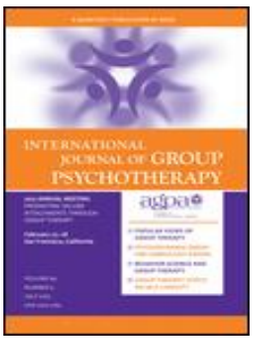

International Journal of Group Psychotherapy

ISSN: 0020-7284 (Print) 1943-2836 (Online) Journal homepage: https://www.tandfonline.com/loi/ujgp20

Application of Social Identity Theory in Group Therapy with Stigmatized Adults

Ron B. Aviram & Sherri Rosenfeld

To cite this article: Ron B. Aviram & Sherri Rosenfeld (2002) Application of Social Identity Theory in Group Therapy with Stigmatized Adults, International Journal of Group Psychotherapy, 52:1, 121-130, DOI: 10.1521/ijgp.52.1.121.45468

To link to this article: https://doi.org/10.1521/ijgp.52.1.121.45468

INTERNATIONAL JOURNAL OF GROUP PSYCHOTHERAPY, 52(1) 2002

CLINICAL REPORT

Application of Social Identity Theory in Group Therapy with Stigmatized Adults

RON B. AVIRAM, PH.D.
SHERRI ROSENFELD, M.A.

ABSTRACT

Social identity theory was applied in group therapy for adults with mild mental retardation. Social identity theory suggests that social group membership, also called collective identity, has an impact on self-esteem. Individuals will try to maintain self-esteem by viewing their social groups positively. This may not be possible for individuals who are members of a stigmatized group. However, it may be possible to enhance self-esteem by broadening one's awareness of collective identity. Furthermore, being able to positively view other individuals who are co-members of one's own stigmatized group can also have positive consequences for self-esteem. A clinical vignette demonstrates this process in group therapy. Results are discussed as being applicable to members of various stigmatized groups.

This paper describes an application of concepts from social-cognitive psychology to group therapy. The potential to integrate concepts from these two fields may be especially relevant to individuals whose groups are burdened with a negative stigma.

Ron B. Aviram is with the Division of Neuroscience at the New York State Psychiatric Institute. Sherri Rosenfeld is at the University of Illinois at Chicago.

The authors would like to thank Joseph Szyszko and Ellen Trenn at the Institute on Disability and Human Development, University of Illinois at Chicago, where this work was carried out, for their support of this project. We are grateful to Henry Spitz, Betsy Benson, and anonymous reviewers for commenting on earlier drafts of this paper.

These individuals may minimize social group affiliation, and possibly lose an important avenue for self-esteem enhancement. Social identity theory has focused considerable attention on the relationship between identity and self-esteem since Crocker and Luhtanen (1990) distinguished between personal self-esteem and collective self-esteem (also see Luhtanen & Crocker, 1992). From this perspective, personal self-esteem is based on an evaluation of skills and attributes that make up one's personal identity. Relatedly, collective self-esteem is determined by evaluating collective identity, which is based on one's social group affiliations (ingroup) and social roles. Social identity theory states that individuals will make efforts to maintain a positive collective identity by evaluating their ingroup positively (Tajfel & Turner, 1986). As such, a positive evaluation of one's ingroup should promote positive collective self-esteem. Consequently, this may not be easily accomplished if one is a member of a stigmatized group.

Mental retardation carries a negative stigma in societies around the world. The ideas described above were applied in a process-oriented psychotherapy group for individuals with mild mental retardation. The goals were to broaden awareness of collective identity, and create positive relations between members of the therapy group, thereby enhancing collective self-esteem. Social identity theory implies that self-esteem problems associated with stigma can be addressed in treatment that promotes positive collective identity.

This report synthesizes terms that have traditionally remained separated by the disparate nature of the group therapy and social psychological fields. Although both fields deal with group phenomena, similar terms can become confusing. Specifically, *ingroups* refers to social groups in which one is a member. *Outgroups* are social groups in which one is not a member. In this paper, *subgroups* are discussed as divisions within a therapy group, but are simultaneously based on social psychological ingroups and outgroups. For example, the subgroup within the therapy group included all Caucasians.

NON-CLINICAL RESEARCH

There is evidence that treatment strategies that focus on collective identity may be effective in countering the negative consequences of stigma on collective self-esteem. For example, recent advances in theory and research suggest that either personal identity, based on traits and attributes, or collective identity, which is dependent on group affiliations and social roles, may be used to compensate when there are deficiencies in either of the identity dimensions. Ng (1989) posits that each identity dimension can be conceived as two structurally distinct components of the self-concept. Each dimension may be enhanced to make up for a weakness in the other. As discussed by Crocker and Luhtanen (1990), either personal self-esteem or collective self-esteem will increase if personal identity or collective identity is strengthened. Testing these notions, Ng (1986) manipulated perception of group status to be inferior and found that study participants behaved in ways that suggested they were protecting personal identity. In a different study, Ng (1985) found that when personal identity was lowered participants compensated by increasing ingroup bias. In this condition, participants emphasized their group affiliation to compensate for lower personal self-esteem. In the case of mental retardation, and stigmatized groups in general, it may be beneficial to enhance the perception of the ingroup or broaden the categories that make up collective identity.

IMPLICATIONS FOR GROUP THERAPY

Applying similar concepts to group therapy, Marmarosh and Corazzini (1997) found that by strengthening collective identity, group members increased their positive evaluation of the therapy group. In their study they found that group members who begin with relatively low personal self-esteem could benefit from this kind of therapeutic strategy.

Identity Exercise

Two groups were formed, each included six members with mild mental retardation. Each group met on a weekly basis for 75 minutes. In the first session, an identity exercise was introduced to highlight the notion of social group membership in concrete fashion. This structured exercise is designed to elaborate what we mean when we talk about collective identity. Members are asked to stand on the line facing one direction, and the task is introduced by stating, "We are going to do an activity to see how you are part of different groups."

The therapist asks members with certain group affiliations to take one large step forward and to look around to see who else is part of their group. Initially, this starts with nonthreatening descriptors, such as all members wearing sneakers, and all members wearing a blue shirt. After each classification members return to the line. As descriptors are called out, members see that their group membership changes with each self-descriptor. Members are directed to notice who is in their group after each descriptor. The emotional meaning of each classification increases as the exercise progresses. These self-descriptors could start with likes and dislikes and intensify to include ethnicity, religion, or stigmatized group membership. Discussion then focuses on how members felt when they were alone and everyone else was part of a different group, or when all of them were part of the same group, and so forth. The goal of the exercise is to experience being perceived by others and conceive of oneself as a member of a variety of groups. In following group therapy sessions, the identity exercise can be referred to whenever identity issues emerge.

Therapy Group Vignette

This group included one Caucasian male, one African American male, two Caucasian females, and two African American females. Ages ranged from 25 to 44. The group developed themes that potentially illuminate specific concerns of members of all stigmatized groups.

Early in treatment, Ms. P stated that she believed people did not want to be her friend because she was in a wheelchair. Mr. B responded that he felt the same way, but attributed this to his acne. In these early sessions, members were concerned with how they were treated by members of other social groups (outgroups). After several sessions, this focus shifted to include relationships within the therapy group itself. In an interchange in which Ms. C was speaking, it seemed that Ms. P was distracted and not paying attention. This promoted a discussion about the way members treat each other in the group. Members began to define how they wanted to treat people who are important to them. They talked about how they experience being listened to, which meant that others are interested and care about them.

An early focus on safety and trust could be expected in any group; however, these group members were especially sensitive to these important experiences. By facing each other in group, they confront the stigma that they prefer to reject. Initially, they avoided their stigmatized group membership by focusing on external attributes like acne or a wheelchair. It is possible to speculate that each individual's experience of rejection by others in the group also parallels rejection of their own ingroup affiliation. On another level, this may be a necessary reenactment that happens in order to have mastery over macrolevel interactions in society between their ingroup and outgroups. In the example in which Ms. P did not listen to Ms. C's comments, these members re-created a similar experience of the stigmatized ingroup in relation to outgroups. In society, stigmatized groups may not have a voice, or are not heard by outgroups.

In the following vignette we highlight an example of this process at a later point in the therapy group's progress. This reflects a developmental process in group members' ability to discuss and internalize collective identity.

Mr. B, a Caucasian member, started to speak about the way people treat each other. He stated that he wants to be treated like a "normal person." He reported that he often feels people don't pay attention to him when he speaks to them, and he wanted people to

tell him directly what they are thinking about him. In response, Ms. P, an African American member, stated that she also feels mistreated by others and suggested that it is because she is African American. Mr. B reported that his family has told him that he can have African American friends, but that he is not supposed to date African American women. Mr. B reported that in the past he had wanted to date an African American woman, but was discouraged by his family. Suddenly, Mr. B wondered if his statements might have hurt other members' feelings. The group was not able to respond directly (as he had requested earlier) to his comments. The therapists commented that the group was talking about being members of groups, like in the identity exercise, and that being part of certain groups may make people not want to get to know them.

In the following session, Mr. B stated that he had been thinking about the discussion from the previous week regarding dating. As could be expected, the group returned to discussing trust and members reported that they had difficulty trusting others. Mr. W and Ms. P, both African American members, reported that they were unsure if they could trust others. Mr. W reported that he did not feel he knew the members well enough to trust them, but that he also has trouble trusting family members, an apparent reference to Mr. B's family. Ms. C agreed that she sometimes has trouble trusting others. Mr. W then returned to a previous discussion about "being slow" and how that affects his relationships. Importantly, it was Mr. B who had first described himself as "being slow" several sessions before. In response, each member expressed having a disability that affects them. Mr. B again talked about "being slow," and that he cannot drive, Ms. P reported that her "handicap" is something that she thinks influences how others respond to her. This was another opportunity to recall the identity exercise. At this point the therapists pointed out how they all share this common difficulty and how that makes them all part of the same group. Also, that it is sometimes safe to feel and be part of a group of people sharing something in common.

Discussion

Mr. B represented an outgroup (racial category) that was less threatening in this therapy group than the stigma associated with mental retardation. As such, he was a catalyst for a discussion about group affiliations. Perhaps because of his membership in a subgroup of Caucasians (which would be considered a nonstigmatized outgroup), he recapitulated the stigma between racial groups within the therapy group experience. In this therapy group, membership in these racial groups created subgroups. Importantly, the supraordinate category that included each member was mental retardation. Interestingly, it was Mr. W, a member of a racially stigmatized group, who reintroduced "being slow" as the supraordinate category. This allowed group members to find a common affiliation that cut across the racial category. It is possible to speculate that it would be a member of a stigmatized subgroup who would seek the supraordinate category. This would eliminate the negative impact to self-esteem stemming from the association with the stigmatized subgroup. These members were able to transcend the Black/White issue in the therapy group by acknowledging their shared supraordinate ingroup affiliation. This is an example of the unifying potential of supraordinate categories associated with collective identity. Social identity theory predicts that supraordinate group membership will override subgroup loyalties. The experience of supporting each other helped to dispel some of the negative beliefs associated with the stigmatized identity and contributed to positive collective self-esteem.

It became apparent that this group needed an extended induction period with a focus on safety and trust (Spitz, personal communication). This is not surprising given that these individuals have been traumatized by repeated abuses. As may have been predicted, these group members were not used to thinking about group affiliations, because their self-esteem enhancing strategies usually did not involve evaluating their membership in a stigmatized group. The early session material conveyed their sense that something was wrong with them, although it was externalized to acne, or a wheel-

chair. The emphasis on negative personal attributes was an effort to explain the poor treatment they receive from outgroup members, as well as an attempt to deflect attention from their membership in a derogated group. Therefore, these members initially avoided discussing issues related to collective identity, and focused on personal identity. This adds support to Ng's (1986) finding that when group status is inferior, people will focus on personal identity as a way to maintain self-esteem. Unfortunately, for these group members personal identity was also debilitated because of their disability. Still, emphasis on these aspects of personal identity may have been less threatening than confronting their stigmatized collective identity. As the group therapy progressed, however, it was important that divisive issues about race were overcome through their shared supraordinate affiliation with the stigmatized ingroup. Members were able to empathize with each other because of their common developmental disability.

There was an ongoing shift in discussion about the way they were treated by individuals outside the therapy group to reactions by members inside the group (from outgroup to ingroup), and from external to internal aspects of the members themselves. Often, stigma is based on external features, but it has an internal impact. The group moved back and forth in their exploration of the external attribution of the stigma, to internal reaction to stigma, from treatment by outgroup members, to treatment by ingroup members. They talked about how others both inside and outside the group affect them, and then wrestled with the thought of affecting others, both positively (by listening) and negatively (by insulting). The ongoing discussion about listening and being heard, as an indication of caring, is also symbolic of the stigmatized group experience in a world that overlooks them, disregards what they say, and appears not to care. Group members examined their similarities and differences with outgroup members, and then similarities and differences with each other. Ultimately, they were able to look at their own stigmatized group affiliation, find cohesion in their shared identity, and move beyond it to examine the possibility of belonging to other groups as well. Such internal/external,

ingroup/outgroup shifting seems to highlight an important process while examining the impact of membership in a stigmatized group and identity issues.

BROADENING THE APPLICATION OF THESE CONCEPTS

In this case, concepts about the interrelationship of identity and self-esteem were applied in group therapy comprised of individuals with mental retardation. However, it is possible to consider applying this type of therapeutic focus in groups made up of individuals from other stigmatized groups, such as substance abusers or psychiatric patients. The negative impact on one's self-concept may be unavoidable when individuals are associated with a stigmatized group. The community around these individuals does not let them forget that they are members of these groups. Often, individuals become isolated or use negative strategies, such as derogating peers, in an effort to enhance self-esteem. In other cases, individuals give up trying to change, and are left with poor self-worth and a sense of hopelessness and futility about improving their situations. For example, substance abusers may give up and continue to use drugs, or psychiatric patients may cope poorly with stressors because their self-concept implies that they cannot cope with difficulties. In such cases, perhaps focusing on collective identity in an effort to broaden the self-concept beyond the stigmatized identity can enhance collective self-esteem, as described by Crocker and Luhtanen (1990). It may not be possible to completely disassociate from one's affiliation with most stigmatized groups. Therefore, it is important to be aware that one is a member of numerous social groups. Such insight would enhance the potential for collective identity to have a positive impact on collective self-esteem.

REFERENCES

Crocker, J., & Luhtanen, R. (1990). Collective self-esteem and ingroup bias. *Journal of Personality and Social Psychology*, *58*, 60-67.

Luhtanen, R., & Crocker, J. (1992). A collective self-esteem scale:

Self-evaluation of one's social identity. *Personality and Social Psychology Bulletin*, *18*, 302-318.

Marmarosh, C. L., & Corazzini, J. G. (1997). Putting the group in your pocket: Using collective identity to enhance personal and collective self-esteem. *Group Dynamics: Theory, Research, and Practice*, *1*, 65-74.

Ng, S. H. (1985). Biases in reward allocation resulting from personal status, group status, and allocation procedure. *Australian Journal of Psychology*, *37*, 297-307.

Ng, S. H. (1986). Equity, intergroup bias and interpersonal bias in reward allocation. *European Journal of Social Psychology*, *16*, 239-255.

Ng, S. H. (1989). Intergroup behaviour and the self. *New Zealand Journal of Psychology*, *18*, 1-12.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behaviour. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations*. Chicago: Nelson-Hall.

Ron B. Aviram, Ph.D.
Division of Neuroscience, Unit 42
New York State Psychiatric Institute
1051 Riverside Drive
New York, NY 10032
E-mail: aviramr@pi.cpmc.columbia.edu.

Received: October 4, 2000
Revision Received: January 5, 2001
Accepted: January 13, 2001