APPLYING IDENTITY THEORY TO THE STUDY OF STIGMATIZED IDENTITIES

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by

Lindsey L. Westermann Ayers

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Dissertation written by
Lindsey L. Westermann Ayers
B.A., Douglass College, Rutgers University, 2004
M.A., Kent State University, 2009
Ph.D., Kent State University, 2014

Approved by

Dr. Kristen Marcussen	Chair, Doctoral Dissertation Committee
Dr. Emily Asencio	Members, Doctoral Dissertation Committee
Dr. Willie Harrell	
Dr. Christian Ritter	
Dr. Richard T. Serpe	
Dr. John Updegraff	

Accepted by

Dr. Richard T. Serpe	Chair, Department of Sociology
Dr. James L. Blank	Dean, College of Arts and Sciences

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CHAPTER ONE

INTRODUCTION

Identity is generally conceptualized as a set of internalized meanings attached to roles that individuals occupy in a social structure (e.g., Burke and Stets 2009; Stryker 2002, 1980). Scholars who study identity have primarily focused on normative and positively-evaluated identities, such as parent, student, employee, and friend. Identity theory (Stryker 1980, 1968) and its theoretical elaborations (Burke 1991; Burke and Reitzes 1991, 1981; Burke and Stets 2009; Serpe 1991, 1987; Serpe and Stryker 2011; Stets 2011, 2006, 2004; Stryker and Serpe 1994) together constitute an influential theoretical tradition in social psychological literature that has contributed substantially to such knowledge about identities. However, in contrast to the well-developed understandings of positive identities generated by this rich theoretical tradition, negatively-evaluated and stigmatized identities (e.g., mental illness, medical conditions, sexually transmitted diseases) have been comparatively underexplored.

Several prominent research programs have emerged offering theoretical and methodological means to examine (primarily normative) identities. Structural identity

theory[1] represents one such approach to the study of identities. Developed and subsequently elaborated by Stryker (1980, 1968), Serpe (1991, 1987), and colleagues (Serpe and Stryker 2011; Stryker and Serpe 1994; Stryker, Serpe, and Hunt 2005), the theory is predicated on the assumption that individuals hold multiple social roles, or positional designations that entail associated behavioral expectations. The self, which is understood to reflect society's complex and multifaceted composition, is likewise understood to be comprised of multiple identities or role-identities. The theory connects structure to individual behavior through specific aspects and characteristics of these role identities. Specifically, large social structure (e.g., gender) and proximate social structure (e.g., social clubs) impact one's ties to an identity and how likely one is to invoke that identity, which further impacts role-related behavior. Outcomes of the model, while initially conceived of as role-related behavior or performance, have been expanded in recent years to include aspects of well-being (Serpe and Stryker 2011). Many scholars have examined concepts central to the theory, including tests of relationships among different levels of social structure (Stryker et al. 2005), among forms of commitment and identity salience (Callero 1985; Marcussen, Ritter, and Safron 2004; Owens and Serpe 2003; Serpe 1987), and among salience and role-related performance outcomes (Merolla

[1] The theory is most often referred to as "identity theory". Recent identity scholarship (e.g., Serpe and Stryker 2011; Stets and Serpe 2013) has sought to deemphasize conceptual and research-based divisions between prominent identity research programs, such as (structural) identity theory, identity control theory (ICT), and affect control theory (ACT), which can impede thinking and research about identity. Such recent work models a more integrated view of these largely complementary programs, using the term "identity theory" to characterize all such work. Given these two uses of the term "identity theory" (to denote work by Stryker, Serpe, and colleagues, and to collectively denote identity research programs), for this dissertation, I use the term "structural identity theory" to characterize identity theory work developed and elaborated by Stryker (1980, 1968), Serpe (1991, 1987) and colleagues and to be clear that I am situating my work exclusively in this tradition.

et al. 2012; Nuttbrock and Freudiger 1991). Although the theory is broadly cited, tests drawing from each component of the full structural identity model are surprisingly rare.

Stigma scholarship, a likewise prominent area of research, derives primarily from the seminal work of Goffman (1963). According to Goffman (1963:3-4), stigma signifies the relationship between "an attribute and a stereotype," such that the attribute is "deeply discrediting" (Link and Phelan 2001). Although his influential formulation emphasizes the social and relational character of stigma (Goffman 1963), much of subsequent stigma research has focused primarily on individual-level attributes and aspects of stigmatization (Link and Phelan 2001; Oliver 1992; Stuber, Meyer, and Link 2008). In particular, as Oliver (1992) and Link and Phelan (2001:366) point out, this research has focused primarily on the link between perception and micro-level interaction, rather than on connections between broader social structures and consequences of stigma. Despite scholars' recent efforts to address individualistic critiques of stigma research (Link and Phelan 2001; Pescosolido et al. 2008; Phelan, Link, and Dovidio 2008; Stuber et al. 2008), social structure and relationships, in particular - a strength of the structural identity theory approach - remain comparatively less central. Moreover, although both stigma and identity scholarship derive from common symbolic interactionist roots, as is particularly evident in modified labeling theory, the two literatures have rarely been directly linked through formal theories of identity (see Asencio and Burke 2011 and Kroska and Harkness 2011, 2008 for exceptions).

For this dissertation, I link identity and stigma literatures by applying structural identity theory to the study of stigmatized identities. My aim is to expand and clarify

understandings of identity and of stigma by examining the extent to which concepts and relationships central to identity theory research can explain stigmatized identity processes. In particular, I use structural equation modeling of telephone interview data (N = 327) to examine whether the structural identity process operates the same for those with stigmatized identities as has been proposed and empirically demonstrated for those with normative identities.

This research contributes to sociological social psychological literature in four ways. First, the study extends the application of identity theory beyond normative identities to that of stigmatized identities, thereby examining the extent to which the theory can explain identity processes for those who possess a stigmatized identity. Second, the study provides a test of structural identity theory drawing from each component of the now-expanded traditional model. Third, the study provides an initial step toward addressing individualistic critiques of stigma scholarship. Fourth and finally, the study incorporates a stigma coping strategy found in modified labeling theory research into the structural identity theory model as a measure of identity performance for those with stigmatized identities.

This dissertation is divided into six chapters. In the present chapter (Chapter 1), I introduce the issues that I will examine and the aims of the current study. In Chapter 2, I provide background for the current study by reviewing relevant theoretical and empirical scholarship in the areas of identity and stigma. In Chapter 3, I describe the data and methods that I use to examine my research hypotheses. In Chapters 4 and 5, I present the findings for my primary and secondary sets of analysis. And finally, in Chapter 6, I

discuss key study findings, contributions and implications of key study findings, limitations of the study, and directions for future research.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, I provide background for the current study by reviewing relevant theoretical and empirical scholarship in the areas of identity and stigma. First, I discuss identity literature, including schools of symbolic interactionism, structural theories of identity, and structural identity theory, in particular. Second, I discuss stigma literature and provide an overview of scholarship on stigma and health, and modified labeling theory. Based on these two bodies of literature, I propose links between stigma and identity theory, focusing particularly on the concept of stigmatized identities. Finally, I present a model that integrates aspects of both literatures and provide an overview of my research and hypotheses.

Identity

Much of the sociological social psychological study of identity is rooted in symbolic interactionist thought. Though symbolic interactionism was so-named in the early twentieth century (Blumer 1937), its foundations can be traced to the insights of the Scottish moral philosophers writing approximately two centuries earlier, and later to the American pragmatists (Serpe and Stryker 2011; Stryker 1981). Although there is no singular statement of the tenants of the framework to which all symbolic interactionist scholars would unequivocally agree (see Stryker 1981 for examples of variations), there

is some agreement about what constitutes the perspective. Symbolic interactionists are unified by a shared interest in explicating the relationship between individual and society, with explicit attention paid to the ways in which subjective experience, the self, self-concept, and social interaction shape and are constituted by these phenomena (Serpe and Stryker 2011; Stryker 1981).

Mead's (1934) work, in particular, is central to these shared contemporary symbolic interactionist understandings. Mead conceptualizes the relationship between self and society as mutually constitutive, arguing that both self and society emerge from interaction. He explains that one of its distinctive features is the ability of the self to take itself as an object, as well as to view itself from the standpoint of particular others or from the standpoint of a generalized notion of others' views (the "generalized other") (Mead 1934:292). According to Mead (1934:293), the self develops through such reflexive processes and, as such, is not only an inextricably social phenomenon, but can be understood as "essentially a social structure". Mead's formulation of the relationship of the relatively stable self to behavior continues to have an enduring impact on how symbolic interactionists conceptualize the relationship between self and behavior - namely, that each is both integrally tied to the other and to the societal context within which it exists.

Mead's general symbolic interactionist proposition grounded in these understandings – that "society shapes self shapes behavior" - constitutes the foundation of theoretical frameworks like structural identity theory (Stryker et al 2005:94), which uses a model that seeks to operationalizes each component (society, self, behavior) of this

proposition (Stryker and Serpe 2011). Moreover, Mead's ideas about the relationship between self and society inform the more specific axiom that stems from his proposition - that social ties are key to social action (Stryker et al. 2005:94), which again constitutes an essential premise of the structural identity theory model.

Mead's insights about connections between society, self, and behavior, together with the additional core components of the symbolic interactionist frame, are foundational to theories of identity that have stemmed from this theoretical tradition. These insights are also of vital importance to other theoretical approaches, including modified labeling theory approaches prominent in stigma research. Labeling theory in general and modified labeling theory in particular underscore the social source of meanings that surround labels. These socially-shaped perceptions have important implications for the subsequent behavior and the sense of self for an individual to whom a label is applied. Thus, identity and modified labeling theories both draw heavily from basic symbolic interactionist tenants that social interactions help to define and shape our sense of self and identity, which in turn influences our behavior. I return to these connections below.

Schools of Symbolic Interactionism

Symbolic interactionist scholarship generally falls into one of two prominent traditions of thought - "processual" (or traditional) and "structural" approaches - which have important implications for the ways in which researchers conceptualize and examine identities. The processual symbolic interactionist tradition or the 'Chicago School', including contributions from scholars such as Blumer (1980, 1969), as well as what

Stryker (1981:13) refers to as "third generation" contributors (e.g., Goffman 1983, 1967; Scheff 1966), emphasizes processes of interpretation and definition in the negotiation of social order, along with a methodological commitment to the explication of social interactional phenomena through primarily participant-observation and narrative data collection techniques (Blumer 1969; Strauss 1962; Stryker 1981). By contrast, structural symbolic interactionism that stems from the work of Iowa and, later, Indiana 'school' scholars (Kuhn and McPartland 1954; McCall and Simmons 1966; Serpe 1987; Stryker 1968) emphasizes the importance of understanding how the stable and constraining force of social structure impacts the self, and the consequences of this relationship for behavior (Stryker and Burke 2000). Structural symbolic interactionist approaches utilize primarily quantitative methodology and survey methods, in particular (Kuhn and McPartland 1954; Serpe 1987; Stryker 1980). Some scholars concede that representations of the two traditions as antithetical are largely artificial or forced - and, thus, inaccurate - dichotomous constructions (Stryker 1981). Despite this observation, scholars continue to maintain relatively close adherence to the conceptual and methodological commitments of the respective approaches.

Structural Theories of Identity

Structural identity theory (e.g., Stryker 1987a, 1980, 1968; Stryker and Serpe 1994; Serpe 1991, 1987; Serpe and Stryker 2011) and identity control theory (ICT) or - more recently - the perceptual control perspective (Burke 1991; Stets 2011, 2006, 2004; Burke and Reitzes 1991, 1981; Burke and Stets 2009) represent two prominent research programs that derive from the structural school of symbolic interactionism (Stryker 1981,

1980; Stryker and Burke 2000; Burke and Stets 2009). The focus of structural identity theory and perceptual control perspective research programs has been on the internalized meanings and behavioral enactments of positively-evaluated role identities, as well as group and person identities (Burke and Stets 2009; Stets and Carter 2011, 2006). The perceptual control perspective focuses on self processes and the impact of these dynamics on individual behaviors, with a particular emphasis on the role of self-meanings, or "reflexive responses to self-in-role" for these relationships (Stryker and Burke 2000:287). The model draws on assumptions about individuals' motives to achieve and maintain cognitive congruence (Rosenberg 1979) or to self-verify (Burke 1991; Burke and Reitzes 1991, 1981; Stets and Harrod 2004), and depicts self processes as a cycle or feedback loop.

Recent scholarship works to deemphasize conceptual and research-based divisions between these complementary programs, calling for a single, more universal framework that integrates the various forms of identity theory (e.g., Serpe and Stryker 2011; Stets and Serpe 2013). Nonetheless, there are several distinctive aspects of structural identity theory that make it an ideal candidate for forming a more formal theory of stigmatized identities. In particular, the theory's emphasis on the impact of social structure and relational ties, a complement to limitations within stigma scholarship (Link and Phelan 2001; Oliver 1992; Stuber et al. 2008), presents a fruitful opportunity to link identity and stigma literatures for this initial examination of stigmatized identities within the identity theory framework. For this reason, I focus exclusively on structural identity theory for this dissertation.

Structural Identity Theory

Structural identity theory draws on the symbolic interactionist understanding that the self reflects the society of which it is a part and, thus, that modern selves reflect society's complexity, patterning, and relative stability (Serpe 1987; Serpe and Stryker 1987; Stryker 1980). This specific understanding of the way in which society and self reflect one another's composition (Cooley 1902; James 1890; Mead 1934) is consequential for structural identity theory conceptions of identity and behavior in several ways. First, the relatively stable patterning of society is reflected in an individual's role-based social relationships and network ties. Second and third, individuals hold multiple social roles, or positional designations that entail associated behavioral expectations, such that the self is understood to be comprised of multiple identities or role-identities (Stryker 1987b, 1981, 1980, 1968; Stryker and Serpe 1982; see also, McCall and Simmons 1978, 1966). Such socially-structured, multiple role occupancy poses a challenge for the prediction of role-related behavior or performance (Stryker and Burke 2000). Stryker and colleagues, however, address this challenge with the development of several key concepts around which much of structural identity theory research revolves. The core theoretical concepts of structural identity theory include commitment, identity salience, and role performance.

Commitment. Commitment has been conceptualized as one way in which the self is linked with social structure through the infusion of social structure, roles, and behavior (Burke and Reitzes 1991:239). Commitment has been represented as the link between an individual and consistent lines of activity (Becker 1964, 1960), an individual and

organizations (Kanter 1972, 1968), and an individual and a stable set of self-meanings (Burke and Reitzes (1991). Within structural identity theory, *commitment* represents the link between individuals and role partners (Burke and Reitzes 1991; Stryker 1980, 1968) - particularly, it represents the extensiveness and intensiveness of network ties (Stets and Serpe 2013) and, by extension, the cost of losing relational ties linked to an identity (Serpe 1991, 1987; Stryker and Serpe 1994; Stryker 1987b, 1980). Thus, commitment, while not analytically part of the self (Stryker 1980), captures social structural linkages to the self. There are two dimensions of commitment that conceptually tap into how one is connected to social roles. Interactional commitment captures the quantity of social relationships associated with having a given identity, while affective commitment captures the quality of these relationships (Kanter 1972; Serpe 1987; Serpe and Stryker 1987; Stryker 1987b; Stets and Serpe 2013). Interactional commitment is typically measured by assessing the number of people an individual knows, the number of interactions an individual has, or the amount of time spent with others, by virtue of possessing a given identity (Owens and Serpe 2003; Serpe 1991, 1987; Stryker et al. 2005). Affective commitment is often measured by assessing how much an individual would miss persons associated with a given identity were they to no longer be in contact with them, how close to those persons they are, or how important those persons are (Merolla et al. 2012; Owens and Serpe 2003; Stryker et al. 2005). However, this dimension of commitment has also been assessed by using reflected appraisals about longstanding, important relationships where the identities in question are relatively new, i.e., first year college students (Serpe 1991, 1987). The two dimensions of commitment

are potentially independent (Serpe 1991). However, Merolla and colleagues (2012:158), for example, find latent constructs of interactional and affective commitment to be highly correlated and therefore model the constructs as one second-order latent variable. Commitment affects relatively stable hierarchically organized salient identities (Serpe 1987; Stryker 1980).

Identity Salience. Scholars across identity traditions have assessed the differential meaning and placement of identities by conceptualizing some identities as more or less important, meaningful, or likely to be activated in social situations than others (Burke and Stets 2009; McCall and Simmons 1978; Stryker 1980; Thoits 1991). In general, scholars have attempted to contextualize identities in relation to one another. Within the structural identity theory model, identities are understood to be arranged hierarchically based identity salience. *Identity salience* is "the probability that an identity will be invoked across a variety of situations or alternatively across persons in a given situation" (Stryker 1980; Stryker and Burke 2000:286). Thus, the more salient an identity, the higher its location within an individual's salience hierarchy, and the more likely that identity will be invoked in a situation. Stryker (1980) explains that in a structurally isolated situation (where distinct sets of relationships do not impact one another) it is likely that only one identity will be invoked. Alternately, in situations that are not structurally isolated, it is likely that more than one identity will be invoked. In these instances where distinct sets of relationships impact one another, an identity's position in the salience hierarchy may be an important predictor of behavior when identities that are concurrently called up have conflicting expectations (Stryker 1980:61). As each of these aspects of salience

highlights, the identity salience concept provides the mechanism to address the challenge of predicting role choice or performance within the model (Serpe and Stryker 2011): the salience of an identity impacts role performance. Empirically, in order to approximate a salience hierarchy, salience has been measured using paired-comparison scaling where the respondent chooses one identity over another (in pairs) to indicate which identity is more characteristic of how the respondent thinks of her or himself (Serpe 1991; 1987:48). Though, the salience concept has primarily been measured as the likelihood of invoking (e.g., telling about) an identity across situations in recent structural identity theory research (Merolla et al. 2012; Owens and Serpe 2003; Stryker and Serpe 1994).

Identity Prominence. Research in the structural identity tradition has also examined the conceptual distinctions and relationships among salience and centrality or prominence, as well as the relationship of these concepts to other aspects of the model (Serpe and Stryker 2011; Stets and Serpe 2013; Stryker and Serpe 1994). The principle of psychological centrality, one of Rosenberg's (1979:73) four principles of self-concept formation, holds that the self-concept is made up of hierarchically organized, interrelated and complex components, such as identities. Centrality represents the importance of these components of the self-concept (Rosenberg 1979; Stets and Serpe 2013). McCall and Simmons's (1978) concept of prominence hierarchy also addresses the relationship

importance to self-organization, with *prominence*[2] representing the importance of identities for the self and the basis for the hierarchical organization of identities.

Although there has been somewhat less focus on prominence in empirical work using structural identity theory, Stryker and Serpe (1994) argue that both salience and prominence should be included in identity research because they find that these concepts, while related, are indeed independent. Conceptually, they argue that the concepts differ in that, while prominence assumes a degree of self-awareness, salience may involve but does not require such direct awareness (Stryker and Serpe 1994:19). Empirically, they find that across four university student roles and identities (academic, personal, extracurricular, and athletic) the measures overlap for some roles, but are independent for others (Stryker and Serpe 1994). As a result, they conclude that salience and prominence will likely have different explanatory power based on the identities and contexts studied (Serpe and Stryker 2011:235; Stets and Serpe 2013). Recent literature (Brenner 2011; Brenner, Serpe, and Stryker Forthcoming) supports the representation of prominence as causally prior to salience.

Identity Cognition. While both salience and prominence help to situate identities in terms of self-structure and the relative meanings that they hold, researchers have also begun to examine the impact of cognition on identity processes (Serpe 1991). Identity cognitions, or thoughts about or related to one's identity, have been conceptualized and

[2] Although psychological centrality and prominence have been used somewhat interchangeably (Stets and Serpe 2012; Stryker and Serpe 1994), I use McCall and Simmons' (1978) prominence concept to refer to these overlapping understandings about the importance of components of the self-concept.

measured in various ways, including frequency of thinking about one's identity[3] (Quinn and Chaudoir 2009), as well as with an emphasis on processes of thinking and planning about identity-relevant activity[4], or "cognitive activity" (Serpe 1991:55). Within the structural identity theory tradition, in studies where commitment, cognitive activity, and salience are examined (e.g., Serpe 1991), both commitment and cognition are posited to impact salience. Serpe (1991:60) explains, "in assuming that cognitions are easier to change than social structure, it follows that, in addition to the social structural impact of commitment on identity salience, [cognitive activity] should also have a direct effect on identity salience." Indeed, he finds a robust relationship between cognitive activity and salience, independent of correlations between commitment and cognitive activity. This finding is an important one, given that Serpe (1991:60) argues that the inclusion of cognitive activity in identity theory is predicated on the existence of a direct or indirect relationship between cognitive activity and salience. Identity cognition may be of particular interest to individuals studying non-normative or stigmatized identities, as these identities may be more likely to be concealed.

Social Structure. Traditionally, the link between commitment and salience has been the focus of structural identity theory, with commitment representing a link to social connections and, ultimately, to social structure. Stryker (1980:65) describes social structure as "patterned human regularities that characterize most human interaction".

[3] Measure characterized as identity salience for concealed identities within this psychological social psychology study (Quinn and Chaudoir 2009).
[4] Measured as frequency of thinking about a given identity, and frequency of planning about a given identity, respectively (Serpe 1991).

Moreover, he explains that these patterns "also reference the more abstract social boundaries that crosscut all societies" and as such most societies contain a class structure, age structure, racial/ethnic structure, and so forth (Stryker 1980:66). One implication of social structure is societal differentiation, such that "it is only certain people who interact with one another in certain ways and in certain settings or situations" (Stryker 1980:66).

While commitment has traditionally been the mechanism for understanding structure in structural identity theory, the importance of larger levels of social structure has been assumed to influence commitment, as well as other aspects of the identity model. Thus, more recently, the structural identity model has been more formally expanded to include such conceptions of social structures at various levels of complexity that extend beyond commitment, including *large social structures*, or aspects of a stratification system (e.g., race/ethnicity, gender and class), and *proximate social structures*, or structures close to the interactional level that provide social relationships associated with a given identity, such as families, teams, and social clubs (Merolla et al. 2012; Serpe and Stryker 2011; Stets and Serpe 2013; Stryker et al. 2005). Stryker and colleagues (2005:95), for example, examine the impact of large, intermediate (e.g., neighborhoods, schools, organized social units), and proximate social structures on affective and interactional commitment to work, family, and volunteer-based relationships. With the incorporation of large and proximate social structures into the model, structural identity theorists have reemphasized a long-standing focus on Meadian (1934) understandings that form the foundation of the theory. Namely, these various levels of structure represent a way to more directly and analytically account for the ways

in which the self arises through interaction and in the context of these larger aspects of social structure and society. Moreover, these additions to the model allow for more direct incorporation of the "social boundaries that crosscut all societies" that Stryker (1980) references in his accounting of social structure.

Identity researchers have accounted for large social structure in different ways, most notably, by controlling for these aspects of social structure (e.g., Merolla et al. 2012; Nuttbrock and Freudiger 1991) or by examining aspects of social structure, most often race or gender - using subsample analyses where sample sizes permit them (e.g., Owens and Serpe 2003; Serpe 1987; Stryker, Serpe, and Hunt 2005). Scholars have noted the value of collecting data with samples sizes sufficient to conduct subsample analyses of racial patterns in particular within social psychology, as such samples and methods of analysis are preferable to test whether theoretical tenants are applicable across racial and ethnic groups (Hunt et al. 2000; Mizell 1999; Sprague 2005). However, where such analysis is not possible due to smaller subsample sizes, accounting for large social structure through the use of controls is preferable to failure to account for social position (Hunt et al. 2000).

Identity Performance. Because identity theorists seek to predict behavior, they have typically focused on aspects of behavior, such as time in role (Stryker and Serpe 1994), role behavior and intention (Burke and Reitzes 1981; Merolla et al. 2012; Nuttbrock and Freudiger 1991) and role performance (Burke and Reitzes 1981; Stryker 1968; Serpe and Stryker 2011). The language of these outcomes has primarily been geared toward use in the study of normative identities. Recent theoretical expansions

also include additional outcomes of the model, such as measures of self, emotion, and mental health (Serpe and Stryker 2011; Stets and Serpe 2013; Stryker 2004). Figure 1 depicts the basic structural identity model discussed above. Figure 2 depicts the expanded model that articulates the relationship between cognition, salience and prominence.

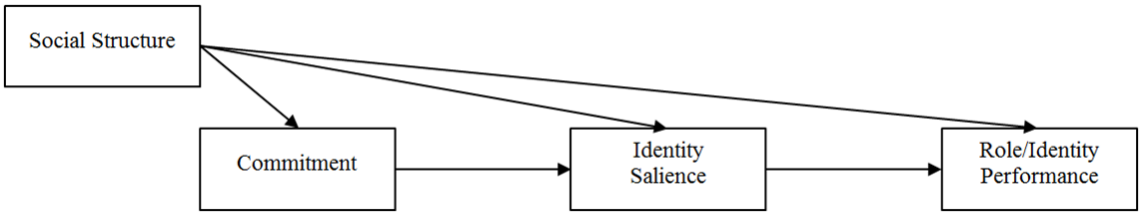


Figure 1. **Basic Structural Identity Theory Model**

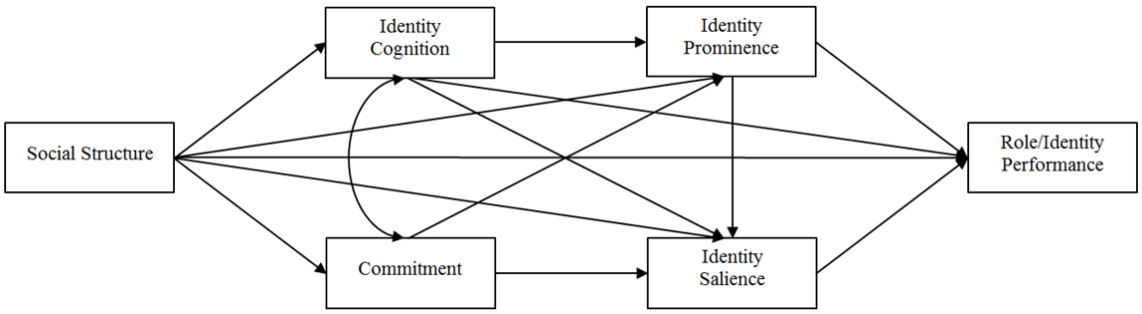


Figure 2. **Expanded Structural Identity Theory Model**

As the model above shows, the primary theoretical focus of structural identity theory concerns how social structure, reflected in the form of large to proximate social structures as well as in the concept of commitment, impacts cognition and self structure, reflected in the concepts of identity salience and prominence, and how these measures, in turn, impact role-related performance (Stryker and Burke 2000:285; Stryker et al. 2005). Many studies have examined key aspects of the structural identity theory model. Such research includes tests of relationships among different levels of social structure (Stryker et al. 2005), among forms of commitment and identity salience (Callero 1985; Marcussen et al. 2004; Owens and Serpe 2003), and among salience and role-related performance (Merolla et al. 2012; Nuttbrock and Freudiger 1991). Although structural identity theory represents a prominent approach to the study of identities, centrally focused on the role of social structure and relationships in shaping self structure and role-related performance, tests including each component of the full model are considerably few in number. Moreover, identity scholarship in general and structural identity theories in particular have contributed substantially to knowledge about normative, positively-evaluated identities. Negatively-evaluated or stigmatized identities (e.g., mental illness, medical conditions, sexually transmitted diseases), however, have received comparatively less attention. As such, the incorporation of insights from stigma scholarship has the potential to extend and expand existing understandings of identity by further specifying the conditions under which structural identity theory applies, including the extent to which theoretical predictions hold for negatively-evaluated identities for each component of the model.

Stigma

In his seminal formulations of the concept, Goffman emphasizes the social and relational nature, sources, and consequences of stigma (Goffman 1963; Link and Phelan 2001). He argues that stigma signifies a "deeply discredited" attribute. For Goffman (1963:4), stigma represents the relationship between an "attribute and a stereotype" (Link and Phelan 2001). This definition is crafted to reflect his caution that "a language of relationships, not attributes, is really needed" (Goffman 1963:3). By employing a language of relationships, Goffman (1963) underscores his conceptualization of stigma as an explicitly social phenomenon. Furthermore, he highlights the relevance of social membership for definitions applied to the stigmatized person. He explains that a stigmatized person is one who "[possesses] an attribute that makes [her or him] different from others in the category of persons available for [her or him] to be - and of a less desirable kind" (Goffman 1963:3). In this way, the stigma concept signifies a mark that links an individual to a stereotype, or a set of socially-meaningful ideas about what is evaluated as desirable (or not) from the perspective of individuals' specific location within a social structure (Jones et al. 1984; Link and Phelan 2001). As such, Goffman's (1963) formulation of stigma emphasizes the social and relational character of the concept.

Stigma and Health

To date, stigma scholars have examined a range of different types of stigma related to physical and mental health. In particular, a considerable body of research has developed examining stigma associated with mental illness (Herman 1993; Link 1987;

Link et al. 1997, 1989; Markowitz 1998; Rosenfield 1997; Wright, Gronfein, and Owens 2000). Studies in this area have addressed a range of issues, including the relative effects of perceived stigma and received services on life satisfaction (Rosenfield 1997), consequences of mental illness for psychological and social outcomes (Link 1987; Link et al. 1997, 1989; Markowitz 1998; Wright, Gronfein, and Owens 2000), and behavioral responses to manage consequences of mental health stigmatization (Herman 1993; Kroska and Harkness 2011; Link et al. 1991, 1989).

Substance use stigma, another specific form of mental health stigma, has also received attention in research, including work examining the consequences of concealable stigmas, such as engaging in drug use, and having a family member with an alcohol addiction, for well-being and health (Quinn and Chaudoir 2009), and perceptions about multiple stigmas, such as HIV/AIDS stigma and stigma associated with IV drug use (Crandall 1991). Concerning general perceptions of substance use stigmas, Link and colleagues (1999) find that individuals with alcohol dependence and cocaine dependence are viewed as most likely to be violent, and prompt the greatest desire for social distance (from the alcohol or drug user) than the any of the other stigmatized conditions they examine (e.g., major depressive disorder, schizophrenia) in a national sample of adults. Much of the research on stigma and mental health has been theoretically framed in terms of labeling and its effects, which I return to below.

Researchers have also examined chronic physical health stigmas. For example, studies of this type have examined the relative effects of perceived stigma for those with cancer and those with HIV/AIDS (Fife and Wright 2000), consequences of concealable

stigmas, such as having a medical condition like diabetes or epilepsy, for well-being and health (Quinn and Chaudoir 2009), and behavioral responses to manage consequences of stigma associated with epilepsy (Schneider and Conrad 1980). Work in this area has shown that possessing a serious and persistent stigmatized physical health identity has an important often negative impact on the self and well-being, prompting behaviors (e.g., secrecy, preventive telling; Schneider and Conrad 1980) that attempt to mitigate these effects.

Recently, a growing body of research has developed examining weight-related stigmas, which are the subject of stigmatization primarily due to the visibility of body size and pervasive beliefs that it should be controllable (Granberg 2011:30). Within this literature, researchers have examined the link between body weight and various forms of discrimination (Carr and Friedman 2005; Schafer and Ferraro 2011), the role of social group membership for what it means to "come out as fat", linking literature on fat stigma and social mobilization (Saguy and Ward 2011), as well as the processes by which individuals exit a stigmatized identity following weight loss (Granberg 2011). Research in this area has generally shown that individuals engage in various efforts to manage and reduce the consequences of stigma attached to this "discredited" identity (Goffman 1963; distinguishable from a "discreditable" identity which can be concealed; Saguy and Ward 2011), and that often the possession of this stigma has consequences for individuals in the form of discrimination and decreased well-being.

Finally, researchers have also examined STD stigmas, such as HIV/AIDS stigma (Alonzo and Reynolds 1995; Berger 2006; Crandall 1991; Rohleder and Gibson 2006;

Tewksbury and McGaughey 1997) and, to a lesser extent, herpes and HPV stigmas (Lee and Craft 2002; Nack 2008, 2000; Roberts 1997). This body of research includes the examination of perceptions and experiences of stigma (Alonzo and Reynolds 1995; Tewksbury and McGaughey 1997), including intersecting sources of stigma (Berger 2006; Crandall 1991; Herek and Glunt 1998), and behavioral responses to manage potential consequences of STD stigmatization (Lee and Craft 2002; Nack 2008, 2000).

Such research on stigmas associated with health and mental health conditions has contributed to broader knowledge about the role that stigmas play in attitudes and perceptions, consequences, and related behaviors. A smaller portion of this work (e.g., Kroska and Harkness 2011; Lee and Craft 2002) has begun to link aspects of identity to stigma using the modified labeling theory approach.

Modified Labeling Theory

Modified labeling theory is a prominent strand of stigma research that examines highly consequential personal perceptions and their implications for the experience and consequences of stigma (Fife and Wright 2000, Link 1987; Link, Mirotznik, and Cullen 1991; Rosenfield 1997). In particular, the approach emphasizes the individual internalization of socially-derived labels that identify difference and norm deviation (Link 1987; Link and Phelan 2001). Traditional labeling theory, as originally articulated by Scheff (1974, 1966), argues that mental illness is a social product. He explains that mental illness - the primary focus of this work - results from a process whereby individuals are labeled deviant from mental health norms by others, and these labels, in turn, route individuals down pathways of thoughts, behaviors, and consequences that

confirm the mental illness label. Link (1987) and colleagues (1991, 1989) extend Scheff's theory with the development of modified labeling theory. Modified labeling theory focuses less on the original source of mental illness (biology and/or social construction), instead highlighting the importance of whether or not individuals internalize or accept socially-derived labels (i.e., "secondary deviance") (Link et al. 1989). Link (1987:97) and colleagues (1991) describe the internalization process as one whereby societal attitudes about a stigmatizing mark, which were once previously innocuous, become personally relevant and meaningful once an individual experiences the possession of that mark (Stuber et al. 2008). The increased personal relevance of labels may then have a considerable impact on expectations of rejection and perceptions of stigma (Link 1987) and, similar to predictions of labeling theory, these factors set into motion a series of thoughts, behaviors, and consequences that may confirm the internalized stigma or label. In this way, possessing a labeled identity that is known to be stigmatized impacts subsequent (stigma) experience, including self-perceptions and the management of others' perceptions through the use of strategic behaviors.

The application of structural identity theory, drawing on modified labeling theory insights about implications of internalizing stigma for subsequent stigma experience and management, holds promise as means to address critiques of stigma scholarship through the explicit incorporation of social structure and relationships. Although emphasis on the internalization of labels has prompted research focused on individual perceptions of labels and stigma in modified labeling theory research, it is important to note that resultant stigma trajectories are joint products of stigmatized individuals' perceptions and

expectations, as well as reactions of and interactions with others (i.e., stigmatized and/or stigmatizing others). Thus, modified labeling insights need not be conceived as applicable only to individual-level analysis, but as also applicable to analysis of interrelated social interactions, relational ties, contexts, and structural location. Therefore, modified labeling insights have the potential to add to existing structural identity theory-based knowledge about the process by which having a stigmatized identity affects experience and behavior. Moreover, the patterns of behavior or strategies that Link and colleagues (1991, 1989), Schneider and Conrad (1980) and others (Herman 1993; Nack 2008, 2000; Tewksbury and McGaughey 1997) describe, which capture individuals' efforts to manage the consequences of stigmatized labels for the self ("stigma management strategies"; e.g., secrecy, withdrawal, and educative telling), fit into the scope of identity-related behaviors, and hold promise to address issues in the measurement of stigmatized identity performance in structural identity theory research as well.

Linking Stigma and Identity

Although the use of modified labeling theory tends to center on connections between stigma and the self, some stigma scholars have also used the concept of identity in their research. The "mark" of stigma as it is applied to the individual has been conceptualized as a master status (one's sense of self is almost completely defined by a particular aspect of that self – e.g., "a patient"), status, label, role, and identity (Becker 1963; Goffman 1963; Link 1987; Link et al. 1991; Link and Phelan 2001; Scheff 1974, 1966). However, when the term "stigmatized identity" is used in stigma research, it has

not tended to denote an analysis of identity or related processes as conceptualized by identity theorists, but rather the understanding of identities as social identifiers or as cultures of people (e.g., Roberts 1997; Rohleder and Gibson 2006; Schafer and Ferraro 2011) - an approach that has been said to depart from the theoretical intent of the concept (Stryker and Burke 2000). Goffman (1963:32) explains that individuals who possess a stigma become socialized to their 'plight" and then experience corresponding changes to conceptions of self - a "moral career". In the first phase of this socialization, an individual "learns and incorporates the standpoint of the normal, thereby acquiring the identity beliefs of the wider society and a general idea of what it might be like to possess a certain stigma….the consequence of possessing it" (Goffman 1963:32). Goffman's (1963) formulation more closely reflects a processual symbolic interactionist understanding of identity, or an understanding of identity as a general social identifier, than a formalized identity theory understanding of the concept. Overall, the treatment of identity in stigma literature has been relatively mixed, with limited direct connections in scholarship between stigma and formal theories of identity.

Empirical Studies Linking Identity and Stigma. Some scholars have made efforts to merge insights from stigma and identity theory literatures. Quinn and Chaudoir (2009), for example, examine specific identity theory concepts such as centrality and salience for those with concealable stigmatized identities (see also Quinn and Earnshaw's 2011 review). Also, Markowitz, Angell, and Greenberg (2011) examine the effects of other, reflected, and self stigmatized identity appraisals for those with mental illness. Although these studies are extremely informative and do draw on identity theory concepts, they

tend to incorporate concepts from the theory, rather than test the theory itself. In other words, formal sociological theories of identity are not fully integrated into this research.

There are, however, several notable exceptions where such integrations have been made. Kroska and Harkness' (2011, 2008) work using affect control theory (ACT) to examine self-evaluation for those with mental illness are two such exceptions. In particular, the authors' 2008 study applies aspects of ACT to modified labeling theory assumptions, using stigma sentiments to operationalize the cultural conceptions of those with mental illness, and self-identity and reflected appraisal sentiments to operationalize self-meanings. Kroska and Harkness (2008) examine the potential moderating role of mental health diagnoses, and find that diagnostic category moderates the relationship between stigma sentiments and self-meanings. The authors' 2011 study extends this work. Using the computer simulation program *Interact*, Kroska and Harkness (2011) again apply aspects of ACT to modified labeling theory assumptions to examine how psychiatric patients' stigma sentiments and diagnostic category affect the likelihood of their use of coping behaviors outlined in modified labeling literature: concealing treatment history, educating others about mental illness, and withdrawing from social interaction (all often termed stigma management strategies).

Focusing on a somewhat different type of stigmatized or non-normative identity, Asencio (2013) and Asencio and Burke's (2011) recent works use a perceptual control perspective to examine identity processes and change among those who have been incarcerated for criminal offenses. In Asencio and Burke's (2011) piece in particular, the authors make a unique contribution to both identity and modified labeling literatures by

addressing limitations in the explanatory potential of the modified labeling theory model with the identity theory framework. Specifically, Asencio and Burke (2011:177) use ideas from identity theory to better explicate the processes between the application and internalization of a label and subsequent behavior, finding - consistent with labeling theory - that reflected appraisals may influence identity and - consistent with identity theory verification processes - identity may influence reflected appraisals.

Finally, two qualitative studies that incorporate identity theory and stigma insights are worthy of note. Lee and Craft (2002) integrate insights from identity theory and stigma literatures in their study of members of a self-help group for those with genital herpes. The authors use aspects of an identity theory framework, particularly, the relationship of feedback and self-consistency motivations to behavior, finding that group members employ stigma management strategies (e.g., secrecy, withdrawal, preventive telling). In her 2011 study, Granberg examines the processes by which individuals exit a stigmatized identity - in this case, an identity as "fat" - following weight loss. For her analysis, she uses a structural symbolic interactionist framework to analyze interviews with individuals who were formerly heavy, including aspects of structural identity theory, such as the link between social ties and identity salience, and aspects of the perceptual control perspective, such as reflected appraisals, internalized identity standards, the motivation to self-verify, and behavioral responses marshalled to self-verify in the event of identity disconfirming feedback. Granberg (2011) finds that when successful exits are possible, they are not easy to achieve or dependent upon maintained weight loss alone.

These studies provide important insight into the ways in which stigma and identity literatures can be integrated using formal theories of identity, and each suggests that the integration of stigma and identity theory scholarship is a fruitful direction for future research. Moreover, Kroska and Harkness (2011, 2008), Asencio and Burke (2011), and Lee and Craft's (2002) studies suggest that the integration of identity theory, stigma literature, and modified labeling understandings, in particular, holds the potential to generate important contributions toward our understandings of negative and stigmatized identities. What remains is the need for work incorporating a structural emphasis to the identity theory ideas applied - integrating structural identity theory emphasis on social connections and relationships and modified labeling understandings about stigma.

Conceptualizing Stigmatized Identities

Integrating insights from structural identity and modified labeling theories necessarily prompts the question of how best to conceptualize stigmatized identities. What sort of identities are they? Normative identities have been conceptualized in various ways. Identity theorists have moved beyond traditional role-based conceptions of identity (McCall and Simmons 1966; Stryker 1980), which have received considerable attention and formalization in identity scholarship, to incorporate additional identity types. For example, identity theorists have examined social or group identities that are based on group membership, such as being a member of a social club or activist group, as well as person identities that are based on the unique ways in which individuals see themselves, such as being organized and dependable (Burke and Stets 2009:112; Stets

and Serpe 2013). Scholarship in this area illustrates that knowledge about normative, positively-evaluated identities has been well-developed across a variety of types. By contrast, how best to conceptualize stigmatized identities has received considerably less attention and warrants further consideration.

Thoits (1991:103), for example, includes in her conception of role identities that they are ongoing, currently enacted, and that they entail clear rights and obligations to others. Although social characteristics, stigmatized attributes, and ex-roles conceptually "could be classifiable as role identities," she excludes these types of self-conceptions or "attribute identities" from her definition of role identities (Thoits 1991:104). She explains that while attributes can influence one's social positions and interactions with others by virtue of their cross-situational influence, they do not serve as the reason(s) for the interactions (Thoits 1991:104). She does, however, make one important qualification:

> If social attributes or stigmas (such as Catholic, alcoholic, or criminal) serve as the actual reason for interaction with others in specific situations (e.g., in Catholic conventions, in AA meetings, or within a prison), those attributes would be considered role-based identities - in these examples, as church member, group member, and deviant identities, respectively (Thoits 1991:104).

Thus, Thoits' conceptualization of role identities - what they do and do not entail - may shed light on how best to conceptualize underexplored stigmatized identities: where stigmatized identities serve as the basis for interacting with others, they may be treated as role-based identities.

The importance of interaction and context is carried through by Burke and Stets' (2009), who build on Thoits and Virshup's (1997) work to argue that the basis for an identity (role, social, or person) may differ depending on context and interaction. For

instance, an individual may hold the role-based identity of worker, but that worker identity may operate or become activated as a social identity when she or he is in the context of a collective of co-workers united against managers (Burke and Stets 2009: 122). The importance of social context outlined in this work may also have important implications for the relationship between social group membership (e.g., proximate social structures) and what type of identity is activated (Stets and Serpe 2013). For instance, it may be that lower levels of proximate social structure are suggestive of a person identity or, conversely, that higher levels of proximate social structure are suggestive of a group identity. Provided stigmatized identities share the same qualities as normative identities, conceptualizing stigmatized identities may be an equally context dependent endeavor.

Work on non-normative (or counter normative) identities more generally might provide some insight into this question. Counter normative identities are those that entail not holding a social role that others value, such as voluntary "childlessness" or being atheist or non-religious, which may engender negative social evaluations (Stets and Serpe 2013:53). The potentially negative social evaluation associated with these identities is in some ways similar to stigmatized identities. However, while all identities that signify a mark linking an individual to a set of socially-meaningful ideas about what is evaluated as negative and undesirable (stigmatized identities) may be viewed as counter normative identities, by definition, not all counter normative identities are stigmatized identities. Furthermore, role, social, and group identities, mentioned above, present additional ways one could conceptualize stigmatized identities. While work on non-normative or counter

normative identities might provide important insight, empirical work in this area is fairly new and still developing, as is the work on stigmatized identities.

Although how researchers define and conceptualize identities is important, it is unclear just what sort of identities stigmatized identities are, and the extent to which any of these bases and types (e.g., role, social, person, master status) are more or less appropriate for understanding the relationship between stigma and identity is an empirical question. It is also, however, dependent on the question at hand. In this study, I am interested in understanding the relationship between stigmatized identities and the performance of these identities as a function of social connections and relationships. As such, structural identity theory provides an ideal framework.

Research Overview and Hypotheses

As the foregoing suggests, despite substantial contributions to knowledge about normative and positive identities generated by identity scholars, negative or stigmatized identities have been comparatively underexplored. Structural identity theory represents a prominent tradition of identity scholarship in which social structure and relationships are central. As such, application of the model, drawing on modified labeling theory insights, holds promise as means to address critiques of stigma scholarship. In this dissertation, I aim to expand and clarify understandings of identity and of stigma by assessing whether or not the arguments advanced by structural identity theory apply to stigmatized identities. In particular, I examine whether relationships between key components of the identity theory model - structure, commitment, cognition, prominence, salience, and identity performance - operate the same for those with stigmatized identities as has been

proposed and empirically demonstrated for those with normative identities. Because structural identity is a formalized theory that has been likewise formally tested, I expect to find a similar set of relationships for those with stigmatized identities as has been proposed and empirically demonstrated for those with normative, positively-evaluated identities. Consistent with structural identity theory propositions and findings using the basic model, I propose the following:

> H1: *Commitment to a stigmatized identity will be positively related to the salience of that identity*.
>
> H2: *The salience of a stigmatized identity will be positively related to stigmatized identity performance.*

Consistent with structural identity theory propositions and findings using the expanded model, I propose the following relationships with proximate social structures (H3), commitment (H4), and identity cognition (H5):

> H3: *Membership in proximate social structures will be positively related to*
> *(a) commitment to a stigmatized identity,*
> *(b) cognition about a stigmatized identity,*
> *(c) the prominence of a stigmatized identity,*
> *(d) the salience of a stigmatized identity, and*
> *(e) stigmatized identity performance.*
>
> H4 *Commitment to a stigmatized identity will be positively related to*
> *(a) the prominence of that identity, and*
> *(b) the salience of that identity*[5].
>
> H5: *Cognition about a stigmatized identity will be positively related to*
> *(a) the prominence of that identity,*
> *(b) the salience of that identity, and*
> *(c) stigmatized identity performance.*

[5] Hypothesis 4b is identical to Hypothesis 1. However, since Hypothesis 4b is part of the expanded (standalone) model, and I am hypothesizing it in the context of other relationships, I assign it a unique name.

Consistent with recent literature (Brenner 2011; Brenner et al. Forthcoming), which suggests that prominence is causally prior to salience, I further hypothesize that:

> H6: *The prominence of a stigmatized identity will be positively related to*
> *(a) the salience of that identity, and*
> *(b) stigmatized identity performance.*

Finally, as hypothesized in the basic model, I expect that salience will be related to performance in the extended identity model:

> H7: *The salience of a stigmatized identity will be positively related to stigmatized identity performance*[6].

In addition to predicting that findings will be largely consistent for those with stigmatized identities with what has been found for those with normative identities, I also expect that the structural identity theory model will be a good fit for these data. Findings consistent with the above hypothesized relationships could provide tentative support that stigmatized identities operate as, or in a way similar to, role identities.

[6] Hypothesis 7 is identical to Hypothesis 2. However, since Hypothesis 7 is part of the expanded (standalone) model, and I am hypothesizing it in the context of other relationships, I assign it a unique name.

CHAPTER THREE

METHODS

In this chapter, I review the methods that I used for the current study. I first describe my study data and measures. I then provide an overview of my analysis, including the statistical procedures and modeling techniques that I used, and the various components that make up my descriptive, primary, and secondary analysis. Finally, I conclude by discussing my approach to addressing missing data.

Data

The data for this study come from a pilot project[7,8] that is related to a broader group of studies conducted by the Community Mental Health Research Initiative (CMHRI)[9]. The CMHRI is a multisite project that includes study partnerships among Northeast Ohio Medical University, Kent State University, Akron University, Hiram College, and Cleveland State University. The initiative focuses on individuals who are receiving services for serious and persistent mental illnesses in a county in Northeast Ohio. The CMHRI conducted a more comprehensive study, which involved face-to-face interviews that covered a variety of topics, including: stigma and stigma resistance, social.

[7] Co-PIs: Kristen Marcussen (PI), Lindsey L. Westermann Ayers, Christian Ritter, and Richard T. Serpe.
[8] Funding for the pilot study provided by Northeast Ohio Medical University, the Kent State University Department of Sociology, and a Kent State University Graduate Student Senate Research Grant
[9] PI: Christian Ritter

support, self processes, health behaviors, and measures of stress and mental health. The pilot data is intended to explore, more closely, identity, stigma, and mental health.

Data for this study were collected through structured telephone interviews of a sample of approximately 1,000 adults (N=1,003), 18 years of age or older, living in a county in Northeast Ohio. In contrast to the CMHRI study, receipt of services for serious and persistent mental illnesses was not a criterion for participation in the pilot study. Data collection took place at the Survey Research Lab (SRL), housed in the Kent State University Department of Sociology, using computer-assisted telephone interviewing that relies on random digit dialing. The SRL is equipped with 18 interviewing stations, and conducts approximately 15,000 telephone interviews per year. All interviewers are trained and supervised at the SRL, and receive additional project-specific training for each study. The sample for this study consists of telephone numbers representing a random area cluster sample drawn from the census tracts in the aforementioned Northeast Ohio county. Approximately 1000 clusters were selected, with one interview completed in each of the clusters. The sample was purchased from Survey Sampling International, Inc., a reputable vendor for phone surveys, and was screened for businesses, group quarters, government offices, and disconnected numbers before it was received and placed into the field by the SRL. Interviewers made eight dialing attempts before retiring a given telephone number. The survey resulted in 1,003 completed interviews and five partially completed surveys. Each interview lasted approximately 15 minutes. Per the AAPOR Response Rate Calculator (American Association for Public Opinion Research 2009), the response rate (RR4) was 20.5 percent.

Measures

For this survey, respondents were asked if they possessed a stigmatized identity from a list of six different types: mental health issues, weight concerns, serious physical health issues, alcohol use, drug use, and sexually transmitted diseases (STD). It is important to note that, while these identities have been previously considered stigmatizing (Quinn and Chaudoir 2009), one of the goals of this pilot study is to assess the extent to which that is true using a variety of measures. As such, the question wording for this item did not include the words "stigmatized" or "identity," in order to avoid leading or priming the respondent by making such a direct reference. Interviewers read the following statement:

> *I am going to read a list of concerns or conditions that may interfere with one's life and relationships. These are often common and can cause considerable difficulty for people. Please let me know if these concerns or conditions are something that you currently experience in your life. You may choose one or all of these concerns or conditions, if they apply to you. I will also provide you with some examples, but please keep in mind that these may not be the only examples of each of the conditions.*

For each of the identities, interviewers offered several examples. For instance, respondents were asked if they were experiencing "mental health issues, such as depression, anxiety, obsessive compulsive disorder"; "weight concerns, such as obesity or eating disorders, like anorexia or bulimia"; "serious physical health issues or limitations, such as diabetes, epilepsy, heart disease"; "alcohol use, such as excessive alcohol use or drinking that interferes with work or family life"; "drug use, such as abuse of illegal substances or prescribed drugs"; and/or "sexually transmitted disease(s) or infection(s), such as chlamydia, herpes, HPV". Respondents who reported mental health

and/or physical health identities were asked open-ended follow up questions to ascertain what type of mental health issues and serious physical health issues they were experiencing.

Respondents who reported having a stigmatized identity were also asked a series of questions related to that identity, including measures of identity, stigma, self, and well-being. For respondents with more than one reported identity, the computer randomly selected one identity to be the focus of subsequent questions. The random selection of identities was important, primarily because if a respondent were to be asked to select the focal identity her or himself, this would risk potentially confounding measures such as identity salience or prominence with the respondent's choice. Respondents who did not report possessing one of the identities presented were asked a small series of demographic questions. Finally, all respondents were asked a series of general questions about the stigmatized nature of the identities discussed in this survey[10], adapted from Quinn and Chaudoir (2009).

For the present study, I focused exclusively on those who reported having a stigmatized identity. Appendix A shows the frequencies for each of the identities that were selected and about which the respondents were asked a series of questions related to that one particular identity. All study measures are included in Appendix B.

[10] For these six items, included in descriptive analysis only in the current study (see Table 3), respondents were asked how they think people with each of the six stigmatized identities are generally viewed by others, with responses ranging from 1 (very negative) to 7 (very positive).

Social Structure Variables

Controls. For this study, I controlled for large social structural variables in all statistical analyses, and did not make specific predictions about how they might operate. Race was measured by asking respondents to identify what race they consider themselves to be. Those who selected white were coded as 0 and those who selected Black or African American, Hispanic or Latino, Asian, and "other" race were coded as 1. Gender was represented by an interviewer coded measure (male = 0; female = 1). Employment status was measured by asking respondents whether they are currently employed (yes = 0; no = 1). Finally, income was measured by asking respondents to select the category that best describes the total annual income of their household, including personal income and the income of others living in the household (less than $14,999 = 1 to above $100,000 = 8).

Proximate Social Structures. I included a two-item index to assess *proximate social structures*. The measures asked the respondent to report whether or not she or he has joined a social group related to her or his stigmatized identity, and whether or not she or he has joined a formal, organized group related to her or his stigmatized identity. The items were summed ($R = .496$, $p \leq .001$), such that values for proximate social structure via group membership were reflective of whether the respondent belonged to no such groups (0), either a social or formal organized group (1), or both social and formal organized groups (2).

Identity Measures

To assess commitment, I used a two-item index that included measures of *interactional commitment* adapted from Owens and Serpe (2003) that address frequency of interaction, and the number of individuals one knows with the same identity. To measure frequency of interaction, respondents were asked "in an average week, how many hours do you spend with other people who have [identity]". Reported values greater than the maximum 168 hours (n = 5) were assigned a value of 168. To assess the number of individuals one knows with the same identity, respondents were asked "how many people do you know who have [identity]". Both items were first standardized to account for the different measurement of each item, then summed ($R = .314$, $p \leq .001$).

Identity cognition was measured with a 4-item scale developed specifically for the stigmatized identities survey. The scale included the following items: "In general, how often do you think about your [identity]"; "how often do you think about your [identity] when you are reading or viewing something in the media (e.g., television, the Internet, newspapers, magazines)"; "how often do you think about your [identity] when meeting new people for the first time"; and "how often do you think about your [identity] when you are at a social event or during social activities". Scale items were summed and divided by the number of items. Responses ranged from 0 (almost never) to 10 (almost always), and the scale was highly reliable ($\alpha = .807$).

My measure of *prominence* captured the relationship between the identity and one's overall sense of self. The 3-item scale was comprised of a selection of items from the Importance to Identity subscale of the Collective Self-Esteem scale (Luhtanen and

Crocker 1992): “my [identity] is an important part of my self-image”, as well as those authored for the broader CMHRI study: “if people do not know that I have [identity] they do not really know who I am” and “if people don’t know that I have [identity] they do not really know who I am”. Scale items were summed and divided by the number of items. Responses ranged from 0 (strongly disagree) to 10 (strongly agree) ($\alpha = .653$).

To measure *identity salience*, I used a 4-item scale adapted from Owens and Serpe (2003). The scale included the following items: “when meeting a person of the opposite sex for the first time, how certain is it that you would tell this person about your [identity]”; “when meeting a friend of a close friend for the first time, how certain is it that you would tell this person about your [identity]”; “when meeting a friend of a family member for the first time, how certain is it that you would tell this person about your [identity]”; and “when meeting a stranger for the first time, how certain is it that you would tell this person about your [identity]”. Scale items were summed and divided by the number of items. Responses ranged from 0 (certainly would not) to 10 (definitely would), and the scale was highly reliable ($\alpha = .890$).

A primary goal in this study is to link identity theory with stigma research, in part, by offering a more formalized model of identity that takes into account identities that are stigmatized. As such, I used a measure of identity performance that was consistent with both structural identity theory - in that the measure is related to behavior associated with the identity - and stigma research - in that the measure reflects a stigma management strategy examined in modified labeling theory (Link et al. 1991, 1989), particularly, work that has used modified labeling theory to expand identity models (e.g., Lee and Craft

2002, Kroska and Harness 2011). Specifically, I measured *identity performance* with a 6-item scale adapted from the Social Withdrawal subscale of the Internalized Stigma of Mental Illness (ISMI) scale (Ritsher, Otilingam, and Grajales 2003). The subscale included the following items: "I don't talk about myself much because I don't want to burden others with my [identity]"; "I don't socialize as much as I used to because my [identity] might make me look or behave 'weird'"; "negative stereotypes about [identity] keep me isolated from the 'normal' world"; "I stay away from situations in order to protect my family or friends from embarrassment"; "being around people who don't have [identity] makes me feel out of place or inadequate"; and "I avoid getting too close to people who don't have [identity] to avoid rejection". Scale items were summed and divided by the number of items. Responses ranged from 1 (strong disagree) to 4 (strongly agree), with higher scores indicating greater identity performance (i.e., greater social withdrawal). The scale was highly reliable ($\alpha = .887$).

Analytic Strategy

Analyses for this study were conducted on a subsample of 327 respondents who reported having at least one stigmatized identity (Appendix A). I examined whether relationships between key components of the identity theory model - social structure, commitment, cognition, prominence, salience, and identity performance - operate the same (i.e., the same direction of relationship) for those with stigmatized identities as has been proposed and empirically demonstrated for those with normative identities (Figures 3 and 4).

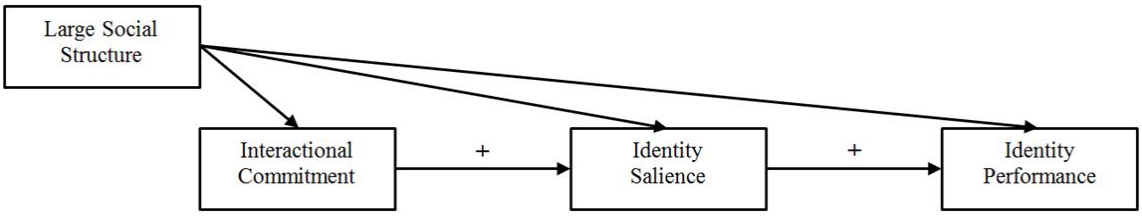


Figure 3. **Basic Theoretical Model with Hypothesized Relationships**

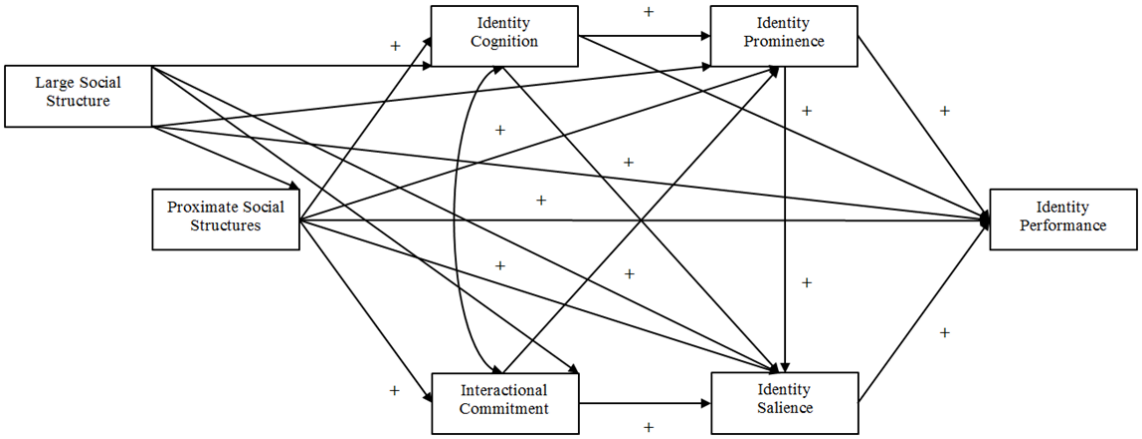


Figure 4. **Expanded Theoretical Model with Hypothesized Relationships**

In order to examine the structural identity theory models depicted in Figures 3 and 4 for those with stigmatized identities, I used structural equation modeling (SEM). SEM allows me to examine all components of the model simultaneously while also allowing for the correlation of error terms and the assessment overall model fit. In particular, I used structural path models for all analyses with all study variables and controls (large social structure) entered as observed variables for this exploratory analysis. All scaled variables had moderate to high alpha reliabilities and the concepts and measures have for the most part been repeatedly used in prior research.

SEM is generally robust to violations of multivariate normality. Nevertheless, preliminary examination of the data, including basic descriptives, skewness and kurtosis values, Mardia's coefficients, correlations, scatterplots and histograms, and normal probability plots, revealed that the assumptions of linear regression and SEM (e.g., linearity, multivariate normality, random residuals) were generally met in the current dataset. Examination of the bivariate correlation matrix also did not reveal any problems with multicollinearity (Table 1). All bivariate correlations were moderate, and not in excess of recommended thresholds for correlations among independent variables (none greater than .80). Maximum likelihood estimation was used because the multivariate normality assumption was not violated to a substantial degree.

Table 1. ***Correlations of Study Variables***

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
(1) Gender	1								
(2) Race	-.030								
(3) Employment Status	-.002	.005							
(4) Income	.016	-.102	**-.413**						
(5) Proximate Structure	.057	**.118**	.070	.023					
(6) Interact. Commitment	**-.139**	**.139**	-.077	.058	.051				
(7) Identity Cognition	.089	.076	.092	**-.132**	**.160**	-.050			
(8) Prominence	-.090	**.186**	**.146**	**-.232**	.029	-.022	**.487**		
(9) Identity Salience	**-.140**	.086	**.137**	**-.173**	.080	.047	**.361**	**.277**	
(10) Identity Performance	.004	.072	**.302**	**-.337**	**.124**	-.031	**.368**	**.402**	**.182**

Bolded coefficients are statistically significant at p>.05 or better

Overview of Analysis

For my descriptive analysis, I first calculated basic descriptives for all study variables. I then conducted an independent samples t-test, comparing mental and physical health identity group means for six cultural stigma items. This analysis is intended to provide information about the extent to which the respondents perceive the six identities of interest to be stigmatized by the public more generally, and provides a basis from which to proceed with my analysis based on the assumption that these are stigmatized identities.

My primary analysis is comprised of two parts. First, I estimated a traditional structural identity theory model, linking commitment, salience, and identity performance, without the inclusion of proximate social structure, cognition, or prominence, to see how identity processes operate for all respondents with stigmatized identities using the basic model (Figure 3[11]). Second, I estimated the expanded structural identity theory model for all respondents to examine identity processes for those with stigmatized identities, taking the basic model as well as proximate social structure, cognition, and prominence into account (Figure 4).

Given the relatively distinct treatment of mental and physical health in stigma literature, it is reasonable to assume that these identities are somewhat different. While structural identity theory would not necessarily predict a different process for these

[11] Although conceptual refinements about how best to characterize aspects of social structure (i.e., large, intermediate, and proximate forms) were formally developed after the advent of the basic structural identity theory model (Stryker et al. 2005), structural identity theorists have included aspects of what are now referred to as large social structure as controls or as a means to conduct subsample analyses for some time (e.g., Owens and Serpe 2003; Serpe 1987; Stryker and Serpe 1994; Nuttbrock and Freudiger 1991). Therefore, I control for large social structure in the basic model as well as all other models.

identities, the extent to which mental and physical health related identities operate in similar ways vis-à-vis structural identity theory remains an empirical question. Therefore, in addition to my primary analysis, which is based on stigmatized health identities more generally, I also conducted secondary analyses to examine focal study variables and relationships separately for individuals who reported on mental health identities and individuals who reported on physical health identities. In order to determine which identities would comprise the mental health group, I used the identities that most closely mirrored conditions included in The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM–5; American Psychiatric Association 2013): the mental health issues identity, as well as the drug and alcohol use identities. The physical health group is comprised of those who claimed serious physical health concerns, weight concerns and STD/STIs identities.

I first conducted an independent samples t-test comparing mental (mental health issues, alcohol use, drug use; N = 138) and physical (weight concerns, serious physical health issues or limitations, sexually transmitted diseases or infections; N = 189) health identity group means for all endogenous study variables. This test was intended to serve as a foundation for the final component of my secondary analysis, in which I estimated a groups model using the expanded structural identity theory model. My final set of analysis examines this question using group models that again separate mental and physical health identity groups. Although I do not offer specific hypotheses for the groups with this exploratory analysis, I examine the extent to which the expanded

structural identity model reveals a similar pattern of relationships when divided into mental and physical health identity groups.

As I note above, for each of my structural equation models, I estimated the models with gender, race, employment status, and income included as exogenous covariates. I include paths from each control - each which is correlated with the others - to each endogenous variable to account for any initial large social structural inequalities among participants, which allowed me to assess the unique effects of all endogenous study variables. Although I calculated modification indices for each model, no path additions or theoretically justifiable deletions were recommended to improve model fit for any of the sets of analysis. Therefore, I estimated and present a single, final model for each set of analyses, rather than multiple iterations of the same model (i.e., covariate, initial, and respecified models).

Missing Data

To address missing values for scaled variables (cognition, prominence, salience, identity performance), I used mean substitution to replace missing scale values for respondents who answered a minimum of two-thirds of each scales' items. Respondents who did not provide answers for at least two thirds of each scales' items were omitted from the study (this equated to no more than two respondents per scale). No more than approximately 3% of the study sample received mean substituted values for each scale (Appendix C). I chose this conservative process of substituting missing data for the individual with the group mean for each item because my data is cross-sectional and each item had a small percentage of missing values. Several study variables had no missing

values (proximate social structure, commitment, gender, employment status). Listwise deletion was used for respondents with missing values on any remaining measures (race and income). The present sample size (N = 327) is sufficient to test all models in the present study with at least 10 cases per variable in each model (i.e., 46 cases per variable in the basic model, 32 cases per variable in the expanded model, and 13 and 18 cases per variable for the mental and physical health groups, respectively, in the expanded groups model).

CHAPTER FOUR

RESULTS

In this chapter, I present the findings for each set of descriptive and primary analysis. I begin by reviewing the results of descriptive analyses that include basic information about the study sample, and an independent samples t-test that compared mental and physical health identity group means for six cultural stigma items. I then present the results of my primary analyses, which includes two structural equation models that examined stigmatized identity processes for all respondents with a stigmatized identity using (1) basic and (2) expanded structural identity theory models.

Descriptive Analysis

Sample Characteristics

Table 2 provides descriptive information for exogenous and endogenous study variables. These analyses showed that the majority of the sample is female (73.4 percent) and white (83.5 percent). Most respondents are not employed (55 percent), and the median annual household income for the sample is between $35,000 and $44,999.

Key study variables were asked of only of those who reported having at least one stigmatized identity (N=327, Appendix A). Approximately one fifth of these respondents reported membership in proximate social structures, that is, social and formal organized

Table 2. ***Percentages, Means, and Standard Deviations of Study Variables (N = 327)***

	Percentage/Mean	SD	Range
Social Structure Measures			
Gender (Female)	73.4	__	__
Race (White)	83.5	__	__
Employment Status (Not Employed)	55.0	__	__
Household Income	4.36	2.41	1-8
Less than $14,999	17.7	__	__
Between $15,000 and $24,999	11.0	__	__
Between $25,000 and $34,999	10.7	__	__
Between $35,000 and $44,999	12.5	__	__
Between $45,000 and $59,999	13.1	__	__
Between $60,000 and $74,999	9.2	__	__
Between $75,000 and $99,999	11.9	__	__
Above $100,000	13.8	__	__
Proximate Social Structures	.30	.62	0-2
Joined No Groups	78.6		
Joined Either Social or Formal Group	12.8		
Joined Both Social and Formal Group	8.6		
Identity Measures			
Interactional Commitment (standardized)	.01	1.64	-1.25-8.50
Interactional Commitment (# Hours)	23.80	39.73	0-168
Interactional Commitment (# People)	18.28	28.49	0-200
Identity Cognition	4.50	2.71	0-10
Identity Prominence	3.46	2.66	0-10
Identity Salience	1.29	2.19	0-10
Identity Performance	1.89	.67	1-4

group membership associated with their stigmatized identities (21.4 percent total; 12.8 percent membership in either type of group, 8.6 percent membership in both types of group). Respondents reported an average of 23.80 hours per week spent with others who share the respondent's identity, and an average of approximately eighteen ($\bar{x}$ = 18.28) people the respondent knows who share the respondent's identity – which together comprise the respondent's interactional commitment ($\bar{x}$ = .01 standardized).

Respondents reported lower levels of identity salience than identity cognition (identity cognition $\bar{x}$ = 4.50; identity salience $\bar{x}$ = 1.29), suggesting a lower likelihood of

invoking a stigmatized identity in different situations and contexts than the likelihood of thinking about a stigmatized identity across situations. Finally, respondents reported relatively moderate levels of identity prominence ($\bar{x}$ = 3.46) and identity performance ($\bar{x}$ = 1.89), the latter indicating that they engage in social withdrawal at relatively moderate levels as a result of their stigmatized identities.

Cultural Stigma Perceptions

Table 3 provides descriptive information for six cultural stigma questions that measure respondents' views about the stigma attached to each of the six identities included in the current study (e.g., "how do you think people with mental health issues, such as depression, anxiety, or obsessive compulsive disorder, are generally viewed by others?", adapted from Quinn and Chaudoir 2009). Although these cultural stigma questions are not included in my primary analysis that assesses respondents' personal stigmatized identity processes, I included them in this preliminary descriptive analysis to provide basic information about how the respondents think others view these identities, or the extent to which respondents find the identities to be generally stigmatizing. This measure is somewhat similar to previous (more detailed) measures in the stigma literature that assess general attitudes of mental illness (e.g., Link's Devaluation-Discrimination scale; Link 1987). The range for the cultural stigma measure is 1 through 7, where high scores indicate generally positive perceptions and low scores indicate negative perceptions. Relatively low means ("negative" values: means of 4 and below; range: 1-7) would provide support for the characterization of these identities as stigmatized identities.

Table 3. ***Descriptive Statistics for Cultural Stigma Items (N = 302)***

	All Identities (N=302)		**Mental Health** (n=130)		**Physical Health** (n=172)		**Mean Difference**
	Mean	SD	Mean	SD	Mean	SD	
Cultural Stigma Measures[1]							
Mental Health Issues	2.97	1.57	3.10	1.61	2.87	1.53	.23
Alcohol Use	2.44	1.76	2.65	1.84	2.28	1.69	.37
Drug Use	2.21	1.80	2.42	1.90	2.05	1.70	.37
Physical Health Issues	4.43	1.79	4.72	1.80	4.21	1.75	.51*
Weight Concerns	2.72	1.73	2.62	1.73	2.80	1.72	-.18
STDs or STIs	2.59	1.78	2.62	1.87	2.56	1.71	.05

[1]Response categories: 1=very negative; 7=very positive
* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

For this analysis (Table 3), only those respondents from the current study sample who provided answers to all cultural stigma questions were included (N = 302).

Taken together, respondents felt that drug use was viewed most negatively by others ($\bar{x}$ = 2.21), followed by alcohol use ($\bar{x}$ = 2.44), sexually transmitted diseases or infections ($\bar{x}$ = 2.59), weight concerns ($\bar{x}$ = 2.72), and mental health issues ($\bar{x}$ = 2.97), with serious physical health issues viewed the least negatively of the six identities ($\bar{x}$ = 4.43). While respondents felt that serious physical health issues or limitations (e.g., diabetes, epilepsy, or heart disease) are viewed as moderately negative by others, they felt that the remaining five identities were viewed more negatively. These findings, particularly the strong negative views associated with drug use, are consistent with previous work from the stigma literature. Link and colleagues (1999), for example, find that alcohol and cocaine dependence were viewed most negatively (violent), and associated with the strongest desire for social distance in a national sample of adults.

As noted above, these analyses included those respondents who indicated they held one or more of these identities, and those who did not. It is possible that holding one of the identities of interest might influence how one rates perceptions of that identity more broadly. To examine this, I conducted an independent samples t-test comparing cultural stigma means for mental and physical health identity groups to determine whether having an identity that falls into the grouping of a mental health identity (i.e., mental health issues, alcohol use, and drug use) or a physical health identity (i.e., serious physical health issues, weight concerns, sexually transmitted diseases or infections) results in having significantly different views about how others perceive the six identities. Results of this analysis are also included in Table 3. Perceptions of stigma for those in the mental health identity group did not differ significantly from the perceptions of those in the physical health identity group for mental health issues, alcohol use, drug use, weight concerns, and sexually transmitted diseases or infections. The groups' perceptions about how others view serious physical health issues, however, did differ significantly.

My final independent samples t-test examined differences between the mental health and physical health groups excluding those who fell into both groups. While the respondent's focal identity for this survey was chosen randomly, a number of respondents reported holding several of the identities examined[12]. These respondents may hold somewhat different views than those who fall more clearly into one (mental or physical

[12] Respondents in the mental health identity group who initially also reported having an identity that falls into the physical health identity group (n = 44 of 130) and respondents in the physical health identity group who initially also reported having an identity that falls into the mental health identity group (n = 52 of 172).

health) category. Results from this t-test (N = 206; mental health identity: n = 86; physical health identity: n = 120) did not differ from the initial analysis with the exception of perceptions about weight issues and serious physical health issues. After excluding respondents who reported stigmas of different types (i.e., mental and physical health identities), the groups' perceptions concerning serious physical health issues no longer differed significantly. Though, the groups' perceptions concerning weight concerns now differed significantly.

Despite some differences in findings concerning serious physical health issues and weight concerns, a point to which I return later, these results suggested relatively consistent and pervasive understandings by respondents about the stigma attached to each of these identities by others in general. Moreover, this analysis suggested that there is reason to believe that these identities are non-normative to some extent, which in combination with literature on mental health and physical health stigmas, provided a basis from which to proceed with my analyses based on the assumption that these are stigmatized identities. My first (primary) set of analyses examined the basic and expanded structural identity models with the full set of identities. Because these findings also suggested that there are some differences across types of conditions, which suggested that groups analysis would be appropriate, my secondary set of analysis (Chapter 5) examined focal study variables and relationships separately for individuals who reported on mental health identities and individuals who reported on physical health identities.

Primary Analysis: General Models of All Stigmatized Identities

Basic Structural Identity Theory Model

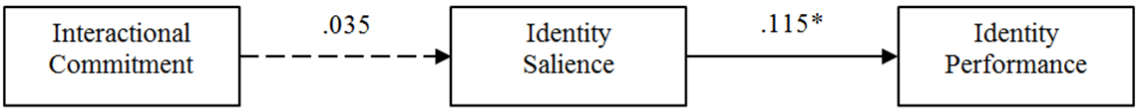
To examine stigmatized identity processes using the traditional structural identity theory model, I estimated the basic model depicted in Figure 3 for all respondents with a stigmatized identity. The basic structural identity theory model fit the data well: χ^2 (df = 1, N = 327) = .040, p = .841, *CFI* = 1.00, *RMSEA* = .00 (*CI* = .00, .09). The chi-square value, which was not significant, indicated that the null hypothesis (that the model being estimated is an exact fit for the data) should not be rejected. Because chi-square test statistics can be affected by multivariate non-normality, I review relevant indicators of normality below. The test is also sensitive to sample and correlation sizes (Kline 2011). Although the potential impact of sample size is important to bear in mind with the current study, no correlations among study variables were in access of .50 (Table 1). The Bentler Comparative Fit Index (CFI; Bentler 1990) is an incremental fit index that compares the fit of the model being estimated to the independence model. A value between .90 and .95 is generally considered to indicate an acceptable fit, and a value above .95 is generally considered to indicate a good fit. Thus, the CFI value of 1.00 suggested a good model fit. The Steiger-Lind Root Mean Square Error of Approximation (RMSEA; Steiger 1990*)* index is scaled so that higher numbers indicate badness of fit – values less than .05 indicates a good fit. The RMSEA is a parsimony-adjusted index, such that greater degrees of freedom (i.e., greater parsimony) will decrease RMSEA values, provided samples sizes are not also larger, which diminishes the effect of parsimony correction (Kline 2011). Therefore, the RMSEA value of .00 for this model and sample suggested a

good model fit (also the RMSEA confidence interval lower bound was at the .00 target, and its upper bound was lower than the .10 target).

Turning to the model in greater detail, univariate statistics did not indicate that skewness or kurtosis values were particularly problematic. No skewness values were greater than recommended bounds of +/- 3 and no kurtosis values were greater than the recommended +/- 10. The Mardia's coefficient was 13.65. Values below 3-5 suggest that multivariate normality is present. Therefore, although SEM is generally robust to violations of multivariate normality, the Mardia's coefficient suggested that this model may have had slight issues related to its (non)normality.

The residual and standardized residual covariance matrices should ideally be evenly distributed and contain smaller values, as close to zero as possible, to indicate a good fit. Most values in both matrices were equal to zero, with a small few just above zero and none in excess of .02 for the residual covariance matrix and .20 for the standardized residual covariance matrix. The matrices indicated that the model was a reasonably good fit for the model variables.

Standardized estimates for all endogenous variables are shown in Figure 5. All standardized and unstandardized estimates for the model are shown in Table 4. Estimates for the basic model indicated that commitment was not significantly associated with salience, failing to support Hypothesis 1. Salience was, however, significantly and positively associated with identity performance, supporting Hypothesis 2.



Correlations between controls and paths from controls to all endogenous variables were estimated (see Table 4) but are not shown

Figure 5. **Basic Model with Standardized Estimates (N = 327)**

Table 4. ***Standardized Estimates, Unstandardized Estimates and Standard Errors for Basic Model[1] (N = 327)***

Path	b	(SE)	B
Key Theoretical Coefficients			
Commitment → Salience	.046	(.073)	.035
Salience → Identity Performance	**.035**	**(.016)**	**.115**
Control Variable Coefficients			
Gender → Commitment	**-.505**	**(.201)**	**-.136**
Race →Commitment	**.618**	**(.241)**	**.140**
Income → Commitment	.035	(.041)	.051
Employment Status → Commitment	-.189	(.196)	-.057
Gender → Salience	**-.649**	**(.269)**	**-.131**
Race → Salience	.374	(.322)	.063
Income → Salience	**-.119**	**(.054)**	**-.131**
Employment Status → Salience	.376	(.260)	.085
Gender → Identity Performance	.039	(.077)	.026
Race → Identity Performance	.068	(.092)	.038
Income → Identity Performance	**-.066**	**(.016)**	**-.236**
Employment Status → Identity Performance	**.253**	**(.075)**	**.189**
Covariances			
Gender ←→ Race	-.005	(.009)	-.030
Gender ←→ Income	.017	(.059)	.016
Gender ←→ Employment	.000	(.012)	-.002
Race ←→ Income	-.091	(.050)	-.102
Race ←→ Employment	.001	(.010)	.005
Income ←→ Employment	**-.494**	**(.072)**	**-.413**

[1]Standardized coefficients for this model are displayed in Figure 5
Bolded coefficients are statistically significant at p>.05 or better

Table 4 shows the relationships between my control variables and endogenous study variables. Race and gender were significantly associated with commitment. Women reported significantly lower levels of commitment than men, while respondents of color reported significantly higher levels of commitment than white respondents. Gender and income were significantly associated with salience. Women reported significantly lower levels of salience than men, while respondents with higher levels of income reported significantly lower levels of salience. Finally, income and employment status were significantly associated with identity performance. Respondents with higher levels of income reported significantly lower levels of identity performance, or withdrawing, while respondents who were not currently employed reported significantly higher levels of identity performance than employed respondents.

In sum, a number of social structural controls were significantly associated with endogenous variables. However, among the endogenous variables representing the basic structural identity model, only salience was significantly (and positively) associated with identity performance.

Expanded Structural Identity Theory Model

To examine stigmatized identity processes using the expanded structural identity theory model, I estimated the model depicted in Figure 4 for all respondents with a stigmatized identity. The expanded structural identity theory model fit the data well: χ^2 (df = 1, N = 327) = .031, p = .860, *CFI* = 1.00, *RMSEA* = .00 (*CI* = .00, .08). The chi-square value, which was not significant, indicated that the null hypothesis (that the model being estimated is an exact fit for the data) should not be rejected. The CFI and RMSEA

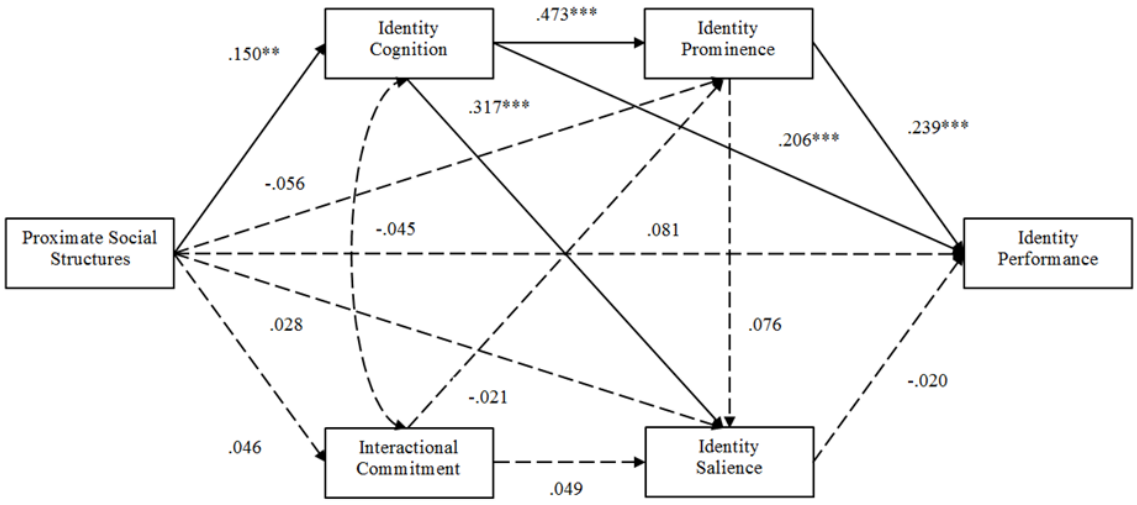
fit indices – at 1.00 and .00, respectively - suggested a good model fit (also the RMSEA CI lower bound was at the .00 target and its upper bound was lower than the .10 target).

Like the basic model, univariate statistics did not indicate that skewness or kurtosis values were particularly problematic. No skewness values were greater than recommended bounds of +/- 3 and no kurtosis values were greater than the recommended +/- 10. The Mardia's coefficient was 18.18. Values below 3-5 suggest that multivariate normality is present. Therefore, although SEM is generally robust to violations of multivariate normality, the Mardia's coefficient suggested that this model may have had slight issues related to its (non)normality.

The residual and standardized residual covariance matrices were relatively evenly distributed and contained smaller values, with most values in both matrices equal to zero and a small few just above zero (none in excess of .01 for the residual covariance matrix and .20 for the standardized residual covariance matrix). The matrices indicated that the model was a reasonably good fit for the model variables.

Standardized estimates for all endogenous variables are shown in Figure 6. All standardized and unstandardized estimates for the model are shown in Table 5. Estimates for the expanded model indicated that proximate social structure was significantly and positively associated with identity cognition, supporting Hypothesis 3b. Hypotheses 3a, 3c, 3d, and 3e, however, were not supported, as proximate social structure was not significantly associated with commitment (Hypothesis 3a), prominence (Hypothesis 3c), salience (Hypothesis 3d), or identity performance (Hypothesis 3e). Commitment was likewise not significantly associated with prominence or salience (similar to the basic

model), failing to support Hypotheses 4a and 4b, respectively. Cognition, however, was significantly associated with several other endogenous variables. Cognition was significantly and positively associated with prominence, supporting Hypothesis 5a. Cognition was also significantly and positively associated with salience, supporting Hypothesis 5b, and significantly positively associated with identity performance, or withdrawal, supporting Hypothesis 5c. Prominence was not significantly associated with salience, failing to support Hypothesis 6a. Unlike the basic model, salience was not significantly associated with identity performance in the expanded model, failing to support Hypothesis 7. However, prominence was significantly and positively associated with identity performance, thus supporting Hypothesis 6b.



Correlations between controls and paths from controls to all endogenous variables were estimated (see Table 5) but are not shown

Figure 6. **Expanded Model with Standardized Estimates (N = 327)**

Table 5 shows the relationships between my control variables and endogenous study variables. Respondents of color reported significantly higher levels of proximate social structure than white respondents. Race and gender were significantly associated with commitment. Like the basic model, women reported significantly lower levels of commitment than men, while respondents of color reported significantly higher levels of commitment than white respondents. Respondents with higher levels of income reported significantly lower levels of identity cognition. Gender, race, and income were significantly associated with identity prominence. Women reported significantly lower levels of prominence than men, while respondents of color reported significantly higher levels of prominence than white respondents, and respondents with higher levels of income reported significantly lower levels of prominence. Also, like the basic model, women reported significantly lower levels of salience than men. Finally, income and employment status were significantly associated with identity performance. Like the basic model, respondents with higher levels of income reported significantly lower levels of identity performance, or withdrawing, while respondents who were not currently employed reported significantly higher levels of identity performance than employed respondents.

Table 5. ***Standardized Estimates, Unstandardized Estimates, and Standard Errors for Expanded Model[1] (N = 327)***

Path	b	(SE)	B
Key Theoretical Coefficients			
Proximate Social Structure → Commitment	.122	(.146)	.046
Proximate Social Structure → Cognition	**.657**	**(.239)**	**.150**
Proximate Social Structure → Prominence	-.241	(.204)	-.056
Proximate Social Structure → Salience	.100	(.182)	.028
Proximate Social Structure → Identity Performance	.087	(.052)	.081
Commitment → Prominence	-.034	(.077)	-.021
Commitment → Salience	.065	(.068)	.049
Cognition → Prominence	**.465**	**(.047)**	**.473**
Cognition → Salience	**.256**	**(.047)**	**.317**
Cognition → Identity Performance	**.051**	**(.014)**	**.206**
Prominence → Salience	.062	(.049)	.076
Prominence → Identity Performance	**.060**	**(.014)**	**.239**
Salience → Identity Performance	-.006	(.016)	-.020
Control Variable Coefficients			
Gender → Proximate Social Structure	.083	(.076)	.060
Race → Proximate Social Structure	**.211**	**(.091)**	**.127**
Income → Proximate Social Structure	.020	(.015)	.077
Employment Status → Proximate Social Structure	.126	(.074)	.102
Gender → Commitment	**-.515**	**(.201)**	**-.139**
Race →Commitment	**.592**	**(.242)**	**.134**
Income → Commitment	.032	(.041)	.047
Employment Status → Commitment	-.205	(.197)	-.062
Gender → Cognition	.516	(.331)	.084
Race → Cognition	.352	(.398)	.048
Income → Cognition	**-.134**	**(.067)**	**-.119**
Employment Status → Cognition	.172	(.323)	.032
Gender → Prominence	**-.758**	**(.282)**	**-.126**
Race → Prominence	**1.022**	**(.339)**	**.143**
Income → Prominence	**-.143**	**(.057)**	**-.130**
Employment Status → Prominence	.269	(.273)	.050
Gender → Salience	**-.764**	**(.254)**	**-.154**
Race → Salience	.143	(.306)	.143
Income → Salience	-.078	(.051)	-.086
Employment Status → Salience	.279	(.243)	.063
Gender → Identity Performance	.005	(.073)	.003
Race → Identity Performance	-.030	(.086)	-.017
Income → Identity Performance	**-.054**	**(.015)**	**-.193**
Employment Status → Identity Performance	**.222**	**(.069)**	**.166**

Table 5 **(Continued)**

Path	b	(SE)	B
Covariances			
Commitment ←→ Cognition	-.191	(.234)	-.045
Gender ←→ Race	-.005	(.009)	-.030
Gender ←→ Income	.017	(.059)	.016
Gender ←→ Employment	.000	(.012)	-.002
Race ←→ Income	-.091	(.050)	-.102
Race ←→ Employment	.001	(.010)	.005
Income ←→ Employment	**-.494**	**(.072)**	**-.413**

[1]Standardized coefficients for this model are displayed in Figure 6
Bolded coefficients are statistically significant at p>.05 or better

Table 6 summarizes findings from all primary analyses. In sum, for the basic structural identity model, only salience was significantly (and positively) associated with identity performance among the endogenous variables representing the basic model. For the expanded model, no paths leading from endogenous variables to interactional commitment, or paths leading from interactional commitment to other endogenous variables were significant. Both cognition and prominence were associated with endogenous variables that preceded and followed them in the model. Proximate social structure was significantly associated only with cognition, which was also significantly associated with prominence, salience, and identity performance. Prominence, in turn, was also significantly associated with identity performance. Although salience was significantly associated with cognition, it was not significantly associated with other endogenous variables in the model. All significant relationships among endogenous variables were in the predicted direction, supporting Hypotheses 3b, 5a, 5b, 5c, and 6b.

Table 6. ***Summary of Hypotheses for Basic and Expanded Models***

	Hypothesis	Result
Basic Model		
1	Commitment to a stigmatized identity will be positively related to the salience of that identity.	Not supported
2	The salience of a stigmatized identity will be positively related to stigmatized identity performance.	Supported
Expanded Model		
3a	Membership in proximate social structures will be positively related to commitment to a stigmatized identity.	Not supported
3b	Membership in proximate social structures will be positively related to cognition about a stigmatized identity.	Supported
3c	Membership in proximate social structures will be positively related to the prominence of a stigmatized identity.	Not supported
3d	Membership in proximate social structures will be positively related to the salience of a stigmatized identity.	Not supported
3e	Membership in proximate social structures will be positively related to stigmatized identity performance.	Not supported
4a	Commitment to a stigmatized identity will be positively related to the prominence of that identity.	Not supported
4b	Commitment to a stigmatized identity will be positively related to the salience of that identity.	Not supported
5a	Cognition about a stigmatized identity will be positively related to the prominence of that identity.	Supported
5b	Cognition about a stigmatized identity will be positively related to the salience of that identity.	Supported
5c	Cognition about a stigmatized identity will be positively related to stigmatized identity performance.	Supported
6a	The prominence of a stigmatized identity will be positively related to the salience of that identity.	Not supported
6b	The prominence of a stigmatized identity will be positively related to stigmatized identity performance.	Supported
7	The salience of a stigmatized identity will be positively related to stigmatized identity performance.	Not supported

CHAPTER FIVE

SECONDARY ANALYSIS

In this chapter, I present the results of my secondary analyses that examined focal study variables and relationships separately for individuals who reported on mental health identities and individuals who reported on physical health identities. I first present the results of an independent samples t-test that compared mental and physical health identity group means for all endogenous study variables. I then present the results of the expanded structural identity theory model, this time using a structural equation groups model that examined the identity processes of those with mental health and physical health identities.

Groups Model Comparing Mental and Physical Health Identities

My second set of analyses examined the identity process independently for mental and physical health identities. Although structural identity theory would not necessarily predict a different process for these identities, given the relatively distinct treatment of mental and physical health in stigma literature, it is reasonable to assume that these identities are somewhat different. Moreover, my preliminary descriptive analysis of respondents' perceptions about the stigma attached to health identities, including some differences in perceptions across types of conditions (Table 3), pointed to the need for

group analysis to examine whether there were key differences in terms of focal study variables and patterns of relationships among these variables for those who reported on mental and physical health identities. Therefore, I explored these issues with my secondary analysis, the results of which are presented below.

Group Study Variable Means

I conducted an independent samples t-test comparing study variable means for mental and physical health identity groups to determine whether having an identity that falls into the grouping of a mental health identity (i.e., mental health issues, alcohol use, and drug use) or a physical health identity (i.e., serious physical health issues, weight concerns, sexually transmitted diseases or infections) results in having significantly different values on proximate social structure and identity measures. This supplemental analysis was intended to serve as a foundation for the expanded structural identity groups model that I present below. Results of this analysis are shown in Table 7. Mean values for those in the mental health identity group did not differ significantly from those in the physical health identity group for proximate social structure, interactional commitment, identity prominence, and identity salience. The groups' mean values for identity cognition and identity performance, however, did differ significantly.

I conducted an additional independent samples t-test excluding respondents in the mental health identity group who initially also reported having an identity that falls into the physical health identity group, and vice versa. Results from this t-test (N = 221; mental health identity: n = 90; physical health identity: n = 131) did not differ from the initial analysis with the exception of comparisons of the groups' mean values for identity

cognition. After excluding respondents who reported stigmas of different types (i.e., mental and physical health identities), the groups' mean values for identity performance still differed significantly (again at the $p \leq .001$ level). However, the groups' mean values for identity cognition no longer differed significantly. Therefore, in the expanded structural identity groups model that follows later, it may be important to note associations between study variables and identity performance (and possibly also identity cognition), and the extent to which they could be constrained to be equal without significantly worsening the model fit.

Table 7. ***Mean Comparisons of Study Variables (N=327)***

	Mental Health (n=138)		**Physical Health** (n=189)		**Mean**
	Mean	SD	Mean	SD	**Difference**
Measures					
Proximate Social Structures	.28	.60	.31	.63	-.03
Interactional Commitment	-.07	1.56	.07	1.70	-.14
Identity Cognition	4.01	2.74	4.86	2.64	-.85**
Identity Prominence	3.76	2.83	3.24	2.52	.52
Identity Salience	1.07	1.96	1.45	2.34	-.37
Identity Performance	2.05	.74	1.78	.59	.26***

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Expanded Structural Identity Theory Groups Model

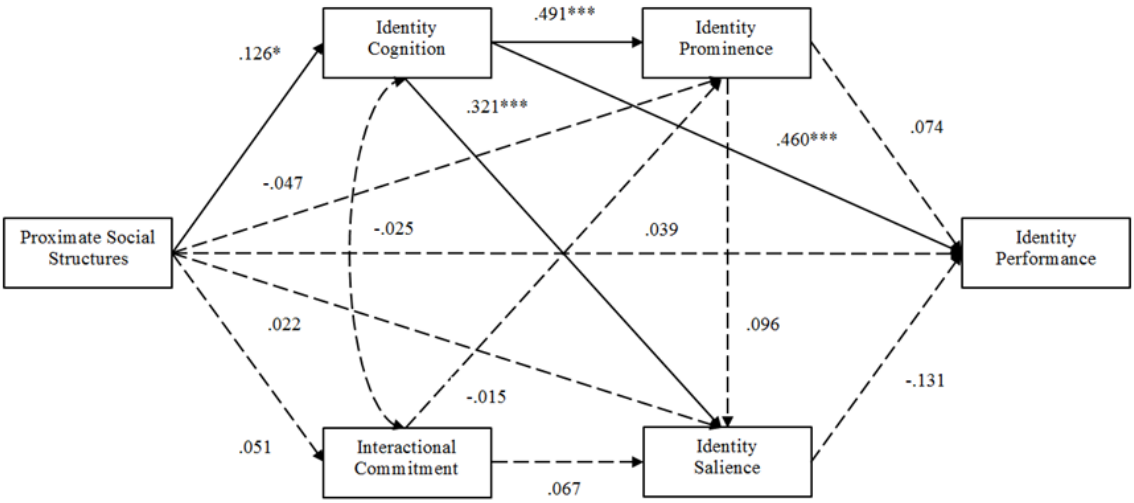
To examine stigmatized identity processes for those with mental health identities and physical health identities using the expanded structural identity theory model, I estimated a groups model using the model depicted in Figure 4. I constrained all paths between endogenous variables that, in doing so, did not significantly worsen the model. The expanded structural identity theory groups model fit the data well: χ^2 (df = 12, N = 327) = 12.626, p = .397, *CFI* = .998, *RMSEA* = .013 (*CI* = .00, .06). The chi-square

value, which was not significant, indicated that the null hypothesis (that the model being estimated is an exact fit for the data) should not be rejected. The CFI and RMSEA fit indices – above .998 and at .013, respectively - suggested a good model fit (also the RMSEA CI lower bound was at the .00 target and its upper bound was lower than the .10 target).

Univariate statistics did not indicate that skewness or kurtosis values were particularly problematic for either group. No skewness values were greater than recommended bounds of +/- 3 and no kurtosis values were greater than the recommended +/- 10. The Mardia's coefficient was 20.78 for the mental health identity group and 14.53 for the physical health identity group. Values below 3-5 suggest that multivariate normality is present. Therefore, although SEM is generally robust to violations of multivariate normality, the Mardia's coefficient suggested that the model may have had issues related to (non)normality for both groups, particularly for the physical health identity group.

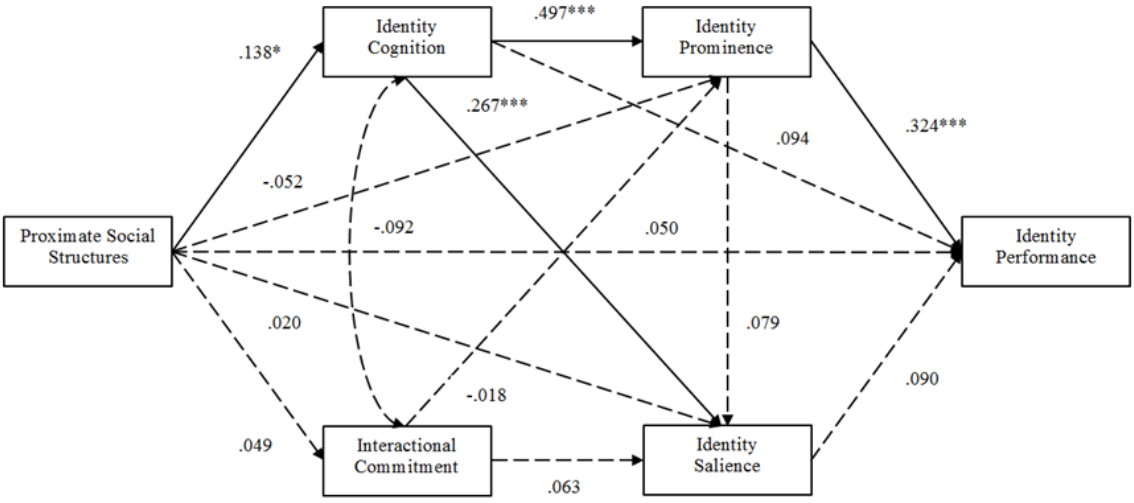
For both the residual and standardized residual covariance matrix, many values were equal to zero. No values above zero were in excess of .6 for both groups for the residual covariance matrix. The standardized residual covariance matrices for both groups each had one value at or close to 1, indicating poorer fit for paths from proximate social structures to identity performance for the mental health identity group, and from commitment to identity performance for the physical health identity group.

Standardized estimates for all endogenous variables are shown in Figures 7 and 8. All standardized and unstandardized estimates for the model are shown in Table 8. All



Correlations between controls and paths from controls to all endogenous variables were estimated (see Table 8) but are not shown

Figure 7. **Expanded Groups Model with Standardized Estimates for Mental Health Group (N = 138)**



Correlations between controls and paths from controls to all endogenous variables were estimated (see Table 8) but are not shown

Figure 8. **Expanded Groups Model with Standardized Estimates for Physical Health Group (N = 189)**

paths among endogenous variables were constrained to be equal for both groups with three exceptions, paths from: cognition to identity performance, prominence to identity performance, and salience to identity performance, which when constrained significantly worsened the model fit. Among the paths with equality constraints, all reflected the same pattern of findings as the expanded model with all stigmatized identities (Figure 6 and Table 5, above). Proximate social structure was significantly and positively associated with identity cognition (Hypothesis 1b), cognition was significantly and positively associated with prominence (Hypothesis 3a) and with salience (Hypothesis 3b), and all other paths with equality constraints were not significant.

Among the three remaining unconstrained paths, the mental and physical health groups each differed from the expanded model with all stigmatized identities in different ways. For the mental health group, like the expanded model with all stigmatized identities, cognition was significantly and positively associated with identity performance (Hypothesis 3c), and salience was not significantly associated with identity performance (again failing to support Hypothesis 7). However, unlike like the expanded model with all stigmatized identities, prominence was not significantly associated with identity performance (failing to support Hypothesis 4b). For the physical health group, like the expanded model with all stigmatized identities, salience was not significantly associated with identity performance (again failing to support Hypothesis 7), and prominence was significantly and positively associated with identity performance (Hypothesis 4b). However, unlike like the expanded model with all stigmatized identities, cognition was not significantly associated with identity performance (Hypothesis 3c). Thus, the two

groups differed from one another only with respect to paths from cognition to identity performance (significant for the mental health group) and from prominence to identity performance (significant for the physical health group).

Table 8 shows the relationships between my control variables and endogenous study variables. The mental and physical health groups, for the most part, mirrored relationships between controls and endogenous variables found in the expanded model with all stigmatized identities. However, each differed from the expanded model with all stigmatized identities in different ways. For the mental health group, unlike the expanded model with all stigmatized identities, gender and race were not significantly associated with commitment, gender, race, and income were not significantly associated with prominence, and income was not significantly associated with identity performance. However, race was significantly associated with identity performance. For the physical health group, unlike the expanded model with all stigmatized identities, race was not significantly associated with proximate social structure, income was not significantly associated with cognition, income was not significantly associated with prominence, and gender was not significantly associated with salience. However, gender was significantly associated with proximate social structure, cognition, and identity performance, and income was not significantly associated with salience. Thus, the two groups differed from each other in all the same ways that they differed from the stigmatized identity group as a whole, with the exception of a lack of significant association between income and salience, which – in contrast to the expanded model with all stigmatized identities – was not significant for either group.

Table 8. ***Standardized Estimates, Unstandardized Estimates, and Standard Errors for Expanded Groups Model[1] (N = 327)***

	Mental Health (n=138)			Physical Health (n=189)		
Path	**b**	**(SE)**	**B**	**b**	**(SE)**	**B**
Key Theoretical Coefficients						
Proximate Social Structure → Commitment	.132	(.147)E	.051	.132	(.147)E	.049
Proximate Social Structure → Cognition	**.575**	**(.234)E**	**.126**	**.575**	**(.234)E**	**.138**
Proximate Social Structure → Prominence	-.212	(.202)E	-.047	-.212	(.202)E	-.052
Proximate Social Structure → Salience	.074	(.181)E	.022	.074	(.181)E	.020
Proximate SS → Identity Performance	.047	(.048)E	.039	.047	(.048)E	.050
Commitment → Prominence	-.027	(.076)E	-.015	-.027	(.076)E	-.018
Commitment → Salience	.085	(.068)E	.067	.085	(.068)E	.063
Cognition → Prominence	**.488**	**(.048)E**	**.491**	**.488**	**(.048)E**	**.497**
Cognition → Salience	**.234**	**(.048)E**	**.321**	**.234**	**(.048)E**	**.267**
Cognition → Identity Performance	**.122**	**(.023)**	**.460**	.021	(.017)	.094
Prominence → Salience	.070	(.049)E	.096	.070	(.049)E	.079
Prominence → Identity Performance	.020	(.022)	.074	**.075**	**(.017)**	**.324**
Salience → Identity Performance	-.048	(.028)	-.131	.023	(.017)	.090
Control Variable Coefficients						
Gender → Proximate Social Structure	-.116	(.108)	-.088	**.245**	**(.105)**	**.167**
Race → Proximate Social Structure	**.467**	**(.143)**	**.268**	.073	(.117)	.045
Income → Proximate Social Structure	.011	(.023)	.043	.027	(.021)	.104
Employment Status → Proximate SS	.035	(.111)	.029	.181	(.098)	.144
Gender → Commitment	-.370	(.488)	-.073	**-.707**	**(.280)**	**-.179**
Race →Commitment	.410	(.386)	.090	**.702**	**(.310)**	**.161**
Income → Commitment	-.069	(.062)	-.104	.091	(.055)	.129
Employment Status → Commitment	-.508	(.293)	-.161	-.005	(.261)	-.001
Gender → Cognition	-.370	(.488)	-.062	**1.241**	**(.429)**	**.203**
Race → Cognition	-.079	(.653)	-.010	.601	(.474)	.089
Income → Cognition	**-.368**	**(.105)**	**-.316**	.000	(.084)	.000
Employment Status → Cognition	-.691	(.497)	-.125	.718	(.399)	.136
Gender → Prominence	-.631	(.427)	-.106	**-.770**	**(.369)**	**-.128**
Race → Prominence	.452	(.571)	.057	**1.457**	**(.405)**	**.220**
Income → Prominence	-.103	(.093)	-.089	-.117	(.071)	-.109
Employment Status → Prominence	.369	(.437)	.067	.238	(.338)	.046
Gender → Salience	**-1.044**	**(.330)**	**-.239**	-.586	(.369)	-.110
Race → Salience	.069	(.442)	.012	.100	(.410)	.017
Income → Salience	-.007	(.073)	-.008	**-.142**	**(.071)**	**-.149**
Employment Status → Salience	.064	(.337)	.016	.443	(.338)	.096
Gender → Identity Performance	-.162	(.115)	-.102	**.174**	**(.087)**	**.126**
Race → Identity Performance	**.301**	**(.147)**	**.143**	-.182	(.096)	-.119
Income → Identity Performance	-.016	(.025)	-.051	**-.052**	**(.017)**	**-.211**
Employment Status → Ident. Performance	**.357**	**(.113)**	**.243**	**.169**	**(.079)**	**.142**

Table 8 **(Continued)**

	Mental Health (n=138)			Physical Health (n=189)		
Path	**b**	**(SE)**	**B**	**b**	**(SE)**	**B**
Covariances						
Commitment ←→ Cognition	-.097	(.339)	-.025	-.373	(.297)	-.092
Gender ←→ Race	-.003	(.013)	-.016	-.008	(.012)	-.047
Gender ←→ Income	.107	(.092)	.100	-.064	(.075)	-.062
Gender ←→ Employment	-.011	(.019)	-.049	.008	(.016)	.039
Race ←→ Income	-.047	(.069)	-.058	**-.136**	**(.069)**	**-.146**
Race ←→ Employment	.001	(.015)	.005	.002	(.014)	.008
Income ←→ Employment	**-.505**	**(.108)**	**-.433**	**-.475**	**(.094)**	**-.397**

[1]Standardized coefficients for this model are displayed in Figures 7 and 8
Bolded coefficients are statistically significant at p>.05 or better; E denotes equality constraints

I conducted additional analysis estimating the expanded structural identity theory groups model once again but excluding respondents in the mental health identity group who initially also reported having an identity that falls into the physical health identity group and vice versa, as was done in the preliminary descriptive analyses. This additional groups model (N = 221; mental health identity: n = 90; physical health identity: n = 131) did differ in some ways from the initial analysis. Like the initial groups model, the path from cognition to identity performance was not constrained to be equal. However, paths from prominence to identity performance (significant and positive) and from salience to identity performance (not significant) were constrained to be equal in this additional analysis, reflecting a difference from the initial groups model, and a poorer model fit: χ^2 (df = 14, N = 221) = 17.791, p = .216, *CFI* = .984, *RMSEA* = .035 (*CI* = .00, .08). Most associations between endogenous variables reflected similar patterns of significance and direction of relationships among significant findings, as the initial groups model. However, there were two key differences: the constrained association between proximate social structure and cognition was no longer significant

(significant at only the .10 level), and the constrained association between prominence and identity performance, previously significant only for the physical health group, was now significant (and positive) for both groups. Paths from all controls to all endogenous variables generally reflected similar patterns of significance and direction of relationships among significant findings as the initial model.[13]

Table 9 summarizes findings from the expanded groups model(s). In sum, all findings from the expanded groups model were consistent with expanded model estimated with all identities, with two exceptions: among those with mental health identities, prominence was not significantly associated with identity performance (failing to support Hypothesis 6b), and among those with physical health identities, cognition was not significantly associated with identity performance (failing to support Hypothesis 5c). When individuals who reported on mental health identities but initially also reported having a physical health identity, and vice versa, were excluded from the expanded groups analysis, among those with mental health identities - like those with physical health identities - prominence became significantly associated with identity performance (supporting Hypothesis 6b). Finally, in this additional analysis, proximate social structure was no longer significantly associated with cognition (significant only at the .10 level) for both identity groups (failing to support Hypothesis 3b).

[13] Exceptions, for mental health: income and employment became significantly associated with commitment, and employment was no longer significantly associated with identity performance; for physical health: gender became significantly associated with salience, associations between gender and proximate social structure, prominence, and identity performance were no longer significant, nor was the association between employment and identity performance.

Table 9. ***Summary of Hypotheses for Expanded Groups Model***

Hypothesis		Result	
		Mental Health	**Physical Health**
Expanded Model			
3a	Membership in proximate social structures will be positively related to commitment to a stigmatized identity.	Not supported	Not supported
3b	Membership in proximate social structures will be positively related to cognition about a stigmatized identity.	Supported[1]	Supported[1]
3c	Membership in proximate social structures will be positively related to the prominence of a stigmatized identity.	Not supported	Not supported
3d	Membership in proximate social structures will be positively related to the salience of a stigmatized identity.	Not supported	Not supported
3e	Membership in proximate social structures will be positively related to stigmatized identity performance.	Not supported	Not supported
4a	Commitment to a stigmatized identity will be positively related to the prominence of that identity.	Not supported	Not supported
4b	Commitment to a stigmatized identity will be positively related to the salience of that identity.	Not supported	Not supported
5a	Cognition about a stigmatized identity will be positively related to the prominence of that identity.	Supported	Supported
5b	Cognition about a stigmatized identity will be positively related to the salience of that identity.	Supported	Supported
5c	Cognition about a stigmatized identity will be positively related to stigmatized identity performance.	Supported	**Not supported**
6a	The prominence of a stigmatized identity will be positively related to the salience of that identity.	Not supported	Not supported
6b	The prominence of a stigmatized identity will be positively related to stigmatized identity performance.	**Not supported**[1]	Supported
7	The salience of a stigmatized identity will be positively related to stigmatized identity performance.	Not supported	Not supported

Bolded text indicates a finding that differed from the expanded model estimated with all respondents
[1] Indicates a finding from an additional groups analysis, where those with identities from another group were excluded from analysis, that differed from the initial groups analysis

CHAPTER SIX

DISCUSSION

For this dissertation, I aimed to link identity and stigma literatures by applying structural identity theory to the study of stigmatized identities. In particular, I examined the extent to which the structural identity process operates the same for those with stigmatized identities as has been proposed and empirically demonstrated for those with normative identities using structural equation modeling of telephone interview data. To do this, I first estimated a traditional structural identity theory model, linking commitment, salience, and identity performance, to see how basic identity processes operate for all respondents with stigmatized identities. I then estimated an expanded structural identity theory model for all respondents to examine identity processes for those with stigmatized identities, taking the basic model as well as proximate social structure, cognition, and prominence into account. I also conducted secondary analyses, estimating a groups model that separated mental and physical health identity groups to examine the extent to which the expanded structural identity process differs for these two identity groups. In the remainder of this chapter, I discuss key study findings from these analyses, as well as contributions and implications of this research. I then review limitations of this work, and suggest directions for future research in this area. Finally, I offer some concluding remarks.

Key Findings

Findings with respect to my primary study aim - determining whether and to what extent the structural identity process operates the same for those with stigmatized identities as has been proposed and empirically demonstrated for those with normative identities – were mixed yet promising. On the one hand, the results of each of my three structural equation models revealed a number of non-significant relationships among key study variables. On the other hand, a number of focal relationships in these models were significant, and each in the predicted direction. Overall, these findings suggest that some aspects of the structural identity process operate similarly for those with stigmatized identities, while others may not. I now turn to these significant and non-significant findings in greater detail.

Identity Cognition and Prominence

For both expanded structural identity models, estimated for all identities and for mental and physical health groups, cognition and prominence were key components of the identity process. For instance, all hypotheses that received support concerning the expanded model (i.e., 3b, 5a, 5b, 5c, and 6b for all identities together) involved either cognition, prominence, or both. Moreover, only cognition and prominence were significantly associated with endogenous variables that preceded and followed them in the model.

Specifically, for both expanded models, greater membership in proximate social structures was significantly associated with increased thoughts about one's stigmatized

identity.[14] Membership in proximate social structures was not associated with any other aspect of the structural identity process. Serpe (1991:60) argues that that the inclusion of cognitive activity in identity theory is predicated on the existence of a direct or indirect relationship between cognitive activity and salience – one that was found in these data. Cognition was also related to the prominence and salience of an identity in all expanded models, such that increased thoughts about one's stigmatized identity was associated with increased importance of that identity for one's sense of self, and increased likelihood of invoking (i.e., telling about) one's identity across situations, for all groups. Despite the relatively central role that salience plays in most normative identity processes, only cognition was significantly associated with salience.

Cognition was also significantly associated with identity performance for all identities together and for the mental health identity group, but not for those in the physical health identity group. The t-test comparing the means of key variables for both groups in my secondary analysis foreshadowed this finding, where only means for cognition (greatest for the physical health group) and identity performance (greatest for the mental health group) differed between the mental and physical health groups. Though, the groups' cognition levels no longer differed when individuals who reported having identities in both groups were excluded from analysis. Ultimately, for the mental health identity group only, increased thinking about one's identity was associated with increased identity performance, or increased social withdrawal. For those with a physical health identity, however, prominence was significantly associated with identity

[14] Significant only at the .10 level in the groups model when individuals who reported having identities in both groups were excluded from analysis

performance. Therefore, relationships among cognition, prominence, and identity performance for those with mental health identities revealed associations between cognition and prominence, and cognition and identity performance. However, relationships among the three variables for those with physical health identities revealed associations between cognition and prominence, and prominence and identity performance. Though, prominence was no longer associated with identity performance when individuals who reported having identities in both groups were excluded from analysis. Taken together, the expanded models suggest that for those with stigmatized identities, cognition and prominence play a key role in the identity process, with different implications for identity performance in the form of social withdrawal depending on identity type.

Interactional Commitment and Salience

In both the basic and expanded structural identity models, salience and interactional commitment in particular, did not play central roles in the identity process. For example, all hypotheses concerning the basic and expanded models that failed to receive support - with two exceptions (3c and 3e) - involved either commitment, salience, or both. Specifically, in both the basic and expanded models, interactional commitment was not significantly associated with any endogenous variables that preceded or followed it in the model. Bivariate correlations among the study variables (shown in Table 1) told a similar story, as commitment was only significantly correlated with aspects of social structure, but not with other endogenous study variables. Although salience also played a relatively minor role in the identity processes of the respondents, salience was related to

select aspects of the models. In particular, with the basic structural identity model, salience was significantly associated with identity performance, such that greater likelihood of invoking one's identity by telling others about it was associated with greater social withdrawal. This relationship held in an additional basic model groups analysis (not shown) where both basic focal relationships (between commitment and salience – not significant, and salience and identity performance, significant) were constrained to be equal for both mental and physical health groups. The relationship did not hold, however, in the expanded model, where salience was no longer associated with identity performance, and was instead associated with cognition for all groups.

In sum, the significant and non-significant findings across all models suggest that some, but not all, aspects of the structural identity process operated similarly for those with stigmatized identities. Cognition and prominence played a more central role in the stigmatized identity process, while commitment and salience played comparatively minor roles. Though these findings are mixed, they hold promise for the application of structural identity theory to better understand stigmatized identity processes and contribute to the literature in a number of key ways.

Contributions and Implications

This dissertation contributes to sociological social psychological literature in a number of ways. I will focus on four contributions related to the goals of the project. The first two contributions address extensions to structural identity theory. The second two contributions address integrating insights from both structural identity theory and stigma literatures. First, the study extends the application of identity theory beyond

normative identities to that of stigmatized identities, thereby examining the extent to which the theory can explain identity processes for those who possess a stigmatized identity. Second, the study provides a test of structural identity theory drawing from each component of the now-expanded traditional model. Third, the study provides an initial step toward addressing individualistic critiques of stigma scholarship. Fourth and finally, the study incorporates a stigma coping strategy found in modified labeling theory research into the structural identity theory model as a measure of identity performance for those with stigmatized identities. I discuss each of these contributions in detail below.

Structural Identity Theory

The first contribution of this study is that it extends the application of identity theory to stigmatized identities, examining the extent to which the theory can explain stigmatized identity processes. Interesting results emerged with respect to this contribution. Namely, key study findings pointed to the possibility that a different identity process exists for those with stigmatized health identities – one with relationships that are not necessarily contradictory to those found in normative identity processes but have different emphases, less heavily rooted in social interaction. Across the models, the findings revealed an emphasis on those components that involve thought and self processes (i.e., the strength of relationships involving cognition and prominence). There was less emphasis, however, on those components of the model more heavily or directly rooted in social interaction (i.e., the lack of relationships involving commitment and salience). For example, interactional commitment was measured by asking respondents "in an average week, how many hours do you spend with other people who have

[identity]", and "how many people do you know who have [identity]". Salience was measured by asking respondents "when meeting [a person of the opposite sex, a friend of a close friend, a friend of a family member, and a stranger] for the first time, how certain is it that you would *tell* this person about your [identity]" (emphasis added). Both commitment and salience, conceptually, represent aspects of an identity process involving internal and cognitive elements. And just as commitment and salience do not only represent interaction devoid of internal elements, cognition and prominence, which represent more internal concepts, are at the same time still very much rooted in social life and informed by social interaction. Nevertheless, commitment and salience were each operationalized in such a way that directly involves and emphasizes social interaction. Therefore, it is an important finding that these aspects of the model were less central.

These findings are in line with Serpe's (1991) proposition that some identities can be enacted without social interaction and that, for these types of identities, one can expect to find a weaker relationship among certain components of the model, specifically, between commitment and cognition. Also, the results reference literature that conceptualizes a number of the identities examined here as concealable identities, which involve internal cognitive and self processes (Quinn and Chaudoir 2009). Findings from the current study suggest that individuals with a stigmatized health identity think about that identity, find it to be important to their sense of self, and even act in ways that take having that identity into account – namely, not taking part in interactions (withdrawal). Each of these aspects of the identity process demonstrate that individuals are experiencing processes related to their identities, but that these processes - while social in

nature - are not as directly interactive as commitment and salience, as they were operationalized in the present study. Finally, the findings point to the utility of the structural identity model to explain stigmatized identities processes, but with attention paid to potential differences in these processes. They also point to the importance of including all aspects of the expanded model - another contribution of this research.

A second contribution of this study is that it provides a test of structural identity theory drawing from each component (i.e., various levels of social structure, cognitive and self processes, and performance) of the expanded traditional model. Findings from the expanded models suggest that for those with stigmatized identities, cognition and prominence played a key role in the identity process, with different implications for identity performance depending on identity type. These findings point to the critical importance of including these various components in structural identity theory models applied to stigmatized health identities. Comparing estimates from the basic and expanded models also illustrate this point. For instance, while salience was significantly and positively associated with identity performance in the basic model, this relationship disappeared in the expanded model when proximate social structure, cognition, and prominence were included. Stryker and Serpe (1994) argue that both salience and prominence should be included in identity research, as they find that these concepts, while related, are indeed independent. In this study, prominence and salience were related through correlation at the bivariate level (shown in Table1), but each had a very different set of relationships to other study variables in the expanded models. The study findings also underscore the comparatively less central but nonetheless important

inclusion of proximate social structures, which was associated with cognition in the expanded model for all identities. Moreover, the inclusion of identity performance proved to be an important one, because even among those with stigmatized health identities, identity performance was linked to other aspects of the model differently dependent upon health identity type (i.e., by cognition for mental health identities, by prominence for physical health identities). Taken together, the study findings point to the benefit of considering each component of the expanded model when testing structural identity theory in general, and particularly for the study of stigmatized health identities.

Structural Identity Theory and Stigma Integrations

A third contribution of this study is that it integrates structural identity theory and stigma literatures by providing an initial step toward addressing individualistic critiques of stigma scholarship. To address limitations in stigma research, I examined stigma with a structural identity theory approach where social structure and relationships (i.e., various levels of social structure, and social connections via commitment) are central. Ultimately, social relationships did not play a central role in identity processes in this study. However, I argue that the inclusion of the proximate social structure and interactional commitment measures was nonetheless important, because the relatively minor role of these connections and relationships is an important finding in and of itself. The present analysis examined only stigmatized health identities. In future research, if the health identities examined are expanded and further articulated (made possible by collecting larger sample sizes) or if other types of stigmatized identities are studied, researchers may find that social relationships (i.e., commitment) play a different role

depending upon the identity under investigation. As Serpe (1991) argues, relationships among commitment and cognition, and cognition and salience will vary dependent upon the nature of the identity being studied. Thus, although this study makes only an initial step toward addressing critiques of stigma literature, it does point to a potentially fruitful pathway forward, where additional analysis of structures at all levels are included and expanded understandings of the role of structure contribute to both identity and stigma literatures.

A fourth contribution of this study is that it integrates structural identity theory and stigma literatures by borrowing a stigma coping mechanism found in modified labeling theory research and incorporating it into the structural identity theory model as a measure of stigmatized identity performance. In order to link identity theory with stigma research, I used a more formalized model of identity to examine stigmatized identities. However, I also operationalized identity performance in a way that is consistent with both structural identity theory (a measure related to behavior associated with the identity) and stigma research (a measure that reflects a stigma management strategy). While structural identity theory has looked at role-related performance, the language of these items is primarily geared toward use in the study of specific normative identities. Stigma management has been examined in modified labeling theory, as well as in recent work that has used this theory to expand identity models (e.g., Lee and Craft 2002, Kroska and Harness 2011). The social withdrawal measure used in the present study served as an outcome potentially associated with multiple types of stigmatized identities.

There are two points worth noting with respect to the inclusion of this measure. First, findings from this study suggest that cognition and prominence played a key role in the identity process, with different implications for identity performance in the form of social withdrawal depending on identity type - association with cognition for mental health identities, and with prominence for physical health identities. Therefore, even among those with stigmatized health identities, we learn that identity performance was differently associated with aspects of the identity process dependent upon health identity type. Second, linking stigma and identity literatures by incorporating this stigma management measure allowed for the assessment of stigmatized identity performance in a form that may differ from normative identity performance. Namely, as these findings suggest, stigmatized identity performance may take the form of a less active performance or non-action, as in the case of social withdrawal. Thus, the use of stigma management strategies as performance outcomes within the structural identity model points to a useful way to link the two literatures and capture the similar and distinctive features of stigmatized identity experience. What we characterize as behavior in identity theory may take a different form for those with stigmatized identities. The incorporation of a full set of commonly used management strategies (i.e., secrecy, social withdrawal, educative or preventive telling) as outcomes in the model would be a useful way to capture a fuller range of activity levels associated with stigmatized identity performance. Moreover, incorporating additional more active stigma management strategy measures (e.g., stigma resistance; Thoits 2011) into future work may likewise provide important insight into the various forms of performance associated with stigmatized identity processes. Finally,

although the inclusion of the social withdrawal measure is a strength of this study, and the location of this measure as an outcome of the model is consistent with its location in both modified labeling and structural identity theory models, longitudinal data will be necessary to determine (beyond theoretical proposition) the causal nature of the relationships between proximate social structure, identity, and identity performance.

Limitations and Future Research

While the current study makes a number of key contributions, this research also has limitations that should be addressed in future research. First, while "large social structure" is discussed and included to some extent in this work, future studies should explore and expand how to more fully account for this important aspect of the structural identity model. Second, while the study of specific types of stigmatized identities - namely, health identities - may be considered a contribution of the study, more work needs to be done to better distinguish these types of identities. Third, it is important to determine the nature of stigmatized identities (i.e., role, social, person identities) to better understand the identity process. Some of these limitations focus on issues of conceptualization, while others are more connected to issues of data and measurement. I discuss each of these limitations, along with suggestions for future research, below.

Large Social Structure

One of the goals of this study was to include variables associated with the expanded identity model, including those that capture large social structure. Including variables such as gender, race, employment status, and income in my analyses revealed a

number of interesting relationships between these controls and my endogenous study variables. For example, I found that women reported significantly lower likelihood of invoking their stigmatized health identities (i.e., reported lower salience) than men across nearly all structural equation models. There were a number of other significant relationships between controls and endogenous study variables, though few revealed consistent patterns across all models.

While I argue that is important to use the more expanded structural identity theory model and to sufficiently account for large social structure as part of that effort, in this study I was not able to look at the sample separately based on social group membership due to sample size concerns. A case can be made that identity theory does not necessarily predict that the basic *processes* of the model should differ based on social group membership, and indeed any variation that might occur within or across groups (e.g., differences in identity salience, cognition or commitment for men and women or between whites and African Americans) is accounted for by controlling for membership in the group. As such, by including large social structural variables in each of my models, I account for any initial inequalities among participants, which allows me to assess the unique effects of all endogenous study variables. Nevertheless, whether and to what extent these processes are in fact the same across social groups remains an empirical question. To examine this question more directly, studies will need to do more than control for these measures.

One way to better address the influence of social structure on identity processes would be to examine these relationships using groups models, as I did for the different

types of health identities. The use of subsample analysis allows for the examination of the applicability of theory across large social structural positions (Hunt et al. 2000; Mizell 1999; Sprague 2005). Future research on stigmatized identity processes should aim to use a stronger approach, conducting subsample analysis of aspects of large social structure with sample sizes and power sufficient for this type of approach. This will enable researchers to determine whether these aspects of large social structure are significantly associated with endogenous variables across various (e.g., racial and ethnic) groups. For instance, research examining differences in vulnerability to network events indicates that, regardless of levels of support, men and women "use" this support differently (Kessler and McLeod 1984). It may be the case, then, that measures of proximate social structure operate in different ways for men and women. Additionally, in the current study there was a bivariate (correlational) relationship between income and identity performance, as well as relationships between income and employment status and identity performance in the basic and expanded models, suggesting that there may be ways in which structural variables allow for (or limit) behavioral options for those with stigmatized identities. This needs to be further explored.

Researchers should seek to incorporate social structure at all levels, including the intermediate social structural level (e.g., neighborhoods, schools, organized social units; Stryker et al. 2005), not included in the current data set. Additionally, future research should include measures of affective commitment in future assessments of stigmatized identities to more thoroughly assess the role of social connections and relationships in the identity process, understanding that some measures are less easily molded to stigmatized

identities. Although researchers have modeled interactional and affective commitment constructs as a single second-order latent variable when the two latent constructs were found to be highly correlated (Merolla et al. 2012), the two dimensions of commitment are potentially independent (Serpe 1991) key aspects of the structural identity model and, therefore, are important to include in future research.

Health Identity Groups

In my second set of analyses, I examined different types of stigmatized identities, focusing on fairly broad categories of mental and physical health. While a strength of this study is that I was able to examine these different types of health statuses, the relatively crude grouping of these categories points to an important direction for future research.

At the outset of the study, I relied on The DSM–5 (American Psychiatric Association 2013), to form my initial health groupings, and ultimately mental and physical health identities. With those criteria in mind, I constructed the mental health identity by including specific mental health issues, as well as drug and alcohol use. Constructing the physical health category was less straightforward for at least two reasons. First, interviewers asked respondents about weight concerns by using the following language and examples: "weight concerns, such as obesity or eating disorders, like anorexia or bulimia". Although these examples have the benefit of helping to ensure that the weight concerns identity was an inclusive and encompassing one, the wording may have also increased the likelihood that anorexia and bulimia, more mental health-related conditions included in the DSM-5, and obesity, a more physical health-related

condition not included in the DSM-5, were included together. Thus, the potential inclusion of these two types of weight concerns posed a challenge for determining whether they are physical health or mental health identities (or both). Although the respondents were provided with examples of types of weight concerns, there is no way to know what type they were considering when they answered the question. One might presume that individuals with weight concerns that would typically be classified as mental health concerns might have categorized them as mental health problems in the interview process. Based on that logic, I included those who claimed weight concerns in the physical health category. However, because there was no follow up question with regard to *type* of weight concern, there is no way to know if this was an accurate portrayal of their weight problems.

In addition to the ambiguity of the weight concern identity, respondents' perceptions of the public stigma attached to serious physical health issues were noticeably different from perceptions of stigma associated with weight concerns and STDs/STIs. This difference suggests potentially important intragroup differences among the physical health identities that I grouped together. Thus, although much careful consideration was given to the construction of the identity groups given the available possible groupings and subsample sizes for this exploratory analysis, ultimately, the mental and physical health group designations are not as refined as they might be, and are a limitation of the study.

Despite the limitations of my group construction, my findings are suggestive of interesting similarities and differences when comparing the mental and physical health

groups with respect to their identity processes. One way to improve upon what is found in the current study is to include more detailed measures in future data collection efforts. Researchers should consider including open-ended items for all reported stigmas to allow for informed decision making when creating groups, such as being able to delineate between what has been designated as a mental and physical health condition in diagnostic manuals. Future studies might also ascertain information about formal diagnoses by a health practitioner. In this study, I focused on perceptions of these illnesses and conditions. In short, I relied on self-diagnostic information. This is a useful approach, as we know that perceptions carry consequences for identity and behavior as much as (and in some cases more than) actual conditions or circumstances (Thomas and Thomas 1928). Nonetheless, the inclusion of an actual diagnosis could help future research enhance the precision of groupings by identity type, and may also provide an interesting way to test the implications of official versus non-official labeling on the structural identity process, informed by work from modified labeling theory scholarship.

Finally, researchers may continue to find value in constructing identity groupings prior to evaluating data. However, with larger sample sizes, they may be able to rely more heavily on items such as the perceived cultural stigma items to clarify the extent to which these various health identities qualify as stigmatized. Taken together, the current study findings suggest that consideration and inclusion of such subsample analysis is a useful way to enhance our understanding of similarities and differences among stigmatized identity processes.

Stigmatized Identities

As part of my preliminary descriptive analysis, I looked at cultural stigma measures to assess the extent to which the health identities of interest are stigmatized. I also examined identity measures in the context of structural identity models to assess stigmatized health identity processes. Despite the findings generated by these analyses, I was not able to determine the bases of these identities – that is, the extent to which they operate as role identities, as opposed to social or person identities (Burke and Stets 2009; Burke 2004). Each of the identities examined in the present study has the potential to operate differently, varying from individual to individual and for a given individual across social contexts and interactions. Such variation could have important implications for the measurement of identities, as well as for theoretical application. In their work linking identity type to self outcomes, Burke and Stets (2009; Burke 2004:10) argue that the basis of an identity (role, social, and person) can have different implications for the self, particularly for the three major bases of self-esteem: self-efficacy, self-worth, and self-authenticity. As I mention above, role identities are based on the social structural positions that individuals hold, social identities are based on membership in groups, (e.g., Democrat or Republican), and person identities are based on the unique ways in which individuals see themselves (e.g., organized and dependable) (Burke and Stets 2009:112; Stets and Serpe 2013). Burke and Stets (2009) explain that identity verification increases feelings of self-efficacy (sense of competency) for role identities, feelings of self-worth (sense of worthiness and value) for social identities, and feelings of self-authenticity (sense of being true to one's self) for person identities. These relationships suggest that

an important way of further advancing our understanding about how and from what bases stigmatized identities operate would be to use a more fully integrated model of identity. Such an integrated model would include measures commonly used in structural identity theory models, as well as measures used in the aforementioned perceptual control models, such as reflected appraisals and specific aspects of identity meaning. Such work would be in keeping with recent scholarship that has sought to deemphasize conceptual and research-based divisions between these complementary programs, calling for a single, more universal framework that integrates various forms of identity theory (e.g., Serpe and Stryker 2011; Stets and Serpe 2013).

Stigma scholars have also talked about stigmatized identities as 'identities'. However, these categorizations tend to be more conceptual or reflective of understanding identities as social identifiers or as cultures of people (e.g., Roberts 1997; Rohleder and Gibson 2006; Schafer and Ferraro 2011). In this study, my aim was to apply a more formalized theory of identity to determine whether these types of identity might be specifically linked to performance outcomes. Therefore, examining stigmatized identities within the formalized structural identity theory model was an important first step. Though, examining identity theory more broadly and deeply will also be an important way to further the examination of stigmatized identities, potentially providing additional context with which to interpret findings in the present study. In particular, the application of the more integrated identity theory approach may provide the expanded framework necessary to understand why various components of the model tested here are more central to the identity process than others – potentially, for reasons stemming from the

bases of the identities under examination. Looking at different stigmatized identity types (e.g., various health identities), as was done in the present study, using an integrated identity approach would also be a strong next step. Finally, future research should include questions regarding normative identities (e.g., spouse/partner, worker, friend), that will allow for more direct comparisons of normative identities and stigmatized identities within respondents, and the examination of identity processes across different types of identities.

Conclusions

For this dissertation, I linked identity and stigma literatures by applying structural identity theory to the study of stigmatized identities to expand and clarify understandings of identity and of stigma by examining the extent to which concepts and relationships central to identity theory research can explain stigmatized identity processes. Findings with respect to this aim were mixed yet promising. Cognition and prominence were found to be key components of the identity process with different implications for identity performance in the form of social withdrawal depending on identity type. Salience and interactional commitment in particular played relatively minor roles in identity processes across types, particularly, relative to other aspects such as identity cognition and prominence.

Findings from the current study point to the utility of the structural identity model to explain stigmatized identities processes, with attention paid to potential differences in these processes. They also point to the benefit of testing structural identity theory drawing from each component of the expanded model, particularly, the inclusion of

proximate social structure, cognition, prominence, salience, and identity performance for the study of stigmatized health identities. Moreover, although this study makes only an initial step toward addressing critiques of stigma literature, it does point to a potentially fruitful pathway forward, where additional analysis of structures at all levels are included. Finally, linking stigma and identity literatures by incorporating stigma management measures allows for the assessment of stigmatized identity performance in a form that may differ from normative identity performance. Namely, as these findings suggest, stigmatized identity performance may take the form of a less active performance or non-action, as in the case of social withdrawal. Taken together, the results of these analyses of a unique data set suggest a fruitful direction for future work examining stigmatized identities in the identity theory research tradition.

APPENDIX A.

COUNTS AND PERCENTAGES OF IDENTITIES IN STUDY SAMPLE (N = 327)

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COUNTS AND PERCENTAGES OF IDENTITIES IN STUDY SAMPLE (N = 327)

	n	Percentage
Selected Identity		
Mental Health Issues	128	39.1
Weight Concerns	99	30.3
Serious Physical Health Issues	86	26.3
Alcohol Use	7	2.1
Drug Use	3	.9
STD(s) or STI(s)	4	1.2

APPENDIX B

STUDY MEASURES

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STUDY MEASURES

Social Structural Measures

Large Social Structure

Gender (Responses: male, female): Interviewer coded

Race (Responses: White, Black or African American, Hispanic/Latino, Asian, Other): What race do you consider yourself to be?

Employment Status (Responses: yes, no): Are you currently employed?

Income (Responses: (1= less than $14,999, 8 = above $100,000): Now I am going to read some income categories. Please stop me when I reach the category that best describes the total annual income of your household. Please include your personal income, as well as the income of others living in the household.

Proximate Social Structures *(Responses: yes, no)*

Have you joined a social group related to your [identity]?

Have you joined a formal, organized group related to your [identity]?

Identity Measures

Identity *(Responses: yes, no)*

I am going to read a list of concerns or conditions that may interfere with one's life and relationships. These are often common and can cause considerable difficulty for people. Please let me know if these concerns or conditions are something that you currently experience in your life. You may choose one or all of these concerns or conditions, if they apply to you. I will also provide you with some examples, but please keep in mind that these may not be the only examples of each of the conditions.

Mental health issues (such as depression, anxiety, obsessive compulsive disorder)

Weight concerns (such as obesity or eating disorders, like anorexia or bulimia)

Serious physical health issues or limitations (such as diabetes, epilepsy, heart disease)

Alcohol use (such as excessive alcohol use or drinking that interferes with work of family life)

Drug use (such as abuse of illegal substances or prescribed drugs)

Sexually transmitted disease(s) or infection(s) (such as Chlamydia, herpes, HPV)

Interactional Commitment *(Responses: ____ number of people; ____ number of hours per week)*

In an average week, how many hours do you spend with other people who have [identity]?

How many people do you know who have [identity]?

Identity Cognition (*Responses: 0 = certainly would not, 10 = definitely would)*

In general, how often do you think about your [identity]?

How often do you think about your [identity] when you are reading or viewing something in the media (e.g., television, the Internet, newspapers, magazines)?

How often do you think about your [identity] when meeting new people for the first time?

How often do you think about your [identity] when you are at a social event or during social activities?

Identity Salience (*Responses: 0 = certainly would not, 10 = definitely would)*

When meeting a person of the opposite sex for the first time, how certain is it that you would tell this person about your [identity]?

When meeting a friend of a close friend for the first time, how certain is it that you would tell this person about your [identity]?

When meeting a friend of a family member for the first time, how certain is it that you would tell this person about your [identity]?

When meeting a stranger for the first time, how certain is it that you would tell this person about your [identity]?

Identity Prominence (*Responses: 0 = strongly disagree, 10 = strongly agree)*

In general, my [identity] is an important part of my self-image.

If people do not know that I have [identity] they do not really know who I am.

When I think of myself, the first thing that comes to mind is myself as a person with [identity].

Identity Performance – Social Withdrawal *(Responses: 1 = strong disagree, to 4 = strongly agree)*

I don't talk about myself much because I don't want to burden others with my [identity].

I don't socialize as much as I used to because my [identity] might make me look or behave 'weird'.

Negative stereotypes about [identity] keep me isolated from the "normal" world.

I stay away from situations in order to protect my family or friends from embarrassment.

Being around people who don't have [identity] makes me feel out of place or inadequate.

I avoid getting too close to people who don't have [identity] to avoid rejection.

Cultural Stigma Measures
(Responses: 1 = very negative, 7 = very positive)
How do you think people with mental health issues, such as depression, anxiety, or obsessive compulsive disorder, are generally viewed by others?
How do you think people with weight concerns, such as obesity or eating disorders, including anorexia or bulimia, are generally viewed by others?
How do you think people with serious physical health issues or limitations, such as diabetes, epilepsy, or heart disease, are generally viewed by others?
How do you think people who have or have had a sexually transmitted disease(s) or infection(s), such as chlamydia, herpes, HPV, are generally viewed by others?
How do you think people who use alcohol, such as excessive alcohol use or drinking that interferes with work or family life, are generally viewed by others?
How do you think people who use drugs, such as abuse of illegal or prescribed drugs, are generally viewed by others?

APPENDIX C

SUMMARY OF MEAN SUBSTITUTION[1] (N = 327)

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SUMMARY OF MEAN SUBSTITUTION[1] (N = 327)

	# of cases	**# items answered / # total items (%)**	**Action taken (# cases)**	**% substituted of 327**
Cognition	8	3/4 (75%)	Mean sub (8)	2.44%
Salience	4	3/4 (75%)	Mean sub (4)	1.22%
Prominence	10	2/3 (66.67%)	Mean sub (10)	3.06%
Withdrawal	1	4/6 (66.67%)	Mean sub (8)	2.45%
	7	5/6 (83%)		

[1]Reflects values after listwise deletion of all variable values not eligible for mean substitution

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