approval, residents at Summit Center were all individually offered the chance to participate in the study. All residents were told about the purpose of the study, its voluntary and confidential nature, and reminded that there will be no consequences should they choose to not participate. If the resident expressed interest in participating, I read over the informed consent form with them line by line to ensure they comprehended the purpose of the study and what would be required of them should they choose to participate. Out of 15 residents that were enrolled at the time of the study, 1 expressed interest in and agreed to participate in the study.

The sample consisted of individuals formally diagnosed with a serious mental illness. The reason for the emphasis on serious mental illness is twofold. First, while Thoits (2011, 2016) contends that those with serious mental illnesses are less likely to use MIID as a viable stigma resistance strategy, her empirical work does not include those who had diagnoses of schizophrenia or schizoaffective disorder. Second, limited prior research contradicts Thoits' assumption in that a significant number of individuals, even those diagnosed with schizophrenia, do engage in MIID in some capacity (Estroff et al. 1991; Ritsher and Lucksted 2000). This tension in the literature suggests the need for clarification on whether such individuals can use MIID as a way to resist stigma.

As defined by the 1992 Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (Public Law No. 102-321), a serious mental illness is a condition that affects

> "persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specific within DSM-IV (APA 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" (Substance Abuse and Mental Health Services Administration 2013: 11).

Disorders that often meet these criteria are schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorder, bipolar I, bipolar II, borderline personality disorder, and severe anxiety and eating disorders. Thus, participants in the present study had been formally diagnosed in a treatment setting with one of these mental illnesses. Although prior qualitative studies examining diagnostic labels have utilized samples where participants *self-identify* as formerly having a disorder (e.g., Howard 2006, 2008), the present study required that participants be formally diagnosed in order to assess how an authoritative labeling procedure (formal diagnosis) is managed in the MIID process.

Other criteria for eligibility include being at least 18 years of age (as the psychiatric facility does not accept anyone under 18) and English-speaking (all residents at the facility spoke English as their first or second language after Spanish). This study excluded the use of additional criteria for exclusion (e.g., race). Because the individuals are being deliberately selected for the study based on the shared characteristic of being formally diagnosed with a serious mental illness, purposive sampling was utilized and is best suited to reach stigmatized or largely inaccessible populations (Guest et al. 2006; Teddlie and Yu 2007).

The desired sample size was 15 individuals or until theoretical saturation was reached. Guest *et al*. (2006) note that while reaching theoretical saturation (the point at which no novel information is uncovered in the interview process) tends to be the "gold standard" for estimating appropriate sample sizes in qualitative research, few studies operationalize or set guidelines for reaching such a standard. The present study had a target goal of 15 individuals diagnosed with serious mental illness as a sample size based on the few notable exceptions that did provide guidelines on minimum sample sizes for qualitative studies (Creswell 2012; Guest et al. 2006; Morse 1994). Moreover, there were a small number of patients at the Center at one time, which limited the number of potential participants for this study. Because residents were largely confined to the interior of the psychiatric facility, interviews took place inside Summit Center in a private room void of other clients or staff.

Table 1 shows the characteristics of the sample. Due to the limited sample size, interviewees were predominantly male (60% male, *N* = 9) and white (60% White, 13.3% Hispanic, 13.3% Middle-Eastern/Sinhalese, 13.3% biracial). Most interviewees were currently enrolled in the in-patient program at Summit Center (73.3%, *N* = 11). Diagnoses were disclosed by interviewees at the beginning of each interview. Schizophrenia was the most common diagnosis among interviewees, with 60% of the sample (*N* = 9) being diagnosed sometime in the past 16 years. After schizophrenia, bipolar was the second most common diagnosis, with only three of the interviewees (20%) being diagnosed sometime in the past 25 years. Three respondents total (20%) had a comorbid diagnosis.

Table 1. Sample Characteristics

Pseudonym	*Age*	*Race/ethnicity*	*Diagnosis*	*Years since first diagnosis*	*Enrollment status*	*Mental illness identity deflection*
Chloe	30	African-American, White	Schizophrenia, schizoaffective	16	Graduated	Moderate
Deb	53	White	Schizophrenia	23	17.5 months in program	Moderate
Benjamin	22	White	Obsessive-compulsive and generalized anxiety disorders	5	14 months in program	Low
Isaac	55	White	Bipolar disorder	22	Graduated	High
Josephine	55	White	Bipolar disorder	2	8 months in program	High
Arlene	45	White	Bipolar, borderline personality, and alcohol use disorders	20-25	2 months in program	Moderate
Samith	54	Sinhalese	Paranoid schizophrenia	19	2 weeks in program	Moderate
Caleb	26	White	Schizophrenia	3	2 weeks in program	Moderate
Amit	29	Mexican, Middle-Eastern	Schizophrenia	6	2 months in program	High
Jason	30	White	Bipolar	19	2 weeks in program	Moderate
Luis	23	Hispanic	Schizophrenia	2	Graduated (early)	Low
Joseph	21	Hispanic	Schizophrenia	3	2 months in program	Moderate
Dina	30	Middle-Eastern	Schizophrenia	4	Graduated	High
Riley	40s	White	Schizophrenia	20	16 months in program	Low
Vicki	30s-40s	White	Schizophrenia	N/A	N/A	Moderate

Measures

The measures include the various sociocultural resources, the relationship between those resources and MIID, the process of MIID itself, and outcomes of MIID on recovery. To measure the various sociocultural resources, the interview was split into sections devoted different categories using the concept of "recovery capital" as a guide (White and Cloud 2004, 2008; refer to Appendix A for the interview protocol). Drawing on Bourdieu (1985) and Coleman (1990, 1998), recovery capital encompasses several domains that cover a wide variety of sociocultural resources: physical, human, family/social, community, and cultural capital (for a review, see Hennessey 2017). Futhermore, recovery capital has potential for use within a mental health context, and emphasizes long-term resources that promote maintenance and sustenance of recovery (Tew 2013; White and Cloud 2008). For instance, for physical capital, open-ended questions asked about the role of money, health insurance, physical environment, and the ability to successfully complete daily tasks in one's recovery. The open-ended nature of the question allowed the participant to emphasize what sociocultural resources were most important for their recovery.

Although the bulk of the interview did not explicitly ask the participants about questions regarding self-concept or identity, the open-ended nature of the questions allowed interviewees the ability to discuss all aspects of their recovery, which often included a change in identity. This corroborates prior research suggesting that recovery is multidimensional, with identity forming just one component of the overall recovery process (Markowitz 2001). Without fail, participants brought up the ways in which certain sociocultural resources assisted the MIID process. Such a set of questions follows Galletta's (2013: 45) suggestion to include both open-ended questions and questions driven by theoretical concepts.

To more accurately assess whether one is engaging in the process of MIID or has in the past, the third and final segment of the interview asks about the salience of the mental illness identity. Additionally, the first phase of the interview was designed to measure the participant's feelings about the diagnosis itself. Because the first section of the interview was broad and open-ended, it helped to promote a narrative that was primarily "determined by the participant" (Galletta 2013: 48). In doing so, the subsequent questions and probes drew from and explored the initial narrative provided. Any points that emerged during this section of the interview that needed additional clarification were returned to later in the interview when discussing resources.

Analysis

All interviews, which lasted approximately one and a half hours, were digitally audio recorded and manually transcribed in Microsoft Word. Atlas.ti, a software for qualitative data analysis, was used to code the interviews and analyze the coded transcriptions. While transcribing the interviews, emerging themes and patterns were identified, and later came to constitute the majority of thematic codes. Initially, code groups were created for each of the major forms of recovery capital—physical, human, family/social, and community capital. Subcodes were created for specific sociocultural resources that fell under each of these major categories, such as self-concept, educational/vocational experience, physical health, beliefs about recovery and mental illness, and several more. Other codes were developed for stigma resistance and mental illness identity deflection, including insight, identity deflection, mental illness identity salience, and lack of insight.

While these codes were derived from previous theory on recovery-oriented sociocultural resources and stigma resistance, some codes emerged inductively across various interviews. These included concepts not explored in much prior work that examines stigma resistance among those with mental illness, including traumatic events, specific beliefs about mental illness (e.g., the belief mental illness was widespread or uncommon), experiences with hospitalization, and more.

While analyzing the data, it became clear that most interviewees engaged in MIID as a form of stigma resistance. Some interviewees made it clear that they utilized other stigma resistance strategies as well. Specifically, 9 (60%) discussed using passing/secrecy in situations where they believed stigma or prejudice might be present, 6 (40%) described withdrawing from social situations where they believed they might be discriminated against, and three (20%) mentioned attempting to educate others about mental illness. Numerous studies have focused on how those with mental illness diagnoses employ these strategies as well as the consequences of doing so (Holmes and River 1998; Ilic et al. 2011; Link et al. 1989; Link, Mirotznik, and Cullen 1991). The present study, however, focuses specifically on MIID because of its glaring absence in the stigma resistance literature, despite the fact that individuals with a variety of diagnoses might engage in it (Estroff et al. 1991; Link et al. 2002; Ritsher and Lucksted 2000; Thoits 2016).

Results

Stigma Awareness

Before engaging in stigma resistance, one must first be aware of stigma of mental illness (Link et al. 1989). In line with modified labeling theory's (MLT) assertion that everyone has some level of awareness of the negative stereotypes surrounding mental illness (Link et al. 1989), all interviewees ($N = 15$, 100%) demonstrated some knowledge of stigma. Many residents defined stigma as "stereotypes," "negative connotations," "lies [about mental illness] that aren't true," "labelling," and "ignorance." Or, as Dina, who was diagnosed with schizophrenia, puts it, "I mean, there's nothing great about somebody being schizophrenic." Beyond that, many interviewees elaborated on specific negative stereotypes of mental illness that had potential to impact them. For instance, Isaac, who who was diagnosed with bipolar disorder, discussed how revealing one's diagnosis can trigger specific stereotypes:

> "I just feel that they'll typecast you when you talk about your condition, what you're dealing with. People won't understand. They'll judge you [as] crazy. Um… psycho. Everybody, even when people are schizophrenic, they get called crazy. They get called nuts. I've heard of it all."

Many respondents had additional ideas about stigma. A common topic of discussion during interviews was the origin of stigma, and how negative stereotypes of mental illness develop. Most respondents either thoroughly discussed or mentioned negative media portrayals of people with mental illness as a leading cause of stigma. According to many interviewees, media portrayals of those with mental illness presented such individuals in a distinctly negative light, as "violent," "crazy," and "uncontrollable." This is in line with Wahl's (1992) finding that most mass media depictions of mental illness are biased toward portraying severe psychotic disorders with wildly inaccurate information regarding its treatment, symptoms, and prognosis. This is because, according to the interviewees, media portrayals only show one side of mental illness—the untreated side—which was often considered to be the root cause of stigma. Untreated mental illness is particularly harmful, according to interviewees, because of its congruence with widespread stereotypes of the mentally ill as dangerous, violent, and unpredictable. Arlene, an interviewee with a comorbid diagnosis of bipolar, borderline personality, and alcohol and substance abuse disorders, illustrates this point:

> "Well, I think that's where the stigma comes from. Untreated mental illness can get pretty ugly. I think a lot of people self-medicate, end up doing drugs, drinking, and end up doing some crazy things and end up in jail and stuff like that for doing crazy things. And maybe if they were getting help or whatever, it wouldn't have ended up like that."

Many interviewees recognized that they had been uniquely stigmatized because of their status living in an in-patient psychiatric facility. When asked why she preferred not to discuss her living situation with others, Josephine, who had been diagnosed with bipolar disorder, emphatically stated "It's stigmatized! It's a mental health facility!" Another respondent, Amit, who was diagnosed with schizophrenia, discussed how he preferred not to tell his close friends where exactly he was living: "I would talk about where I am. But I would just say, like, instead of a mental health facility, I would say that I'm in a group home." Clearly, interviewees were privy to the stigmatized nature of living in a psychiatric facility designed to treat serious mental illness. As a result, interviewees engaged in protective strategies to keep this information unknown to others, especially close friends.

Mental Illness Identity Deflection

In response to an acute awareness of stereotypes and stigma attached to mental illness, the vast majority (80%, $N = 12$) of interviewees reported engaging in MIID in some capacity. Importantly, the interviews revealed how individuals engaged in MIID in various ways, including the three aforementioned methods in which Thoits (2011) described. However, beyond engaging in MIID in these ways, interviewees also engaged in this form of stigma resistance in varying *degrees* of strength.

For instance, the three methods put forward by Thoits (2011) could be conceptualized as *moderate* degrees of MIID. This is because her definition of MIID requires that diagnosed individuals acknowledge to themselves, at some point, the possibility that they had a mental health issue and/or needed treatment for a mental health issue. Therefore, the interviewees that did engage in this moderate degree of MIID (53.3%, $N = 8$) possessed insight into their mental illness. That is, they acknowledged their diagnosis, agreed with it, and many were able to recognize specific symptoms that were associated with their particular diagnosis. However, in line with MIID, this cognitive identification with their diagnosis was not particularly salient for these interviewees; rather, they cognitively distanced themselves from the diagnosis, and therefore the accompanying stereotypes and stigma, in much of the same ways that Thoits (2011) describes. Jason, who had been diagnosed with bipolar disorder, explained his diagnosis this way:

> "It's nothing more than a label. I do believe I have bipolar disorder, but it's also just a label. It's part of who I am. And it is a big part. I mean, that's what I have to live with. My whole personality is based around that bipolar label. Everything about me, all my personality traits, what I'm good at, what I'm not good at, kind

> of comes from that. I can't be one of those people that denies the whole title and all that. But it's just a label."

Jason's discussion makes it clear that he identifies with his diagnosis in a significant way. Jason even goes so far as to recognize that his diagnosis makes up an integral part of his personality, yet he framed the diagnosis as "nothing more than a label." Other interviewees described engaging in this moderate degree of MIID using very similar phrasing when discussing their diagnosis: "It's not the strongest identifier of myself," "It doesn't define who I am," "It's the least important part of me," "It doesn't make me who I am." What is notable about this phrasing is that interviewees still identified with their diagnosis in some way while cognitively distancing themselves from it by relegating the mental illness identity to a place of lesser importance. Perhaps this degree of MIID can best be described with a simple statement by Arlene: "It's part of who I am, but not really who I am."

The interviewees who engaged in this moderate degree of MIID, then, still demonstrated a significant amount of insight into their mental illness despite engaging in stigma resistance. Yet, a little over a quarter of the interviewees engaged in a much stronger variant of MIID where the mental illness identity was outright rejected since the time of initial diagnosis. In these cases, interviewees staunchly disagreed with their diagnosis from the time they were diagnosed (which was typically several years ago), and often vehemently opposed it. Oftentimes, these declarations took the form of interviewees discussing the mismatch between their own behaviors and the symptoms commonly associated with their particular diagnosis. Amit, who had been diagnosed with schizophrenia, acknowledged the obvious incongruence between his own level of functioning and others with the same diagnosis:

> "They took me to a hospital. And I saw people who were schizophrenic, and I was like, no, that's not me. I saw some guy, he thought he could talk to people on Wall Street or something. He would just do that hours at a time. And I was like, *that's* what schizophrenic means, that's not what I have."

Although this is quite similar to a method of MIID that Thoits (2011) describes where individuals highlight the mismatch between their own behaviors and stereotypical perceptions of mental illness, it differs from her conceptualization in an important way. That is, individuals *never* acknowledged the possibility that their diagnosis might be correct, or that they needed treatment for whatever their diagnosis was. Indeed, their opposition toward their diagnosis was often so strong that their disbelief in it extended toward *all* mental illnesses in general. For instance, Josephine, who was diagnosed with bipolar disorder two years prior to the interview, spoke emphatically:

> "I don't feel like I have bipolar. I don't believe in mental illness. I don't believe in *any* mental illness. I shouldn't even be here! I should be out sitting by a pool reading a book or something. I was quietly angry when I was diagnosed. I don't have mood swings, the symptoms just aren't accurate."

Not only did these four interviewees express distaste at living in a psychiatric facility that constantly tried to instill insight into their mental illness, but they also disagreed with the entire mental health care system in the United States, and many did not believe in the idea of "mental health" more generally. Dina, who had been diagnosed with schizophrenia four years prior to the interview, put it this way:

> "Yeah, I think [mental illness] is bullshit. Because I just think, like, the doctors here, they learn some sort of art, like, the art of psychotherapy, the art of psychiatry, or the art of psychology. And it's just putting people in one box, and it's not right. Because everybody's unique and different, and we all have our individual needs. And when you do that, it's like labeling them. It totally confines them to a smaller, smaller bucket, you know?"

Here, Dina expresses skepticism at the entire mental health care system. Notably, she strongly disagrees with the way in which diagnoses act as negative labels that rigidly categorize individuals who have diverse needs that ultimately go uncared for. This is a degree of MIID that has not yet been addressed in the literature. Not only did these interviewees strongly deflect the mental illness identity, but they disagreed with their own diagnosis and the idea of "mental health" more broadly, even in the face of being formally diagnosed and treated (often several times by different mental health professionals).

This outright rejection of one's mental illness since the time of initial diagnosis is at odds with Thoits' (2011) definition of MIID, where she states one must acknowledge the potential applicability of their diagnosis and/or treatment at one point or another. However, for these interviewees, it contains many features of her conceptualization, such as identifying with less stigmatizing mental health conditions (e.g., stress), and emphasizing the incongruence between one's own behaviors and stereotypical behaviors associated with particular diagnoses. Therefore, it could be concluded that MIID's definition should be broadened to include those individuals who explicitly engage in these particular MIID techniques to ward off stigma, but who never acknowledged that their diagnosis may be accurate or correct.

Finally, a small minority of interviewees (20%, *N* = 3) engaged in little to no MIID. Rather than discussing potential methods in which to dissociate themselves from a mental illness identity, these interviewees openly discussed their diagnosis, agreed with the diagnosis, and felt rather indifferent/neutral toward mental illness and their own recovery. Benjamin was one such interviewee:

> "I didn't feel bad about my diagnosis because I already knew. Um, if I was describing myself to someone, I'd say I have a history of depression and whatever else. I've let people know. I'm not, like, embarrassed about it. I don't think I'd be hesitant talking about [my diagnosis] to other people. If someone views me differently, I just try to be myself."

Benjamin fell into a small group of respondents who expressed identification with his diagnosis. Not only did Benjamin agree with his diagnosis, but he felt comfortable sharing this information with others because it was part of his description of who he was. Riley, who was diagnosed with schizophrenia, expressed similar indifference about his diagnosis: "My diagnosis doesn't bother me. Not at all. I've always been kind of whatever about it. If someone were to talk smack to me, I'd just ignore it. I just walk away. It's never bugged me." Thus, all interviewees fell into one of three categories in Table 2.

Table 2. Categorization of Mental Illness Identity Deflection

Degree of mental illness identity deflection	Expression
Moderate	"I'm not like other mentally ill people/patients," "My mental illness is not the most important part of me"
Strong	"I am not mentally ill," "I don't believe in mental illness or mental health"
Weak/none	"I have a mental illness"

Positive Self-Concept

Given that all interviewees demonstrated some knowledge of the stigma attached to mental illness and that the majority used MIID as a way to resist it, it is unsurprising that certain recovery-oriented resources were emphasized as being particularly conducive to MIID. While some of these resources were more internal to the individual (self-concept, positive outlook on recovery and mental illness in general, specific beliefs and values about one's diagnosis), others were more external and emanated from the interviewees' experiences in Summit Center (coping tools, living environment, resources, and social relationships).

All interviewees who engaged in a moderate degree of MIID (*N* = 8, 53.3%) possessed a positive self-concept, which was particularly important for their capability to engage in MIID. A positive self-concept typically the took the form of a high-functioning identity, where interviewees highlighted their own functional capabilities compared to less functional others with the same (or similar) diagnosis. Specifically, a positive self-concept was necessary for interviewees to use what Snow and Anderson (1987) termed "associational distancing" in their study of identity among those who were homeless, whereby stigmatized individuals attempt to construct a positive and socially valuable identity in the face of their discredited identity (in this case, of a "mentally ill" person). All interviewees except one were enrolled in either Summit Center or a neighboring mental health facility, leading to frequent contact with others who had the same or similar diagnoses. Associational distancing was used by these interviewees when emphasizing differences between themselves and others who fall in the same stigmatized category, leading to one way in which interviewees could cognitively distance themselves from the other residents in which they frequently were in contact (Snow and Anderson 1987).

Similar to how Snow and Anderson (1987: 1349) found this sort of associational distancing was most frequent among those who were "firmly rooted in [the] life-style" of homelessness, it was those interviewees who had been diagnosed at least 15 years prior who engaged in this form of MIID. Notably, a positive self-concept as a "high-functioning" individual was crucial in helping interviewees set themselves apart from other residents who were perceived to be more mentally ill than themselves. Oftentimes, this was accomplished through a comparison to other residents whom they thought had higher levels of functional impairment. Chloe, who was diagnosed with schizophrenia, put it this way:

> "I just believe I was a little bit higher-functioning than some of the people at [Summit Center]. Because, I mean, I was going to school while I was there and I was doing other activities while I was there. I mean, a lot of the stuff there was stuff I already knew. Like, I already knew how to cook. I didn't have a problem keeping my room clean. I didn't have a problem waking up and taking a shower everyday and changing my clothes. I mean, I didn't have a problem… I wasn't told everyday, 'Oh, you have to go to group [therapy], you have to do this or that.' I knew what I needed to do without being told to do it."

Here, Chloe describes herself as a "higher-functioning" individual in comparison to other residents at Summit Center, including many individuals who had the same or similar diagnoses. She emphasizes her own level of functioning by comparing it to others' inability to complete basic daily tasks and chores.

In some cases, residents emphasized a high-functioning self-concept through highlighting their own personal achievements. Deb, who was diagnosed with schizophrenia, illustrates this point:

> "But I did… one of the things I've done is, I went out and saw, um, experiences that tested me and spoke to my individual original ability. Like, my Master's degree at Towson University. I saw… what's the word… I sought self-efficacious building experiences. I took taekwondo, and I did have a few friends. And um, I actually got a Master's degree. I have marked events and milestones in my life that I sought to prove quite clearly that I think well, I do well, I am capable, and I am capable on my own. And it's obvious. I went out and found my own experiences. And proved to myself repeatedly."

Deb shows that she is able to maintain distance from the stereotypical conception of schizophrenia by highlighting her “events and milestones” that others may not have. Jason, an interviewee diagnosed with bipolar disorder, voiced similar thoughts:

> “It’s, like… I guess I’m not, like, a typical person to stay here [at Summit Center]. Because I’ve had my, I’ve had, like, everything that I’ve needed in my life before. I’ve had my apartment, I’ve been married two times, I’ve lived with other people, I’ve lived with step kids, I’ve had consistent jobs over the years. I’ve never had, like, substance abuse problems. I never really smoked. I never really had issues with alcohol. So, it’s like, my whole thing is that I’m bipolar, but I’m functional, so…”

Jason later described how staff at Summit Center also refer to him as a high-functioning resident, which makes him “feel like almost halfway between a staff and a resident,” suggesting that Jason perceives himself to be quite unlike other residents at Summit Center.

As illustrated in Jason’s closing statement above, although the respondents emphasized a high-functioning self-concept, it is important to note that they did not outright reject a mental illness identity. Chloe, Deb, Jason, and other interviewees that engaged in this type of MIID all demonstrated a significant level of insight—that is, they acknowledged and agreed with their diagnosis, and properly attributed their symptoms to their particular diagnosis.

Yet, following Snow and Anderson’s (1987) concept of associational distancing, this moderate degree of MIID still allowed interviewees to maintain significant distance from others with mental illness that are somehow worse off than them. This degree of MIID—manifested through a cognitive belief of “I’m not like the others,” “I’m much different than other mentally ill people/patients”—allows one to disengage from negative stereotypes of mental illness. In other words, because of an obvious incongruence between widespread negative stereotypes of schizophrenia and interviewees' high-functioning self-concept, interviewees are able to engage in stigma resistance (Estroff et al. 2001; Thoits 2011, 2016). For many interviewees, having a high-functioning self-concept was often related to positive attitudes about one's own recovery, as well as mental illness more generally.

Positive Outlook on Recovery and Mental Illness

For those respondents engaging in a moderate degree of MIID (8, *N* = 53.3%), maintaining optimism about their own recovery from mental illness and/or a good outlook on mental illness in general was crucial in not letting the mental illness identity becomesalient. By remaining optimistic, interviewees were able to do two important things that allowed them to distance themselves from a mental illness identity: 1) envision a future in which their respective diagnoses would no longer apply to them, and 2) describe mental illness in a way that disassociated interviewees from negative stereotypes.

First, most interviewees (*N* = 9, 60%) had a decidedly optimistic outlook on their recovery, allowing them to envision themselves as not having a mental illness sometime in the future. Importantly, this allowed respondents to relegate the mental illness identity to a place of little importance. For instance, when Deb was asked if her diagnosis of schizophrenia was a salient component of her identity, she replied,

> "It's not the strongest identifier of myself, no. Especially not the way I feel now. There is a sense of myself when I was younger and feeling very healthy. And I feel that I'm coming upon the doorstep of feeling that way again. I'm feeling like that a lot actually now. I'm getting there. I wanna be able to move easier, run easier, get

> the weight off, have the schizophrenia managed. And that's kind of the way I'm moving towards."

Some interviewees, like Caleb who was diagnosed with schizophrenia, psychosis, and substance abuse, more explicitly used their recovery as a way to distance themselves from the mental illness identity: "I try not to dwell, like, 'Oh, I'm a mentally ill addict.' I try to dwell, like, 'Hey, I'm a recovered mentally ill addict.'" Another interviewee, Amit, who strongly disagreed with his diagnosis of schizophrenia, believed he had already recovered from less severe mental health issues: "I think that If I did recover from something, it only took a week or something for it to happen. So, I feel good."

In these instances, interviewees, by either reporting they would eventually recover from mental illness or had already done so, were able to successfully distance themselves from a mental illness identity. These participants believe the mental illness identity appears to be a temporary one, and therefore cannot constitute an important part of their overall identity. This closely aligns with Howard's (2006) finding that some individuals who identify with a mental health issue in some capacity are able to anticipate a healthy life due to a positive future orientation.

Another way in which an optimistic outlook on recovery and mental illness assisted interviewees to engage in MIID was that it allowed them to compare mental illness to other conditions (e.g., physical illness) that are far less stigmatized. For instance, when asked whether his mental illness constituted an important part of his identity, Joseph, who was diagnosed with schizophrenia, replied,

> "No, it doesn't. Not at all. Because it's, it's, um… I find it to be, like, cancer kind of. Like, it, uh… it, like, when someone has cancer, it doesn't become part of you. It doesn't make you some… it's just, like, I don't know. It's not me. It's just

> something I have. Like, for example, I may have colored eyes but it doesn't make me who I am."

While Joseph compared schizophrenia to cancer, Chloe compared it to having diabetes: "It's just like any other disease. It's just like if you have diabetes. People aren't ashamed of having diabetes. It's just a disease that you have. Same thing with any mental illness. It's nothing to be ashamed of." Physical diseases might be perceived to be less stigmatized by interviewees because they are simply something you *have*, whereas a mental illness might be perceived to be as something you *are*. By comparing it to physical illnesses that interviewees perceive to be far less stigmatized than mental illness (see Weiner 1995, Weiner et al. 1989), interviewees dissociate from the highly stigmatizing nature of mental illness and its accompanying stereotypes.

As will be shown, possessing positive attitudes about recovery and mental illness in general is distinct from harboring particular values and beliefs about one's own individual diagnosis. Attitudes about recovery were more future-oriented, allowing interviewees to anticipate a bright future. In contrast, beliefs about one's own mental illness tended to focus on the current reframing of one's diagnosis that allowed interviewees to disassociate from the attached stigma and stereotypes.

Values and Beliefs About One's Own Mental Illness

Some respondents were able to engage in a moderate and strong degree of MIID (*N* = 12; 80%) by describing themselves as having less stigmatizing or discrediting mental health issues compared to whatever they were diagnosed with. While the interviewees who used a stronger variant of MIID never acknowledged the potential relevance of their diagnosis, others who engaged in a more moderate degree initially *did* agree with their diagnosis, but no longer do. Amit was one such respondent who engaged in a stronger variant of this kind of MIID:

> “Obviously, I disagree with my diagnosis. It’s just like, when I think about it, I think about when I first went to [the hospital] and they said I had schizophrenia. I didn’t believe it. I thought I just had stress and depression instead of something like that. It was always stress or depression. I had it for, like, three months or something like that.”

What is notable about such interviewees is their identification with *some* mental health issue, but not whatever mental illness they were initially diagnosed with. Rather than identifying with their diagnosis, which is typically a highly stigmatized condition such as schizophrenia, some interviewees describe their identification with less severe (and less stigmatized) issues. Most commonly, respondents describe themselves as suffering from merely stress and/or depression. Another respondent who engaged in a strong degree of MIID, Josephine, described why she disliked group therapy sessions that discussed diagnoses: “I don’t think the groups are appropriate for me because I don’t believe the diagnosis [of bipolar disorder] is correct. I just feel it’s sort of depression, definitely.”

This is conceptualized as a strong degree of MIID because it constitutes the outright rejection of whatever diagnosis one initially received. As Thoits (2011: 13) describes, rejecting the diagnosis of schizophrenia and accepting mental health issues of either depression, anxiety, or stress means identifying with a more “temporary, less serious, more understandable, and socially more acceptable response to stressful life circumstances.” By engaging in this degree of MIID, these interviewees are able to distance themselves from the intensely negative stereotypes that are applicable to schizophrenia and bipolar disorder.

Unlike these interviewees who outright rejected their diagnosis in favor of a less stigmatized and stereotyped mental health issue, some interviewees engaged in a moderate degree of MIID while still identifying with their initial diagnosis. These respondents bore similarities to Howard's (2006, 2008) "delabelers" who chose to disidentify with their diagnostic label. However, the delabelers in Howard's (2008) study chose to disidentify for reasons unrelated to stereotyping and devaluation. For instance, they felt a strong identification with a diagnostic label served as an excuse to not attempt to alter problematic behaviors/symptoms. It may be that because Howard's (2008) respondents were only self-identified as having a mental illness, the effects of stigmatization associated with a more formal diagnostic labeling process (e.g., from a psychiatrist) were not felt.

The interviewees in this study were much more concerned with being negatively stereotyped and devalued. To manage this, interviewees were able to distance themselves from popular negative perceptions of mental illness by describing their diagnosis as an issue contingent on very particular situational factors. In other words, interviewees created narratives regarding the etiologies of their diagnosis which included incredibly traumatic circumstances that triggered the mental illness. Such a narrative allowed interviewees to look back on their diagnosis as something that occurred at some distant time, allowing them to overcome it in a similar manner as the initial trauma. As a result, these interviewees no longer felt their original diagnosis applied to them. One such interviewee, Isaac, describes how experiencing the loss of his significant other triggered bipolar disorder:

> "I'm dealing with a personal issue that caused me to attempt my life. My condition isn't… I'm trying to think of the word. It's circumstantial. It's, uh… based on circumstances. What happened to me happened to me because I was dealing with a loss of somebody that I loved to the point where I just broke down and cried. I just fell apart. I drank like a fish. I popped some pills. I tried to take my life. And that's basically how I ended up dealing with what they call mental illness."

Another interviewee, Samith, described how his diagnosis of paranoid schizophrenia was a result of "many things" that occurred around the same point in time. One of these situational factors was his car breaking down, but more importantly, a traumatic incident while working as an assistant manager at a convenience store was described as the impetus for the diagnosis: "I was held up by gunpoint. One of the robbers came in, grabbed the money, and ran from the store with a pistol. It was really hard for me to go on with life. That was the situation. I got home, sat down, and then I collapsed." Immediately following this incident is when Samith was diagnosed.

Whether interviewees described their diagnosis as being contingent on either traumatic or nontraumatic situational factors, what is important to note is that they did not identify with whatever diagnosis they were originally given. Instead, their diagnosis was described as a "collapse" or a "breakdown" that could be or had already been overcome. For instance, Samith was sure to note that his diagnosis is no longer relevant because "it was a long time ago": "I know the reality, no hallucinations, no delusions. I'm a normal person. Today, I want to enjoy my life." Similarly, Isaac believes he no longer has bipolar disorder: "I don't feel that I'm bipolar. I feel that, um… I'm just depressed. I'm dealing with emotional issues due to the past, what I was going through, and that I can recover from it and never look back."

Because these interviewees described their diagnoses as being circumstantial and not something inherent within them, they were able to craft a narrative in which the diagnosis was temporary—that is, it would only last as long as the unfortunate circumstances lasted. These narratives are incompatible with the popular stereotypical notion that mental illness is a "dysfunction located within the person," a sort of internal or innate failing that the diagnosed individual should be held responsible for (Gergen and McNamee 2000). By specifying the cause of their mental illness as some traumatic exogenous factor, interviewees reframed their diagnosis merely as temporary byproducts from past circumstances.

Thus far, largely internal factors that have directly influenced MIID have been discussed, such as one's beliefs about mental illness, mental health, and individual diagnoses. In the following sections, more external sociocultural factors that appeared to impact one's ability to engage in MIID will be delineated, including coping tools, recovery-oriented resources, living environment, and social relationships.

Coping Tools

For interviewees who engaged in moderate degrees of MIID ($N = 8$, 53.3%), coping tools to help manage symptoms was a vital mechanism to make the mental illness identity less salient. This is largely because increased symptom severity or a state of being symptomatic in general led to an acute awareness that one was mentally ill. Some interviewees, such as Chloe, described this as a process of preventing symptoms, including the hallucinations and delusions that commonly accompany schizophrenia, from having power:

> "The schizophrenia is the least important part of me. But it's when I go off in my episodes, when things get really, really, bad, or if I have a panic attack. Then it shows. But I don't try to give it power. Because if I give it power, then that means the voices have more control over me than I want them to have. And I don't give [the voices] the opportunity to say, hey, this is a part of who you are and you have to deal with it. So, I use the coping tools. I do a lot of grounding techniques. I make sure that I'm in the present."

For Chloe, it was imperative she uses her coping tools, or what she calls grounding techniques, to make sure auditory hallucinations did not heighten the importance of the mentally ill identity. Her grounding techniques included counting objects in her environment, including trees, number of steps, or the number of people walking in the opposite direction. She describes this as “the one thing that really, really helps me stay focused and not focused on what the voices are telling me in my head.”

Jason expressed similar concerns about how particular symptoms, such as becoming aggressive or argumentative with others, might allow his diagnosis (bipolar disorder) to become salient.

> “I think that’s some of the psychosis going on. It’s like, just wanting to fight with people and, um… just realizing when I’m getting aggressive. If I’m getting, like, arguing with people or whatever it is, that’s definitely a bad sign for me, getting into that gray area. The danger zone. But now, I’ve learned a lot of different ways of coping. Like, one of the things I do, I would be so frustrated sometimes… I would go out to the back alley, and just scream. Shoo! Really loud. Make sure no one’s around. But it’s just like, ahhhhh [*screams*]!”

Jason’s use of coping tools, particularly what he later calls “scream therapy,” helps combat the aggressiveness he sometimes experiences as a result of bipolar disorder. By using this coping tool, the symptoms of his diagnosis become less apparent, allowing Jason to make his diagnosis a less salient feature of his identity and behavior. Other interviewees, such as Samith, insinuated that the use of coping tools (focusing on reality and positivity) led them to dissociate from a mental illness identity altogether: “At one time, I had symptoms. I had hallucinations and delusions. Now, I always try to focus on the reality and think about whatever situation I’m in. I think about what’s positive and what’s not positive.” In sum, for these interviewees, the coping tools act as buffers against the expression of symptoms that might match stereotypical perceptions of mental illness (Thoits 2011), such as auditory hallucinations associated with schizophrenia or the “flying off the handle” nature of bipolar disorder.

Recovery-Oriented Resources

While coping tools were learned over long periods of time, all (100%, N = 15) interviewees mentioned having consistent access to various recovery-oriented resources available to them whenever needed. These resources, particularly a consistent medication regimen, group memberships (church, AA/NA, etc.), group therapy sessions, and on-site nurses and psychiatrists, make the mental illness identity less salient in various ways. First, by directly alleviating symptoms, medication effectively “erases” some interviewees’ diagnoses, thereby reducing the importance of mental illness for one’s self-definition. Samith illustrated this point when he explained that his diagnosis of schizophrenia “disappeared” because he had been prescribed anti-psychotics and Cogentin, allowing him to feel “okay most of the time.”

Maintaining a strict medication regimen resulted in a complex relationship with having insight into one’s mental illness and ability to engage in MIID simultaneously. Many interviewees felt that maintaining some sense of insight into their mental illness by acknowledging and agreeing with their diagnosis was crucial for one’s recovery. This strongly aligns with the psychiatric approach to mental illness that maintains one must embrace their diagnosis in order to initiate and remain in treatment, ultimately leading to positive recovery outcomes. Yet, for these interviewees, the relationship between medication and insight was much more complex. While insight was required in order to recognize the need for a strict medication regimen, the medication was necessary in order to prevent the diagnosis from becoming a salient component of one's self-definition. Arlene, in her discussion of the importance of medication, breaks down the complexity of this process:

> "My mental illness is important in the way of, I need to take my medication and be regulated as well as I can and be spiritually maintained so that my character stays in a nice, positive range. Do you know Maslow's hierarchy of needs? Because if they're properly medicated or whatever, they jumped up the hierarchy a little bit, and that would make the mental illness not as much of an issue because your basic needs are met. That right there is going to be putting the mental illness down, it's going to be way less important, as long as it's being maintained medically."

In essence, Arlene makes the explicit connection between medication and the decreasing importance of one's diagnosis. However, by saying her "mental illness is important," she makes it clear that one must first demonstrate insight into their mental illness—that is, agree with their diagnosis and recognize associated symptoms—before one can follow a medication regimen. Jason was another interviewee who stressed the importance of medication. After describing his experience spending time in jail due to an incident related to his diagnosis of bipolar disorder, he related that his condition had improved drastically. When asked why, he responded,

> "Getting back on consistent meds. Taking Lithium every single day, because [staff at the jail] would check. They would give our meds and make you open your mouth like that and check, make sure you're taking it. If I was on my own, I would have never been taking it every single day. I skipped days. That's what I was doing, that's what was causing all of this [symptoms and manic episodes]."

Ultimately, according to Arlene, Jason, and many other interviewees, the medication will allow one's diagnosis to become "way less important." Caleb, who was managing a dual diagnosis of schizophrenia and psychosis, explains the importance of medication when asked if his diagnosis was part of his identity on an average day: “I pray to be healed from it all, and I pray that it’ll go away with my medication and stuff like that.” Chloe, who had discussed how increased symptom severity was inextricably tied to heightened mental illness identity salience, was another interviewee who described how her medication alleviates symptoms: “I start to believe the voices [auditory hallucinations] and what they’re saying when I’m off my medication. That’s the major thing.”

As another example, group therapy sessions were important for many interviewees in preventing the mental illness identity from becoming too salient. Again, this process was quite complex, and involved a significant degree of insight into one’s mental illness before making MIID a possible option as a form of stigma resistance. This is because most of the group therapy sessions were structured around attempts to foster insight in the participating residents, with topics including what to do when experiencing increased symptom severity, symptom recognition and management, and identifying triggers. Luis, who was diagnosed with schizophrenia, describes the content of these sessions quite well:

> “They teach you about a lot of aspects for stuff like depression, anxiety, schizophrenia, stuff like that. It relates to everyone in the program. Just kind of teaching us how to cope with our sickness. And how to deal with others, too. Like, how to talk to others. Like, not approaching someone in a bad way that might hurt them or trigger their symptoms.”

In other words, the group therapy sessions appear to be designed to make participants “more knowledgeable about issues about mental health,” as Chloe aptly put it. What is important about these sessions and the topics discussed therein is the way it helps interviewees engage in MIID *through fostering a sense of insight into residents' diagnoses*. Arlene, who was diagnosed with bipolar disorder, helps describe how this process occurs:

> "The more educated a person is towards their mental illness, the more they start seeing positive things as they're medicated or whatever, and getting the proper help. Then they're going to want to maintain that, learn more about it, and maybe help others learn about it. Maybe it won't be as big of an issue. Ignorance is really hard for people with mental illness. Because we don't know what's going on with you, no one else really knows what's going on with you. And how can you really get better at that point?"

Arlene explains that education about one's mental illness is linked to more positive attitudes about mental illness. This suggests that learning more about one's diagnosis might detract from a more negative and stereotypical understanding of mental illness. To Arlene, the end result is that one's diagnosis will no longer be "as big of an issue" as it once was. When asked what had helped her diagnosis of schizophrenia become less salient for her overtime, Chloe was another interviewee who explicitly referenced the various group therapy sessions she's attended in the past. Chloe had experienced multiple hospitalizations at facilities of varying quality, but she recalled the groups at Summit Center were especially helpful: "I liked the groups that they had there. It was very educational for some of the groups. I mean, it really helped me out in the time being and the help that I needed."

Living Environment that Promotes Recovery

While participants found value in many of the resources offered within Summit Center, some found the very living environment of Summit Center itself was helpful to engage in MIID. Most respondents ($N = 12$, 80%) had favorable views about their living environment in Summit Center. Respondents viewed Summit Center as a place of stability, consistency, and order. Certain mechanisms operating within allowed the environment of the facility itself to reduce the salience of the mental illness identity for these interviewees. One of these mechanisms was an environment that resembled a "home," helping interviewees feel a sense of normalcy while residing in Summit Center that starkly contrasted with more unpredictable living environments they might otherwise find themselves in (e.g., homelessness). Additionally, other resources offered within Summit Center, such as basic necessities (food, water, beds), helped these interviewees to retain a sense of being healthy and high-functioning. Jason, who said he'd "probably be homeless" if he were not admitted to Summit Center, describes it this way:

> "This place feels normal. It's solid. It's got everything you need. They take outings, they go everywhere. They go to YMCA, they go to movies, they go to the stores. Whatever they don't have here within the property, they do it out there. You have this safe haven here, all the food's provided, the nurses, the blood testing, the therapist, everything's provided here, the doctors. This place has everything."

Although the three interviewees who engaged in a strong degree of MIID felt Summit Center was a highly stigmatized place, these 12 interviewees felt that the stability afforded from the structured environment in Summit Center promoted recovery from mental illness, allowing them to feel healthy and functional. For instance, Arlene felt that Summit Center was allowing her to "manage" her comorbid diagnoses so she could rebuild previously damaged relationships with family. Similarly, Isaac, who was diagnosed with bipolar disorder, credited Summit Center with putting his life back together: "It kept me from being homeless. It got me back on my feet. It's a stable environment." Benjamin, who was diagnosed with obsessive-compulsive disorder and generalized anxiety disorder, more explicitly explains how Summit Center alleviates his symptoms:

> “I may not have realized it at first, but by now I feel like I needed to be here. It definitely helped me with, like, issues I had and being depressed and sleeping all the time. Because before I would sleep all the time during the day, but now I’ve learned from being here it’s really important to be in the sunlight and see the sunlight and push yourself to get up and be active during the day.”

For these interviewees, it was clear that Summit Center helped them cognitively distance themselves from the mental illness identity by promoting a more functional and healthy self-definition. For some interviewees, entering treatment at Summit Center was equated to saving their life during a time when symptoms were at their worst. Caleb describes how enrolling in Summit Center’s program preventing him from self-harming, and ultimately allowed him to identify as someone who is no longer mentally ill:

> “This is why I wound up here. Because I told my doctor, and I told my mom, and my mom was like, if you need to go somewhere… you need to go to an inpatient and seek help for this. And by that time, these spirits [visual hallucinations] were trying to cause me to hurt myself. Now I’m here in this year long program being able to grow like I am now, being able to blossom before I go out and try to pursue a wife, or be the man that my future family needs. Not identifying as a mentally ill addict, not identifying as that because I’m healed here, I’m treated here, I’m set free, and I just need to stand upon that.”

Whether it be through providing numerous recovery-oriented resources, stability, and/or directly alleviating symptoms, these interviewees, despite living in a psychiatric facility, did not feel like typical “mental patients.” This is in stark contrast to previous findings in the stigma resistance literature that suggest individuals who have received treatment recently or anytime in the past (especially in-patient treatment) are unable to resist the stigma of mental illness (Thoits 2011, 2016; Sibitz 2011). Instead, the very living environment provided at Summit Center is what helped individuals engage in

MIID, where they were able to deflect the mental illness identity through a sense of feeling healthy and less symptomatic.

Relationships that Support Recovery

Finally, having a social support network that promoted recovery from mental illness was salient for many interviewees. Despite living in an environment where interviewees often felt disconnected from society, many described relationships with friends and family members outside Summit Center that strengthened them to engage in MIID in various ways. Indeed, all interviewees (*N* = 15, 100%) mentioned or discussed having positive relationships that promoted recovery from mental illness. These relationships often assisted interviewees in providing some distance from the mental illness identity. Oftentimes, simply being able to socialize with others acted as a distraction from one's own mental illness. Luis, who was diagnosed with schizophrenia, describes it this way:

> "I try to socialize with everyone [at the facilities] a lot. The good thing is that a lot of them are going through the same experiences as me, so I try to interact with them and see what I can do to help them. You can see your sickness in other people, so you see what you can do to help. It gets me in touch with other residents and makes me not think about my disease."

For Luis, having beneficial and reciprocal relationships with other residents was important for him to dissociate from a mental illness identity. Deb was another interviewee who found value in these relationships: "They talk well. They do well with themselves. They're friendly. We're kind of a group in a way. I can relate to them… it's not a bad group to be a part of."

However, it was not only relationships with other residents that were valued by interviewees. Another key way in which relationships helped to dissociate interviewees from a mental illness identity was through the provision of recovery-oriented resources and/or support from family. Importantly, the resources and support provided by these relationships helped steer interviewees away from contexts in which the mental illness identity might become more salient, such as homelessness, prison, or mental health hospitals. As an example, Isaac described how his mother and sister have helped him try to find a stable living environment following his graduation from the treatment program he was enrolled in during the time of the interview. Without his mother specifically, he feels he might have "nowhere else to go":

> "My mom, she's trying to help me. Believe it or not, of all things, she's willing to let me move up north because they're planning on moving up north. So, she's looking into a housing project in NorCal for $350 a month. She's trying to get me into that program."

What is important to note about Isaac's relationship with his mom is that, without it, he feels he may wind up in a "crazy" living situation where his diagnosis and symptoms might become more evident: "I'll be packing a tent and a sleeping bag and I'll be living in a campground, that kind of crazy stuff." Caleb, who had a comorbid diagnosis of schizophrenia and psychosis, stated that if it weren't for his grandpa, he'd be "dead right now" or "in prisons, jails, and institutions," or as he says, "the three places for the mentally ill and addicts." The resources provided by these important relationships allows interviewees to maintain distance from stereotypical images of the mentally ill as unkempt, disheveled individuals in precarious living situations, such as homelessness, prison, and mental health hospitals (Corrigan 2000; Koegel 1992).

Thus far, I have discussed the particular sociocultural resources that were particularly conducive to engaging in MIID. Next, I will demonstrate the differential recovery outcomes according to the different degrees of MIID. Specifically, while those interviewees who engaged in a moderate (or low) degree of MIID appeared to most frequently discuss positive recovery outcomes, the few interviewees who engaged in a strong degree of MIID spoke negatively of their experiences with recovery.

Consequences for Recovery

The findings illustrate that engaging in MIID in particular ways was obviously beneficial to particular interviewees' overall recovery from mental illness. Results show the participants who engaged in moderate MIID spoke frequently about experiencing positive recovery outcomes. This is because the process of accepting one's diagnosis (insight)—but not letting it become a salient part of one's overall identity—was crucial to initiate and stay in treatment that was perceived to be beneficial, while allowing for a deflection of negative stereotypes and devaluation attached to their diagnosis.

This did not operate smoothly for all interviewees however. Individuals who engaged in a stronger degree of MIID disrupted treatment in various ways (e.g., disagreeing with some aspect of their medication regimen, refusing to participate in therapy sessions), and emphasized the many barriers that prevented them from seeking treatment. This is because a strong degree of MIID was associated with a lack of insight, whereby individuals do not believe they have a mental illness, leading to the conclusion that treatment is unnecessary. This is in stark contrast to the moderate degree of MIID, which was much more conducive, and often a necessary precursor, to beneficial treatment for the interviewees. Deb describes it this way:

> "I had difficulty accepting my diagnosis [at first]. The psychologists really got mad at me because I refused so much medication on the basis of this. But I had my own ideas of schizophrenia. I mean, they said you're schizophrenic, and as far as I was concerned, schizophrenia was all this ridiculous idiocy that didn't fit me. I said, I'm not schizophrenic! Whatever schizophrenia is, it's simply not me. No, I will not take that medication."

Here, Deb explains how a strong degree of MIID, whereby one completely rejects the potential applicability of the diagnosis in response to negative stereotypes, disrupted treatment through her rejection of medication. Deb later describes how although she now agrees with her diagnosis, it is "not the strongest identifier" of herself. Accepting the diagnosis, but using MIID to dissociate from the negative stereotypes that prevented her from agreeing with the diagnosis initially, played a crucial role in Deb's initiation of treatment.

This story—of disagreeing with the initial diagnosis due to the attached stigma and accepting it at a later point while taking care to make sure negative stereotypes are not personally applicable—was commonly told by those interviewees who exhibited moderate MIID regularly. Arlene discusses how she initially struggled with her diagnoses of bipolar and borderline personality disorders:

> "I didn't want to accept either one, I think that's why I used drugs and drank for so many years because I didn't really want to accept any of that. I knew I was different from other children. I didn't understand what other kids understood, so I just went to drugs and alcohol. So, like, right now, I'm accepting it better than I did before."

Although an outright rejection of her initial comorbid diagnoses led to self-destructive self-medicating, Arlene illustrates how eventually engaging in moderate MIID is connected with positive recovery outcomes, such as increased self-esteem and reconnecting with family:

> "[My diagnosis] is part of who I am, but not really who I am. Like, I can handle a mental illness now. Since I've been on medication, I've been working on that stable mental health, you know? So, a lot of times, I couldn't do that, I couldn't get the help I needed. It's pretty new that I'm really positive about it and I've also started to reconnect with some family."

Ultimately, the varying aspects of treatment—medication, therapy sessions where knowledge about mental illnesses is learned, positive self-concepts, learning coping tools, etc.—led to positive recovery outcomes for these interviewees. Notably, one such important positive consequence for recovery was increased self-esteem, which operated primarily through a positive attitude toward mental illness fostered through various aspects of treatment at Summit Center and high-functioning self-concepts. By learning accurate information about different mental illnesses, these interviewees came to see their own as well as other diagnoses in a more positive light. As interviewees became more knowledgeable about their mental illness, they learned that mental illness was widespread and therefore a normal component of mental health. This fact made many interviewees "feel better" about their own diagnosis. Jason, diagnosed with bipolar disorder, summed it up nicely:

> "I feel much, much better about my diagnosis. Because I've learned so much about it. And these days, um, mental illness is way more understood now. And it's like, mainstream as far as like… back in the day, 19 years ago or whatever, it was more like a stigma, I guess. It's accepted now, it's normal. Not like back then, when people thought you had a disease. I don't look at it like a disease, I look at it as a disorder—bipolar disorder. And in a lot of ways, I look at it as a gift more than a disease."

Other interviewees emphasized that it was specifically *learning* about mental illness, through treatment, that led to increasingly positive attitudes about one's diagnosis. Chloe described what helped her feel "less embarrassed" about her diagnosis of schizophrenia:

“A lot of learning, a lot of learning about what it is.”

Another notable positive recovery outcome associated with treatment was decreased symptom severity. Oftentimes, this was accomplished through a strict medication regimen that helped to alleviate symptoms, but group therapy sessions that taught about identifying triggers and symptoms, and coping tools to help deal with such symptoms, also played a vital role. For instance, Caleb described how “getting treated with the right medication” helped alleviate symptoms of schizophrenia and psychosis, which he identified as “outbursts or episodes” where he becomes “righteously angry.” Similarly, Samith described how he has “no further mental illness” of schizophrenia because he has been on “medication for a very long time.” Another interviewee, Benjamin, clearly illustrates the benefits of medication prescribed for his depressive and OCD symptoms:

> “I saw a doctor originally for OCD symptoms and he put me on medication for it, and it really helped. I was on and off the medication for a while, and before Summit Center, when I was at [another program], that was when I started taking the same medication again and I’ve been on it everyday since. [My diagnosis] is pretty manageable now. I feel like the medication’s helping, like it’s doing what it’s supposed to do.”

The distinction between a moderate and strong degree of MIID for consequences of recovery is crucial. While those who engaged in a moderate degree of MIID often spoke of experiencing a positive recovery from their mental illness, interviewees where a strong degree of MIID was present often spoke negatively about recovery. As mentioned earlier, these interviewees did not believe they had a mental illness to recover from, and as a result, frequently spoke of attempting to disengage from treatment. As a result, they did not experience the same positive recovery process as other interviewees who engaged in a moderate degree of MIID. Josephine describes her experiences living with a diagnosis of bipolar disorder that she does not agree with:

> "I'm really uncomfortable here [in Summit Center]. You know, I don't even believe in mental illness. I don't believe there's a recovery for me. And I don't like how there's medication or nurses here—I don't like that. I really don't believe in medication. There's something weird going on in the world right now, where people are on this sort of mental health craze. I almost think that people think it's cool to say you're bipolar right now. I don't like it."

As a result of her diagnosis, Josephine went on to describe how she had felt disconnected from friends and family, negative attitudes about her mental illness and mental health more generally, and lived in a negative environment with few resources to help her. Dina was another interviewee who struggled with her diagnosis of schizophrenia (which she disagreed with), and believed she had experienced negative outcomes as a result: "Living in these places [mental health facilities], it doesn't make life easier. It just makes you… I feel like I'm falling behind in my life because I want to get to other things, to more things that I can't while I'm here." In this case, Dina's reference to "falling behind in life" is reminiscent of Goffman's notion of "civil death," where those who are enrolled in total institutions find that they may not be able to make up the time they lost spent in such places in terms of missed educational, vocational, or other opportunities (Goffman 1961: 15). Although both moderate and strong degrees of MIID are responses to stereotyping and devaluation like Thoits (2011) described, the findings show they lead to widely differential recovery outcomes. Because those who staunchly oppose their diagnosis do not believe they have anything to recover from, it is unsurprising these interviewees describe their experiences with mental health in a negative way.

Finally, the few interviewees who engaged in a low degree of MIID also spoke of experiencing positive recovery outcomes. Luis, for example, had graduated early from Summit Center, an option reserved only for those residents who were making great strides in their recovery: "What was wrong with me, it got better a lot. So, they graduated me earlier." Both Benjamin and Riley discussed positive recovery outcomes as well, such as feeling less symptomatic. It should be noted, however, that while these three interviewees did not appear to engage in any of the MIID methods Thoits (2011) described, they still engaged in other types of stigma resistance—namely, passing and/or secrecy in situations where stigma was perceived to be present. Because only three interviewees fell in this category and they only briefly mentioned stigma resistance in general, definitive conclusions cannot be drawn about the association between MIID (or other stigma resistance strategies) and recovery outcomes for these individuals.

Discussion

While this study was not an explicit test of Thoits' (2011) important theoretical propositions about the antecedents of MIID, the findings here inform her work in a few important ways. First, my findings point to the potential expansion of her conceptualization of MIID in that not everyone who uses this form of stigma resistance agrees with or acknowledges the potential applicability of their initial diagnosis. They still may perform important features of MIID as a response to stereotyping and devaluation, such as highlighting the mismatch between their own behavior and stereotypical behaviors associated with their diagnosis, indicating a stronger variant of MIID than has been previously discussed in the extant literature.

Second, one of Thoits' (2016: 136) antecedents for a higher likelihood of engaging in MIID is having "no recent or prior history of mental health treatment" and having a "mild or manageable" diagnosis. This assertion has face validity: an individual undergoing intensive in-patient treatment for a serious mental illness might be less inclined to engage in MIID in an environment that is endlessly making the mental illness identity salient through therapy sessions, staff-patient interactions, medication regimens, and other recovery-oriented routines. Quantitative studies appear to confirm this. For instance, in a study examining stigma resistance and its correlates among those diagnosed with schizophrenia and schizoaffective disorder, Sibitz et al. (2011) found that inpatient and day clinic patients exhibited lower levels of stigma resistance when compared to their outpatient counterparts. The authors speculated this may due to the "total institution" nature of in-patient treatment where patients experience "a clear break with normal life, possibly implying loss of autonomy and self-determination" (Siblitz et al. 2011: 321).

The findings in my analysis paint an altogether different picture of in-patient treatment centers and stigma resistance. Although the sample is limited, the vast majority of interviewees (N = 12; 80%) who had serious mental illnesses (primarily schizophrenia) engaged in stigma resistance, whether it be MIID or some other form of stigma resistance (challenging stereotypes, social withdrawal, educating others). In fact, specific features of the in-patient treatment program itself helped to make MIID possible for many of the interviewees, such as a strict medication regimen and group therapy sessions. Goffman (1961) describes this as a "secondary adjustment" to the mental health facility. Specifically, interviewees used Summit Center for the "unauthorized" purpose of resisting stigma as they stand apart from the "mental patient" role bestowed upon them by such a facility (Goffman 1961: 189). It is clear that individuals with serious mental illness within in-patient facilities *can* and *do* resist stigma in various ways.

Moreover, these findings revealed that while most interviewees did engage in MIID, they did so in varying degrees and in ways that have not been previously described in the stigma resistance literature. I propose that there are *moderate* forms of MIID whereby the individual still identifies in some capacity with their diagnosis (or some mental health issue) yet deflects the mental illness identity. This degree of MIID is what has been emphasized in the extant literature (Thoits 1985, 2011, 2016; Thoits and Link 2016). In an expansion of Thoits' (2011) conceptualization, there also exists a *strong* degree of MIID where individuals completely reject their diagnosis in response to stereotypes and devaluation, and therefore fully dissociate with any mental illness identity.

This was accomplished in several ways including rejecting one’s diagnosis in favor of a less stigmatized and more socially acceptable condition (e.g., stress) and emphasizing a significant incongruence between stereotypical perceptions of a diagnosis and their own behavior (Thoits 2011). These methods led individuals to disagree with their diagnosis from the time they were initially diagnosed. Thus, such individuals never acknowledged the possibility or relevance of a mental illness identity, and made it explicitly clear during interviews that they did not have a mental illness and were never mentally ill to begin with. Lastly, there are individuals who engage in little to no MIID, choosing to incorporate an identification with their diagnosis and mental illness into their overall identity.

Lastly, and most importantly, the findings presented here suggest the potential of an integration of the different conceptualizations of MIID proposed by the two theoretical frameworks—the psychiatric approach and modified labeling theory (MLT). The psychiatric approach is staunchly opposed to individuals engaging in MIID because of its conceptualization of it as denial of, or lack of insight into, one’s mental illness. According to the psychiatric approach, logic follows that MIID inhibits one’s desire and ability to engage in much needed treatment, leading to detrimental outcomes for diagnosed individuals. Conversely, MLT views MIID as an effective form of stigma resistance against harmful stereotypes of mental illness, potentially leading to positive outcomes for those who have been diagnosed. The way it is currently framed in these two opposing bodies of literature suggest MIID could not possibly co-occur with the possession of insight into one’s mental illness. That is, if one acknowledges and agrees with their diagnosis in order to enter treatment, engaging in MIID would be counterintuitive. In other words, why accept the diagnosis to only dissociate from it at a later time?

The results here provide insights that address this query. The majority of interviewees who engaged in moderate MIID not only possessed a significant degree of insight into their mental illness, but they believed that such insight was necessary in order to engage in MIID. This process of engaging in MIID *through the possession of insight* revealed itself in many interviews. This is because insight acted as a prerequisite for many sociocultural resources that helped individuals to engage in MIID. For instance, several interviewees believed insight was necessary to maintain a strict medication regimen, which later helped them to deflect the mental illness identity through the erasure of symptoms. Other interviewees needed insight in order to identify the need for coping tools, which ultimately led to MIID through the management of symptoms and diagnoses.

By possessing significant insight and engaging in MIID many individuals deflected the mental illness identity, which they described as being associated with positive recovery outcomes (e.g., a high-functioning self-concept, being able to envision a healthy future). This finding lies in stark contrast to early labeling theory that argued labeling (or in this case, diagnosing) someone with a mental illness should negatively affect their self-concept through negative societal reactions, stereotyping, and devaluation (Lemert 1951; Scheff 1966). The present findings show the consequences of the labeling process as it relates to mental illness is much more nuanced than originally thought.

Interviewees felt they had little choice but to accept the diagnostic label in order to enter necessary treatment, which they perceived to be beneficial to their overall recovery. But in order to not let the diagnostic label alter their identity in a negative way, they engaged in the various methods of MIID, illustrating how these interviewees' agency in resisting stigma was ultimately beneficial for them.

Thus, both insight *and* certain forms of MIID appear to be instrumental in the maintenance of a healthful and effective recovery from serious mental illness. This suggests the need to consider a revision of the two opposing conceptualizations in the psychiatric and labeling literatures to include an integration of insight and MIID, and how they are both linked to positive recovery outcomes. This becomes even more crucial when we realize that psychiatric facilities are often structured around the possession of insight, and reject the positive consequences certain forms of MIID might have for individuals in in-patient treatment. The results suggest that it may be beneficial for treatment programs to incorporate strategies of moderate MIID—or making the mental illness identity less salient—as a way to achieve desired recovery outcomes.

While this study provides contributions to the literature on mental illness and MIID, more information about how other sociocultural resources are tied to specific forms and degrees of MIID, and how these varying manifestations of MIID are differentially tied to particular recovery outcomes is needed. What resources lead to specific forms of MIID in and outside of these facilities, and are the different forms of MIID consequential for recovery in a patterned way? Future qualitative studies using in-depth interviews may capture this information quite well, especially with larger samples consisting of individuals in both in- *and* out-patient treatment settings who have access to differential amounts of resources.

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Appendix A

1. Demographics
    a. Basic information and demographics
        i. What is your age?
        ii. What is your self-identified race?
        iii. What is your self-identified gender?
        iv. How long have you been in the current rehabilitation program?
        v. Have you been in rehabilitation programs prior to this one?
        vi. Do you plan to enroll in another rehabilitation program upon graduation of the current program?
        vii. When do you expect to graduate the program?
        viii. What is your formal diagnosis?
        ix. When were you first formally diagnosed?

2. Segment One: Opening Narrative
    a. Can you tell me how you feel about your diagnosis? Do you agree with it? Do you feel differently about it now than you did in the past when you were first diagnosed?
    b. Before moving on to the next phase of the interview, I'd like to get an overall sense of your experiences with your disability. Have you experienced anything positive as a result of being diagnosed? On the other hand, is there anything negative you have experienced as a result of the diagnosis? [*probe for examples*]

3. Segment Two: Questions of Greater Specificity
    a. Personal recovery capital
        i. Physical capital
            1. Has money ever played a role in your recovery in the past or present? If so, how?
            2. How has health insurance played a role in your recovery?
            3. How would you describe your overall physical health?
            4. Do you believe the environment in which you live promotes or undermines recovery?
            5. Do you feel like you are successfully able to complete tasks you need to get done on a daily basis?
        ii. Human capital
            1. What are your values and beliefs about recovery? Are you pessimistic or optimistic about it? Do you have goals or hopes for your future?
            2. Could you describe any educational or employment opportunities you've had in the past?
            3. Could you describe your coping tools you use to manage challenging situations?

b. Family/social capital
    1. Could you describe your social support network? Do you have any important relationships with family, friends, or loved ones that have impacted your recovery? If so, how?
    2. Are you connected with any groups outside of [*name of mental health facility*], such as school or a religious organization, that have impacted your recovery? If so, how?

c. Community recovery capital
    1. What do you think the people in the community in which you reside in believe about mental illness and recovery?
    2. Could you describe any role models you have that have impacted your recovery?
    3. Would you say you have access to a wide variety of resources to help maintain your recovery? Could you describe them for me?
    4. In what way does the treatment program you reside in help sustain your recovery?

  ii. Cultural capital
    1. Has your culture impacted your recovery in any way? For instance, have you ever participated in any programs that have been specific to your lifestyle or culture that have impacted your recovery in any way?

d. Delabeling and Stigma
    1. Do you tell your diagnosis to other people? If so, who do you tell about it, who do you choose to not talk to about it, and why and why not?
    2. [*if respondent has disclosed to others]* What sort of reactions have you received when you do tell your diagnosis to others? Please describe both positive and negative experiences.
    3. Do you feel you are treated differently based on your diagnosis? Why or why not?
    4. Do you have any strategies you employ to manage the stigma associated with your diagnosis? (*For instance, passing as someone who does not have the diagnosis, only telling a selective few people, educating others about the diagnosis, or withdrawing from social situations where you perceive such stigma to be present.*) Could you provide a specific example of this? Did you use any particular resources that we previously discussed, such as social relationships, prior educational or work experiences, etc. to help you do this? If so, could you describe the resources for me and how they helped you to manage the stigma?

4. Segment Three: Closing Statements
    a. If you had to describe yourself to me, would your diagnosis be part of your description of who you are? Why or why not? [potentially leading]
        1. If yes, do you ever see yourself being able to describe yourself without mentioning your diagnosis? Why or why not?
        2. If no, was there a time where would have described yourself in such a way? What's changed since then?
        3. Do you anticipate any future issues in regards to telling people about your diagnosis? Do you plan on telling people? If not, how will you take steps to do this?
    b. Is there anything else you'd like to add that wasn't touched on during the interview?