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## **Stigma in Class: Mental Illness, Social Status, and Tokenism in Elite College Culture**

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Stigma in Class: Mental Illness, Social Status, and Tokenism in Elite College Culture

A Thesis Presented

by

KATIE R. BILLINGS

Submitted to the Graduate School of the  
University of Massachusetts Amherst in partial fulfillment  
Of the requirements for the degree of

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Sociology

**Stigma in Class: Mental Illness, Social Status, and Tokenism in Elite College Culture**

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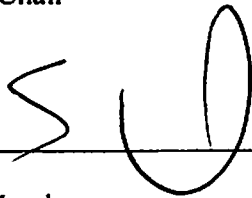
**KATIE R. BILLINGS**

**Approved as to Style and Content by:**



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**Mark Pachucki, Chair**



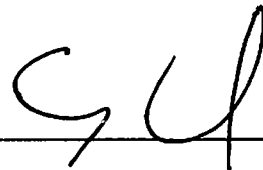
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## ABSTRACT

STIGMA IN CLASS: MENTAL ILLNESS, SOCIAL STATUS, AND TOKENISM IN ELITE

COLLEGE CULTURE

MAY 2019

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The majority of mental illness on college campuses remains untreated, and mental illness stigma is the most cited explanation for not seeking mental health treatment. Working-class college students are not only at greater risk of mental illness, but also are less likely to seek mental health treatment and hold more stigmatized views toward people with mental illness compared to affluent college students. Research on college culture suggests that elite college contexts may be associated with greater stigmatization of mental illness. This study bridges the social status and college culture literatures by asking—does social status and college context together predict students’ mental health attitudes? By surveying 757 undergraduates at an Ivy League university and a Non-Ivy League university, I found that 1) elite college students had greater mental illness stigma than non-elite students, 2) social status was positively related to personal stigma and negatively related to perceived stigma, and 3) low social status students at the Ivy League university had greater personal mental illness stigma compared to their counterparts at the Non-Ivy League university. Low social status students’ perceptions of themselves as social status minorities may be responsible for their greater stigmatization of mental illness in the elite college context. These findings suggest that increasing socioeconomic diversity on college campuses may improve lower social status students’ mental health attitudes.

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# CHAPTER I

## INTRODUCTION

The incidence and severity of mental illness is increasing on U.S. college campuses. In a study of 70 American colleges and universities, Drum et al. (2009) found that more than one in three undergraduates reported “feeling so depressed it was difficult to function” at least once in the previous year. Alarming, one in ten undergraduates reported “seriously consider[ing] attempting suicide” in the previous year (Drum et al. 2009). Moreover, undergraduate mental illness usually goes untreated. A study at Emory University found that 85% of students with moderate to severe depression were not receiving any form of mental health treatment (Garlow et al. 2008). Similarly, Blanco et al. (2008) found that over 80% of students with diagnosable anxiety disorders receive no treatment. Worse, failure to seek early treatment is related to prolonged mental illness and more frequent relapses (Hingson, Heeren, and Winter 2006; Post and Leverich 2006).

The most frequent barriers to seeking treatment include personal stigma (one’s own views of people with mental illness), perceived stigma (how individuals believe others stigmatize people with mental illness), lack of knowledge about mental health services, lack of time, privacy concerns, and doubt about mental health service efficacy (Givens and Tjia 2002; Komiya, Good, and Sherrod 2000; Mowbray et al. 2006; Vogel, Wade, and Haake 2006). Stigma is the main reason people fail to seek mental health care (Corrigan 2004)—and poverty is related to increased stigma around mental illness (Eisenberg et al. 2009; Steele, Dewa, and Lee 2007). Since mental illness stigma is intricately related to social status, research examining the relationship between the two in

different college contexts can uncover how stigmatization processes occur among these vulnerable populations.

## **CHAPTER II**

### **BACKGROUND**

#### **A. Effects of Mental Illness Stigma**

Stigma refers to the degradation and devaluation of individuals within socially undesirable groups (Goffman 1963). Though one in five Americans suffers from a mental illness in his or her lifetime, mental illness continues to be viewed as socially deviant and dangerous (Merikangas 2010). Mental illness stigma includes personal (one's own views) and perceived (one's understanding of others' views) negative perceptions of people with mental illness. Personal and perceived stigma have debilitating effects on those with mental illness, leading to decreased self-efficacy, self-esteem, life satisfaction and social functioning (Bordieri and Drehmer 1986; Corrigan 1998; Link 1987; Link et al. 2001; Rosenfield 1997; Wahl 1999).

While less than 30 percent of people with psychiatric disorders seek mental health treatment at all (Kessler et al. 2001; Regier et al. 1993), this problem is even more pronounced for those who perceive mental illness as stigmatizing (Cooper, Corrigan, and Watson 2003; Corrigan 2004; Eisenberg, Golberstein, and Gollust 2007). Even for those who do manage to seek treatment, stigma diminishes treatment efficacy by decreasing compliance with treatment plans (Sirey et al. 2001). For example, Corrigan (2004) found that perceived stigma predicted whether adults took their prescribed antidepressants.

#### **1. Socioeconomic position and mental illness**

Socioeconomic position encompasses both social status and social class. Social class refers to the groupings of people within a society based on their economic and social positions, while social status is a continuous measurement of individuals'

hierarchical placement within a social setting according to their economic, social, and cultural capital. The two terms are frequently operationalized using the same measures: educational attainment, income, occupational prestige, and economic capital. Given the overlapping nature of these concepts, this paper will review the literature on socioeconomic position, including both social class and social status research.

People from working-class backgrounds are at far greater risk of mental illness than people from higher status backgrounds (Adler et al. 1994; Dohrenwend 1990; Holzer et al. 1986). On college campuses, working-class students are at greater risk of depression and anxiety disorders—the two most common mental disorders among undergraduates—than affluent students (Cuellar and Roberts 1997; Eisenberg, Golberstein and Gollust 2007; Weitzman 2004). Working-class undergraduates are also less likely to seek treatment (Eisenberg, Golberstein, and Gollust 2007; Hunt and Eisenberg 2010; Rosenthal and Wilson 2008), and to hold more stigmatized views of people with mental illness compared to their more affluent peers (Eisenberg et al. 2009).

Scholars have suggested that working-class students' high level of mental illness stigma is responsible for their disinclination to seek mental health services (Eisenberg et al. 2009; Steele, Dewa, and Lee 2007). One study revealed that low-income individuals were more likely to report acceptability barriers to mental health care than their high-income counterparts (Steele, Dewa, and Lee 2007). While researchers assume that working-class students hold more stigmatized views of those with mental illness because of their decreased social status compared to their middle- and upper-class peers, no research has examined the relationship between individuals' relative social status and mental illness stigma.

## **B. Elite Academic Culture**

Research suggests that the stigmatization of mental illness may be greater in elite academic settings. Though elite student bodies are overwhelmingly composed of students from higher socioeconomic positions, elite culture promotes the idea of individual agency and creates a cultural norm of perfection, which may fuel stigma. Khan's (2010) qualitative investigation of elite culture at a secondary school illustrates how elite students learn to believe that their elevated social status is solely the result of hard work and intelligence, without acknowledging social forces like social class and cultural capital. Their belief in individual agency leads students to accept full responsibility for both their successes and failures—consequently, mental illness may be framed as an individual failure. Additionally, elite culture is characterized by a norm of effortless perfection. Khan (2011) found that elite secondary school students who were perceived as “trying too hard,” defying the social norm of effortless perfection, were rejected by their peers. In addition, their successes were minimized since they did not fit the ideal, effortless version of success. In sum, mental illness defies the social values and norms of elite academic culture.

Relatedly, numerous non-academic works document the relationship between the culture of perfection and mental illness stigma. Deresiewicz (2008) explains this elite norm of perfectionism as the “pressure to maintain the kind of appearance—and affect—that go with achievement” (29). Though many students at elite schools suffer with mental illness, the social context requires individuals to hide symptoms to remain socially acceptable. At Stanford University, Khan's effortless perfection norm is called the “Duck Syndrome” (Scelfo 2015). Ducks appear to glide effortlessly across the water, but

beneath the surface, their feet paddle frantically. The Duck Syndrome is commonly applied to the culture of all elite academic institutions, but particularly the Ivy League. Scelfo suggests that the culture of effortless perfection at elite schools causes students to conceal mental illness, withdraw socially, and consequently increase their risk of suicide. Alongside academic examinations of elite culture, these non-academic works further illustrate the negative effects of elite academic culture and how they may exacerbate mental illness stigma.

Working-class students at elite institutions face additional social pressures and make substantial social sacrifices to attend elite institutions. Their acculturation to affluent colleges dislocates them from their home networks and forces them to juggle two opposing worlds, never feeling like full members of either (Aries 2008). This disconnect is fueled by working-class students' struggle to maintain their home ties because of a cultural disconnect between their elite and non-elite communities (Lee and Kramer 2013; Lubrano 2004). Consequently, working-class students struggle to form relationships in elite institutions while sacrificing their social ties at home. Extant literature illustrates how elite college campuses are especially socially-, academically-, and mentally-taxing for lower-income students (Aries 2008; Aries and Seider 2005; Bergerson 2007; Lee 2016; Lee and Kramer 2013; Torres 2009; Walpole 2003).

Alongside their struggles at elite colleges, working-class students are also severely underrepresented on elite campuses. Most elite universities have more students from the top 1% of income earners in the U.S. than from the bottom 60% combined (Aisch et al. 2017). Hefner and Eisenberg (2009) found that working-class students experience more social isolation and alienation on college campuses than their middle-

class counterparts. This effect is likely exacerbated at elite colleges due to their smaller proportions of working-class students. Since working-class students represent approximately 10 percent of elite college populations, they often have difficulty forming meaningful social ties. In fact, social psychological research demonstrates that people from different social class backgrounds tend to opt out of interacting with one another (Côté et al. 2014). When asked about their choice not to interact with individuals outside of their social class, people explained that they did not have shared values or experiences with other-classed people. Relatedly, qualitative work on social class in college demonstrates that working-class undergraduates often have difficulty forming friendships in college because of their class backgrounds (Aries 2008; Aries and Seider 2005; Armstrong and Hamilton 2013; Lee 2016). Jack (2016) also found that working-class students who graduated from distressed high schools then attended elite universities withdrew from authority figures and developed a defensive stance against faculty. In sum, working-class students in elite college contexts tend to be isolated from other students and authority figures.

### **C. Contributions and the Present Study**

The relationship between social class and mental illness stigma is well documented. Research suggests that differential levels of social status drive this relationship. However, no research has examined the relationship between social status (a continuous measurement of individuals' hierarchical placement within a social setting according to their economic, social, and cultural capital) and mental illness stigma. If differential levels of mental illness stigma among people from varying social class



backgrounds are the result of different levels of social status, researchers should measure social status to more accurately examine this association.

In addition, existing research suggests a link between college context and stigma, but has not specified whether college context affects the stigmatization of mental illness, nor if college context interacts with social status to determine the extent to which students stigmatize mental illness. This study aims to bridge the gap between the socioeconomic position and elite culture literatures by examining whether college context impacts the way social status affects the stigmatization of mental illness.

In accordance with analyses of elite culture, mental illness stigma should be greater in elite than non-elite contexts due to the elite cultural norm of perfection. Based on this literature, I believe that students in an elite context will have more stigmatizing views of people with mental illness compared to students in a non-elite context.

*Hypothesis One:* Students in an elite context will have greater mental illness stigma compared to students in a non-elite context, regardless of social status.

Since previous research suggests that elite culture and social status separately affect mental illness stigma, the two may interact to determine students' mental health attitudes. If lower social status and elite context are separately related to increased mental illness stigma, the two combined may lead to even greater stigma. In other words, I believe that lower status students will have greater mental illness stigma, and the effect of status on stigma will be more pronounced for students in an elite context. This leads to the second hypothesis:

*Hypothesis Two:* Social status will be inversely related to mental illness stigma, and this effect will be exacerbated in the elite college context.

## **CHAPTER III**

### **METHOD**

#### **A. Sample**

Students were recruited from an Ivy League university (ILU) and a non-Ivy League university (NILU). These populations were selected to examine the effect of elite culture on university students' mental health views. While both universities have fewer than 5,000 students and are located in rural, New England towns, their student bodies and campus cultures differ significantly.

ILU is a private research university located in New England with an acceptance rate of approximately 10%. In a given year, about 50% of ILU students receive financial aid, yet only 14% of students receive Pell Grants.<sup>1</sup> The percentage of students receiving Pell Grants is generally used as an indicator of the percentage of low-income students on a given campus. ILU has one of the lowest proportions of low-income students in the Ivy League. The average first-year retention rate is approximately 98% and the four-year graduation rate is about 90%.

NILU is a private institution in New England with a high acceptance rate (>80%). Every student at NILU receives some form of financial aid. While aid varies widely, 31% of NILU students receive Pell Grants. The average first-year retention rate is approximately 65% and the four-year graduation rate is around 40%.

757 undergraduate students completed the Mental Illness Stigma Survey—542 students from ILU and 215 students from NILU—in the winter of 2016. The Mental

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<sup>1</sup> To qualify for a Pell Grant, a student's annual family income is generally below \$50,000, with the majority of Pell Grants awarded to students whose annual family incomes are below \$20,000 (National Scholarship Providers Association 2015).

Illness Stigma Survey included measures of race, gender, age, class year, school, objective social status, subjective social status, personal mental illness stigma, perceived mental illness stigma, likelihood to seek mental health services, knowledge of mental health services and whether or not the respondent or respondent's family had ever sought mental health services. All undergraduate students at both universities received the Mental Illness Stigma Survey via email. The survey took approximately 20 minutes to complete. The response rate was 14% at ILU and 13% at NILU. Chi-square tests compared the demographic proportions of each sample to their respective student bodies to ensure that the samples were representative of their schools.

Sample characteristics are presented in Table 1. Student samples from both universities closely resembled their respective university student bodies. With the exception of white students, the proportions of all racial categories were not significantly different from the racial proportions of their respective student bodies. White students were overrepresented in the ILU ( $\chi^2 = 23.113, p < 0.001$ ) and NILU ( $\chi^2 = 21.534, p < 0.001$ ) samples. In addition, both college samples included a greater proportion of women than their respective student populations (ILU:  $\chi^2 = 55.257, p < 0.001$ , and NILU:  $\chi^2 = 17.534, p < 0.001$ ).<sup>2</sup>

Compared to one another, the ILU sample included significantly more students from racial minorities than the NILU sample; these samples represent the differing racial compositions of the schools. In addition, the ILU sample contained significantly more high status students and significantly fewer middle status students than NILU. The

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<sup>2</sup> I ran the quantitative models with all racial groups (as presented), with race as a binary white/non-white variable, and with only white respondents. In all iterations, no significant racial differences emerged and results were not significantly different from those presented below. Results available upon request.

Table 1. Demographic Characteristics of Student Respondents from Ivy League University and Non-Ivy League University

Characteristic	Ivy League (N = 542) N (%)	Non-Ivy League (N = 215) N (%)	Total (N = 757) N (%)
<b>Race/Ethnicity</b>			
White*	333 (61%)	193 (90%)	526 (69%)
Hispanic/Latino*	38 (7%)	6 (3%)	44 (6%)
Asian*	80 (15%)	2 (<1%)	82 (11%)
Black/African American	37 (7%)	8 (4%)	45 (6%)
Other	54 (10%)	6 (3%)	60 (8%)
<b>Gender</b>			
Female	367 (67%)	151 (70%)	518 (68%)
Male	175 (32%)	64 (30%)	239 (32%)
<b>Age</b>			
18 – 19	200 (37%)	76 (35%)	276 (36%)
20 – 21	275 (51%)	103 (48%)	378 (51%)
22 – 23	57 (10%)	30 (14%)	87 (11%)
24 +	10 (2%)	6 (3%)	16 (2%)
<b>Class Year</b>			
First-Year	127 (23%)	57 (26%)	184 (24%)
Sophomore	127 (23%)	47 (22%)	174 (23%)
Junior	142 (26%)	58 (27%)	200 (26%)
Senior	146 (27%)	53 (25%)	199 (26%)
<b>Subjective Social Status</b>			
1-3	36 (6.6%)	21 (9.8%)	57 (7.5%)
4-7**	260 (48%)	130 (60.5%)	390 (51.5%)
8-10***	246 (45.4%)	64 (29.8%)	310 (41%)
<b>Family's Annual Income<sup>3</sup></b>			
\$0 - \$49,999***	65 (12%)	56 (26.1%)	121 (16%)
\$50,000 - \$149,999***	102 (18.8%)	91 (42.3%)	193 (25.5%)
\$150,000 + ***	375 (69.2%)	68 (31.6%)	443 (58.5%)

*Note.* T-tests were used to compute significant differences in characteristics by type of institution. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

<sup>3</sup> Family's annual income served as a proxy for social class background.

proportion of low social status students did not significantly differ across universities.

Participants' genders, ages, and class years also did not differ across university samples.

## **B. Independent Measures**

### **1. Social Status**

The MacArthur Scale of Subjective Social Status measured social status (Adler and Stewart 2007; Cundiff et al. 2013). Social status was measured subjectively because literature across a variety of subfields suggests that perceived inequality is more relevant for predicting social psychological outcomes than objective inequality (Greenstein 1996; Lively, Steelman, and Powell 2010). In addition, health research suggests that subjective status is more powerful in predicting health-related outcomes than objective status (Demakakos et al. 2008; Singh-Manoux, Marmot, and Adler 2005). Participants situated themselves on a social ladder to demonstrate their perceived social position relative to their college peers. The ladder ranged from 1 to 10 with higher numbers referring to higher status positions (See Appendix A).

## **C. Dependent Measures**

### **1. Stigma**

**a. Personal stigma.** The 9-Item Attribution Questionnaire (AQ9) measured personal mental illness stigma (Corrigan et al. 2003). The AQ9 is a shortened form of the Attribution Questionnaire (AQ-27). The AQ-27 consists of 9 subscales that comprise mental illness stigma: blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. The shortened AQ9 contains one item from each subscale. A

brief vignette presents the case of a 35-year-old, single man with schizophrenia named Harry. After reading the vignette, participants answered nine questions (e.g. “How dangerous would you feel Harry is?”) on a 9-point Likert scale from “not at all” to “very much.” The nine responses were summed to calculate the total stigma score (one question was reverse scored). Total scores range from 9 to 81, with higher scores representing more stigmatized views of people with mental illness. The AQ9 measure proved sufficiently reliable ( $\alpha = 0.728$ ).<sup>4</sup> (See Appendix B.)

**b. Perceived stigma.** The Devaluation-Discrimination Scale (D-D Scale) measured individuals’ perceptions about stigma in their communities (Link, Mirotznik, and Cullen 1991). The D-D Scale is a 12-item inventory that measures perceived mental illness stigma. This measure assesses the respondent’s perception of most other people’s beliefs about mentally ill patients. Respondents rated their agreement or disagreement with statements that claim that most people devalue current or former psychiatric patients. Each item is measured with a 6-point Likert scale from “strongly agree” to “strongly disagree.” The scale includes items concerning devaluation and discrimination in friendships, jobs, and romantic relationships. The D-D Scale allows researchers to understand the extent to which people believe mental illness stigma exists in their communities. The D-D Scale was highly reliable ( $\alpha = 0.859$ )(Bland and Altman 1997). (See Appendix C.)

#### **D. Control Measures**

Gender, race/ethnicity, family’s annual income, and experience with mental health services were included as control measures. Gender included male and female

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<sup>4</sup> Bland and Altman (1997) recommend Cronbach’s alpha should exceed 0.7 to be considered satisfactory. High reliability is established as an alpha level of 0.9 or greater.

response options. Race/ethnicity categories included Native American, Hispanic/Latino, Asian, White, Black/African American, Multiracial/Mixed Race, Pacific Islander, and Other. Respondents were prompted to select the best-fitting race category. Due to small sample sizes, the Native American, Multiracial/Mixed Race, Pacific Islander, and Other categories were combined into an “Other Race” category. A question from the 2014 U.S. Census Bureau measured students’ self-reported family’s annual income (U.S. Census Bureau 2014)(See Appendix D). While social status and social class are highly correlated, this measure allowed controlled for differences in social class to examine the effects of social status. Lastly, experience with mental health services was measured by asking respondents if they or a family member had ever sought mental health treatment. This variable was included as a binary predictor coded 1 for yes and 0 for no.

### **E. Statistical Analysis**

Data analysis involved a series of seemingly unrelated regression (SUR) and ordinary-least-squared (OLS) regression models. As expected, chow tests indicated that the samples from the two schools could not be pooled. Consequently, regression models were run separately for each school. Each regression model analyzed the significance of social status, family’s annual income, race/ethnicity, gender, and experience with mental health services as predictors of the two dependent measures: personal and perceived mental illness stigma. The Ramsey Regression Equation Specification Error Test indicated that the variables within the models were correctly specified and did not need to be transformed. Post-hoc t-tests were used to evaluate the average levels of stigma for students with different social statuses across the two samples in order to compare the effects of social status in different college contexts.

## **CHAPTER IV**

### **RESULTS**

#### **A. Bivariate Analyses**

Table 2 shows bivariate analyses comparing the average scores of the two dependent variables based on demographic characteristics between ILU and NILU students. The only racial differences between the two schools were present for white students: white students at ILU reported greater perceived mental illness stigma and held more stigmatized views of people with mental illness than white students at NILU.

Gender differences were significant for both of the dependent variables. Women at ILU reported higher perceived mental illness stigma than women at NILU. There were no differences between perceived mental illness stigma for men at the two schools. Men and women at ILU reported greater personal mental illness stigma compared to men and women at NILU.

To examine differences for social status, I divided the social status measure into low, middle, and high social status groups. Students with a ladder score of 0 through 3 were classified as low social status; those with a score of 4 through 7 as middle social status; and those with a score of 8 through 10 as high social status. These divisions were based on previous researchers' divisions of the MacArthur Subjective Social Status scale (Dennis et al. 2012) and were only used for the bivariate comparisons. Middle and high social status students at ILU reported greater perceived mental illness stigma compared to middle and high social status students at NILU. Low social status students did not report significantly different scores for perceived mental illness stigma. Alternately, low and middle social status students at ILU held more stigmatized views of people with mental



Table 2. Descriptive Bivariate Analyses for Personal and Perceived Mental Illness Stigma for Ivy League and Non-Ivy League Universities

Characteristics	Personal Mental Illness Stigma <i>M ± (SEM)</i>		Perceived Mental Illness Stigma <i>M ± (SEM)</i>	
	Ivy League University	Non-Ivy League University	Ivy League University	Non-Ivy League University
<i>Race</i>				
White	34.189*** (.485)	30.900*** (.674)	50.246** (.448)	48.212** .604
Hispanic	33.079 (1.397)	27.833 (3.807)	50.105 (1.313)	46.833 (3.928)
Asian	35.038 (.877)	29.000 (3.000)	50.163 (.831)	49.000 (6.000)
Black	34.027 (1.715)	35.125 (2.856)	50.243 (1.600)	47.125 (2.224)
Other Race	32.444 (1.207)	33.667 (3.676)	50.389 (1.076)	45.167 (5.776)
<i>Gender</i>				
Female	33.619*** (.459)	30.536*** (.776)	50.387** (.426)	48.192** (.684)
Male	34.960* (.664)	32.188* (1.075)	49.926 (.610)	47.734 (1.089)
<i>Subjective Social Status</i>				
1-3	33.278*** 1.451	23.667*** 1.411	51.417 1.613	50.286 2.649
4-7	33.192* .530	31.3* .833	50.742** .504	48.085** .737
8-10	35.073 .575	32.891 1.065	49.533* .502	47.266* .888
<i>Total</i>	34.052*** .378	31.028*** .633	50.238** .349	48.056** .578

Note. The “Other Race” category includes Native American, Multiracial/Mixed Race, Pacific Islander, and Other categories.

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

illness compared to low and middle social status students at NILU. High social status students' views of people with mental illness were not significantly different. As a whole, ILU students reported greater perceived and personal mental illness stigma compared to NILU students.

### **B. Multiple Regression Models**

Table 3 shows the step-wise ILU regression results. A Breusch-Pagan test indicated that the errors for the two ILU models were correlated, therefore, a SUR model is superior to OLS because it accounts for the correlation of model errors. Though model 3 is not the best fitting model according to BIC estimates, I will present the results from model 3 because the control variables are theoretically important. Model 3 indicates that experience with mental health services is negatively predictive of personal mental illness stigma ( $\beta = -3.044, p = 0.000$ ). Specifically, if students indicated that they or one of their family members had previously sought mental health treatment, their personal stigma was much lower than those who had not. The perceived mental illness stigma model demonstrates that subjective social status is predictive of perceived mental illness stigma. Higher social status is related to lower perceived stigma ( $\beta = -.885, p = 0.001$ ). Family's annual income, race, and gender were not significant predictors of personal or perceived mental illness stigma at ILU (all  $ps > 0.49$ ).

Table 4 shows the results of the NILU regressions of the predictor variables on the two dependent stigma measures. A Breusch-Pagan test indicated that the errors for the two NILU models were not correlated, therefore, I used an OLS regression to model these data. Model 3 demonstrates that only subjective social status was predictive of

Table 3. Ivy League University Predictors of Personal and Perceived Mental Illness Stigma (Seemingly Unrelated Regression)

Predictor Variables	Model 1		Model 2		Model 3	
	Personal Mental Illness Stigma*	Perceived Mental Illness Stigma**	Personal Mental Illness Stigma*	Perceived Mental Illness Stigma**	Personal Mental Illness Stigma***	Perceived Mental Illness Stigma
	<i>B</i> ( <i>SE</i> )	<i>B</i> ( <i>SE</i> )	<i>B</i> ( <i>SE</i> )	<i>B</i> ( <i>SE</i> )	<i>B</i> ( <i>SE</i> )	<i>B</i> ( <i>SE</i> )
<i>Subjective Social Status</i>	.460* (.184)	-.501** (.169)	.227 (.278)	-.836*** (.255)	.207 (.276)	-.885*** (.258)
<i>Family's Annual Income</i>			.346 (.309)	.497 (.284)	.444 (.308)	.459 (.288)
<i>Race</i>						
Hispanic					-.087 (1.583)	-1.574 (1.479)
Asian					.488 (1.120)	-.691 (1.046)
Black					.374 (1.543)	-1.038 (1.441)
Other Race					.319 (1.199)	-.406 (1.120)
<i>Female</i>					-1.038 (.798)	.510 (.745)
<i>Experience with Mental Health Services</i>					-3.044*** (.800)	-.623 (.747)
<i>Constant</i>	30.811*** (1.347)	53.764*** (1.241)	27.669*** 1.161	53.066*** (1.300)	32.304*** (1.790)	54.001*** (1.672)
R <sup>2</sup>	.011	.016	.033	.021	.049	.025
BIC	7708.284	7708.284	7716.944	7716.944	7770.889	7770.889

Note. Reference variables included white for race and male for gender. Experience with Mental Health Services is a binary variable indicating either a yes or no response to the respondent or the respondents' family member seeking mental health treatment in the past. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .00$ .

Table 4. Non-Ivy League University Predictors of Personal and Perceived Mental Illness Stigma (Ordinary Least Squared)

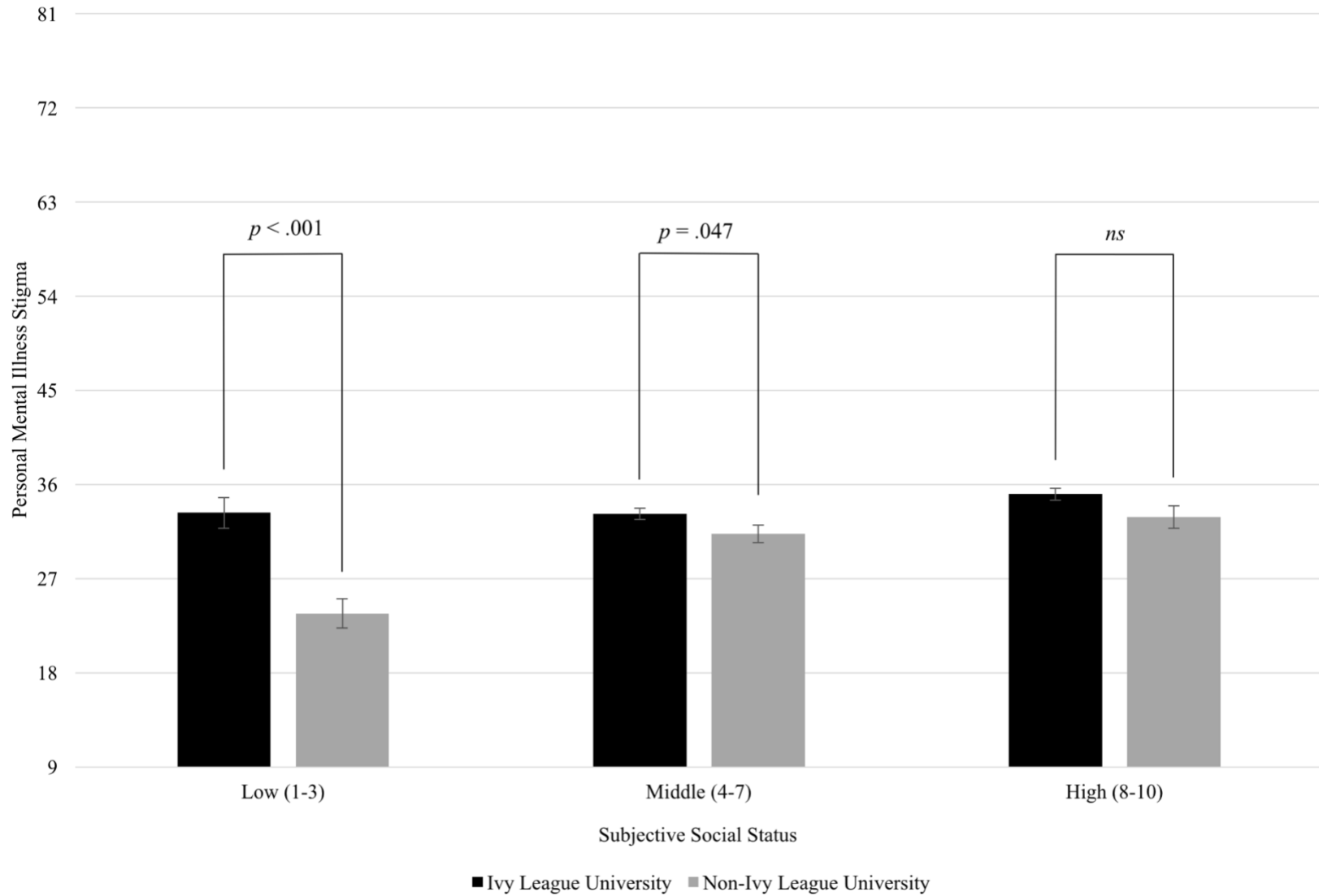
Predictor Variables	Model 1		Model 2		Model 3	
	Personal Mental Illness Stigma*** <i>B</i> ( <i>SE</i> )	Perceived Mental Illness Stigma <i>B</i> ( <i>SE</i> )	Personal Mental Illness Stigma** <i>B</i> ( <i>SE</i> )	Perceived Mental Illness Stigma <i>B</i> ( <i>SE</i> )	Personal Mental Illness Stigma* <i>B</i> ( <i>SE</i> )	Perceived Mental Illness Stigma <i>B</i> ( <i>SE</i> )
<i>Subjective Social Status</i>	1.164*** (.325)	-.446 (.305)	1.113** (.462)	-.657 (.432)	1.032* (.478)	-.608 (.450)
<i>Family's Annual Income</i>			.086 (.543)	.350 (.508)	.114 (.556)	.310 (.523)
<i>Race</i>						
Hispanic					-1.970 (3.810)	-2.200 (3.582)
Asian					-.515 (6.537)	.900 (6.146)
Black					4.156 (3.298)	-1.012 (3.101)
Other Race					2.954 (3.082)	-1.568 (2.897)
<i>Female</i>					-.754 (1.391)	.103 (1.307)
<i>Experience with Mental Health Services</i>					-.734 (1.285)	1.092 (1.208)
<i>Constant</i>	23.674*** (2.145)	50.874 (2.009)	23.603*** (2.197)	50.584 (2.055)	24.709*** (2.753)	49.952*** (2.588)
R <sup>2</sup>	.011	.010	.057	.012	.073	.019
BIC	1565.127	1536.923	1570.472	1541.813	1598.992	1572.451

*Note.* Reference variables included white for race and male for gender. Experience with Mental Health Services is a binary variable indicating either a yes or no response to the respondent or the respondents' family member seeking mental health treatment in the past. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .00$ .

personal mental illness stigma; students who reported greater subjective social status held more stigmatized views of people with mental illness ( $\beta = 1.032, p < 0.05$ ). Family's annual income, race, gender, and experience with mental health services were not significantly predictive of personal stigma (all  $ps > 0.49$ ). Lastly, none of the covariates significantly predicted perceived mental illness stigma at NILU.

T-tests compared students who reported the same subjective social status across college contexts. Figure 1 presents the results of the independent sample t-tests for personal mental illness stigma. Low social status students at ILU held much more stigmatized views of people with mental illness compared to low social status students at NILU. This same effect was present for middle social status students at the two schools, though to a smaller degree; middle social status students at ILU reported greater personal mental illness stigma compared to middle social status students at NILU. Lastly, high status students at ILU and NILU were not significantly different.

Figure 1. The effect of subjective social status and college context on personal mental illness stigma ( $M \pm SEM$ )



## **CHAPTER V**

### **DISCUSSION**

#### **A. College Context**

In accordance with Hypothesis One, ILU students had significantly higher personal and perceived mental illness stigma compared to NILU students. According to the literature, elite educational settings maintain a culture of perfection and individual agency (Khan 2010; Scelfo 2015). If, in this perspective, elite students are more likely to accept individual agency, perhaps they view people with mental illness as partly responsible for their suffering. In addition, students at elite institutions may hold more stigmatized views of people with mental illness because mental disorders threaten the norms of their elite culture.

#### **B. Social Status**

This section will review the findings concerning social status across social environments. Explanations for how social status operates differently in different contexts is reviewed in the following section. While subjective social status was only significantly predictive of perceived stigma at ILU and personal stigma at NILU, two general trends are apparent in nested presentations of the SUR and OLS models: subjective social status was positively related to personal stigma and negatively related to perceived stigma. Though some of the effects were not statistically significant, the directions of the associations remained across all nested versions of the personal and perceived models across both schools. These findings partially support Hypothesis One—that social status would be inversely related to mental illness stigma. Social status was negatively related to perceived mental illness stigma, but it was positively related to

personal mental illness stigma. In other words, lower social status students believed their communities held more stigmatized views of people with mental illness while higher social status students held more stigmatized views of people with mental illness.

The finding that social status was negatively related to perceived mental illness stigma is widely supported by the literature. Numerous studies suggest that people with mental illness fail to seek mental health services in order to avoid the stigma that accompanies the mentally ill label (Clement 2014; Cooper, Corrigan, and Watson 2003). In addition, lower status college students are less likely to seek mental health treatment compared to their higher status peers (Eisenberg, Golberstein, and Gollust 2007; Hunt and Eisenberg 2010; Rosenthal and Wilson 2008). In conjunction with my findings, these findings suggest that lower status students' perceptions of greater stigma in their college communities are likely the cause of their decreased likelihood to seek mental health treatment. Given lower status students' increased likelihood to experience mental illness, these findings suggest that lower status students represent a highly vulnerable population that is both more likely to experience mental illness and less likely to receive mental health treatment.

Unexpectedly, social status was positively related to personal mental illness stigma in both college contexts, which contradicts previous literature (Eisenberg et al. 2009). The positive relationship between subjective social status and personal mental illness stigma is likely a product of lower status individuals' greater familiarity with mental illness. People from lower socioeconomic backgrounds suffer with mental illness more than people from higher socioeconomic backgrounds, and are therefore more likely to have experienced or know someone who has experienced mental illness. While this



study controlled for some exposure to mental illness with a question about whether the individual or the individual's family members had previously sought mental health treatment, this measure did not include friends with mental illness. Since people in lower socioeconomic positions report decreased likelihood to seek mental health treatment (Eisenberg, Golberstein, and Gollust 2007; Hunt and Eisenberg 2010; Rosenthal and Wilson 2008), the lower status students in this study may be more likely to have been exposed to a person with untreated mental illness. Importantly, the measure of previous exposure to mental illness only asked about individuals who sought treatment, which does not account for students' exposure to individuals with symptoms of mental illness that go untreated. Since lower socioeconomic status individuals are more likely to be exposed to untreated mental illness, the lower status students in this sample may be more likely to have experience with mental illness that was not captured in the measure of previous exposure to mental illness.

Numerous studies demonstrate that greater familiarity with mental illness reduces mental illness stigma (Corrigan et al. 2001; Couture and Penn 2003; Rüsch, Angermeyer, and Corrigan 2005). Four factors may make lower status people more familiar with mental illness compared to middle and high social status people: 1) Low status individuals are more likely to have exposure to people with mental illness, either their own, their families, and/or their friends, since lower social status people are more likely to have mental illness (Hudson 2005). 2) Mental illness in family and friends may be more obvious to lower status individuals because they are more likely to have untreated mental illnesses and may exhibit more symptoms, making low status people more aware of their contact with people who are mentally ill. 3) Low status individuals may be more

likely to know about their family and friends' mental health problems as a result of their collectivist culture. People from low socioeconomic status backgrounds are more likely to perform prosocial behaviors (Piff et al. 2010), experience more compassion for others, and are more attuned to and impacted by the distress of others (Stellar et al. 2012). If, as these studies suggest, collectivism is stronger among lower status individuals, then they would be more likely to know about and empathize with their family and friends' mental health struggles. 4) Low status individuals are less likely to seek mental health treatment, which may lead to a greater reliance on family and friends for mental health needs. If lower social status individuals are not receiving professional mental health support, their mental health needs may become family responsibilities by necessity. Multiple configurations of these explanations most likely explain the positive association between social status and personal mental illness stigma. Since people who are lower social status probably have greater familiarity with mental illness, the finding that they have reduced mental illness stigma aligns with previous literature on familiarity and mental illness stigma. Future research should explore this association.

### **C. College Context and Social Status**

According to Hypothesis Two, social status would be inversely related to mental illness stigma, and this effect would be exacerbated in the elite college context. I ran independent sample t-tests between groups of similar status individuals at both schools and compared the means of the two dependent measures to further investigate whether status operated differently across college contexts. Though these analyses did not suggest a differential effect of social status on perceived stigma based on college context, they

did suggest that social status had a differential effect on personal stigma depending on the college context.

Social status had a different effect at ILU than at NILU on students' personal mental illness stigma. Low social status students at ILU had significantly higher personal mental illness stigma than their counterparts at NILU, and this difference was larger for low social status students than middle and high social status students. These findings indicate that social status has differential effects on students' personal mental illness stigma based on the type of school the students attend, especially for lower social status students.

The differential effect of social status based on college context in determining personal mental illness stigma partially supports the original hypothesis. Hypothesis Two states that social status will have a negative relationship with mental illness stigma and that the effect will be exacerbated at ILU. Though social status was positively related to personal mental illness stigma, low status students at ILU did have significantly higher personal mental illness stigma than did low status students at NILU, and this difference was larger than the middle and high status groups. Collectivist ideals, elite culture of perfectionism, and tokenism are possible explanations for why the difference between low status students' stigma at ILU compared to NILU was larger than the difference between middle and high status students' stigma at ILU compared to NILU. While the first two explanations are plausible, the theory of tokenism presents the most convincing explanation for the differential effects of social status based on college context.

Differing levels of collectivism may explain why low status students at ILU reported greater personal mental illness stigma compared to students at NILU. Generally,

lower status individuals are more other-oriented than higher status individuals (Piff et al. 2010). However, low status students at ILU may be an exception if they do not hold the same interdependent values that are characteristic of most lower socioeconomic positioned individuals. Given their membership in an elite college culture, low status students at ILU may have internalized individualistic values, which may cause their elevated personal mental illness stigma, and explain how they gained entry to an elite university. Additionally, low status students may be socialized to accept the individualistic ideals of their elite college environments, which leads them to stigmatize those with mental illness more than low social status students in non-elite contexts. If this explanation is valid, and the acceptance of individualistic ideals leads to greater stigmatization of people with mental illness, then future research should explore the role of collectivism in predicting mental illness stigma.

Closely related to individualism is the idea of controlling one's life outcomes. Students who believe they have control over their lives may be more likely to view mental illness as a negative reflection of an individual, and therefore, have more stigmatized views of people with mental illness. Some evidence suggests that people from working-class and, therefore, lower social status backgrounds perceive less control over their life outcomes compared to their middle- and upper-class counterparts (Bosma, Schrijvers, and Mackenbach 1999). Though lower social status people perceive less control over their lives, low status students at ILU may be an exception. If elite, low status students attribute their academic success to their own agency, they may believe that

- 1) they have more control over their life outcomes than most lower status people do, and
- 2) people who experience mental illness are responsible for their conditions.

The elite college culture of perfectionism may be responsible for low social status students' elevated personal mental illness stigma at ILU. As Khan (2010) explains, elite educational institutions promote a culture where perfection is the social norm. Maintaining perfection includes a specific affective presentation, i.e. happiness and effortlessness. Mental illness threatens the elite college social norm and is, therefore, condemned. Low social status students at ILU may have higher personal mental illness stigma because they view mental illness from the frame of their college campus' culture.

The theory of tokenism provides the best explanation for why low social status students held highly stigmatized views of people with mental illness at ILU but not at NILU. Most importantly, tokenism provides an explanation for why perceptions about social status produce this effect. Kanter (1977) developed the theory of tokenism to understand the social dynamics of groups with varying proportions of culturally-different people. Kanter's theory explains that skewed groups contain an overwhelming majority of one social type ("dominants") alongside a non-dominant social type ("tokens"), where tokens comprise less than 15% of the entire group. While Kanter's theory is widely applied to more visible social categories like gender and race, her framework can also be useful for understanding the internal processes through which individuals perceive themselves as tokens. While social status can be visible (e.g. class markers), this social grouping is different from gender and race because a person's understanding of her social status relies more heavily on individual perception. Kanter argues that three perceptual phenomena result from such skewed social groups: visibility, polarization, and assimilation. She claims that these processes of tokenism are group processes external to

the individual, but these concepts can also be applied to understand the internal processes that may occur when an individual *perceives* herself as a token.

Low social status students at ILU are status tokens. Only 14% of students at ILU receive Pell Grants, an indication of family income below the median national income. On the other hand, 31% of students at NILU receive Pell Grants. The perceived minority status of low social status students at ILU may explain why they are more likely than low social status students at NILU to believe that mental illness would stigmatize them. Kanter explains that increased visibility of a minority group leads to increased performance pressures. If low social status students *perceive* themselves as members of a token social group, their perception may lead to increased performance standards, or holding themselves to higher standards. Students at ILU who did not perceive themselves as tokens did not demonstrate elevated mental illness stigma. The perception of one's status as a token should be considered in future mental health research.

## CHAPTER VI

### CONCLUSION

This study demonstrates the power of social status and college context in determining personal and perceived mental illness stigma. Since students on the elite college campus reported greater stigmatized views of people with mental illness, elite campuses should question why their culture and/or their students hold stigmatized views of people with mental illness. Elite campuses should provide potential solutions to reduce mental illness stigma in order to create a less stigmatized culture for their students, especially those from lower socioeconomic positions.

The most striking finding from this project is the differential effect of social status on personal mental illness stigma in the two college contexts. Lower social status students, specifically those who perceive themselves as lower status, represent an at-risk group that should be studied in order to provide them with the resources they need to maintain mental health through college. While this study design did not allow me to unpack students' disparate experiences, previous qualitative research thoroughly documents lower status undergraduates' experiences in elite colleges (most notably—Aries 2008; Aries and Seider 2005; Bergerson 2007; Lee 2016; Lee and Kramer 2013; Torres 2009). Future research should build on these qualitative works by examining lower status students' mental health experiences and beliefs—especially at elite colleges.

Most importantly, this research suggests that socioeconomic diversity on college campuses may be causally linked to personal mental illness stigma. In other words, a lack of students from different social status backgrounds may be responsible for lower status students' greater stigmatization of mental illness. Future research should continue to

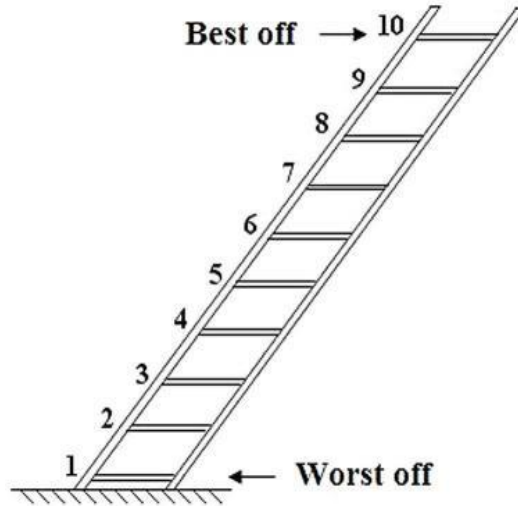
investigate the culture of elite academic institutions and the relationship between elite culture and students' mental health attitudes and behaviors. Special attention should be paid to the socioeconomic diversity of elite academic institutions. If my application of tokenism is valid, greater socioeconomic diversity in elite spaces will lead to decreased personal mental illness stigma. Consequently, socioeconomic diversity on college campuses should improve lower status students' health-related attitudes and behaviors.



## APPENDIX A

### THE MACARTHUR SCALE OF SUBJECTIVE SOCIAL STATUS

Imagine this ladder represents the social hierarchy at your college. At the bottom of the ladder are students who come from families with the least money and lowest social status. At the top of the ladder are students who come from families with the most money and social status.



Chatelard, Sophia; Bodenmann, Patrick; Vaucher, Paul; Herzig, Lilli; Bischoff, Thomas; Burnand, Bernard (2014): MacArthur scale of subjective social status. Figure\_1.

Now think about your family. Where would you be on this ladder compared to your college peers?

- Lowest Social Status - 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- Highest Social Status - 10

## APPENDIX B

### THE 9-ITEM ATTRIBUTION QUESTIONNAIRE

Please read the following: Harry is a 35 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He had been hospitalized six times because of his illness. To what extent do you agree or disagree with the following statements?

	1	2	3	4	5	6	7	8	9
I would feel pity for Harry. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How dangerous would you feel Harry is? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How scared of Harry would you feel? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would think that it is Harry's own fault that he is in his present condition. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think it would be best for Harry's community if he were put away in a psychiatric hospital. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How angry would you feel at Harry? (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How likely is it that you would help Harry? (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would try to stay away from Harry. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to? (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## APPENDIX C

### THE DEVALUATION-DISCRIMINATION SCALE

Please answer the following questions.

	Strongly Agree (1)	Agree (2)	Somewhat Agree (3)	Somewhat Disagree (4)	Disagree (5)	Strongly Disagree (6)
Most people would willingly accept a former mental patient as a close friend. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people believe that a person who has been in a mental hospital is just as intelligent as the average person. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people believe that a former mental patient is just as trustworthy as the average citizen. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people would accept a fully recovered former mental patient as a teacher of young children in a public school. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people feel that entering a mental hospital is a sign of personal failure. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people think less of a person who has been in a mental hospital. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most employers will hire a former mental patient if he or she is qualified for the job. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most employers will pass over the application of a former mental patient in favor of another applicant. (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most people in my community would treat a former mental patient just as they would treat anyone. (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most young women would be reluctant to date a man who has been hospitalized for a serious mental disorder. (11)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Once they know a person was in a mental hospital, most people will take his or her opinions less seriously. (12)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## APPENDIX D

### FAMILY'S ANNUAL INCOME MEASURE

What is your family's annual income?

- \$0 - \$24,999 (1)
- \$25,000 - \$49,999 (2)
- \$50,000 - \$74,999 (3)
- \$75,000 - \$99,999 (4)
- \$100,000 - \$149,999 (5)
- \$150,000 - \$199,999 (6)
- \$200,000 and above (7)

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