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The “Own” and the “Wise”: Does Stigma Status Buffer or Exacerbate Social Rejection of College Students with a Mental Illness?

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Abstract

Drawing on Goffman’s *stigma status* framework, this study examines how being diagnosed with a mental illness or knowing someone close diagnosed with a mental illness affects responses towards persons exhibiting symptoms of various mental illnesses. Using data from a survey administered to a sample of college students ($n = 556$), we find that respondents who have been diagnosed with a mental illness (the “own”) or who know a family member or friend with a mental illness diagnosis (the “wise”) express lower desired social distance from persons with symptoms of a mental illness than other respondents (“normals”). Also, informally labeling symptoms as ‘mental illness’ reduced social distance among those similarly diagnosed. However, perceived dangerousness did not vary across stigma status, and the socially-distancing effects of perceived dangerousness were more pronounced among the “own,” indicating that labels and stereotypes operate in countervailing ways.

In Goffman’s seminal book on stigma (1963), he described processes by which those who are stigmatized, or ‘marked by an attribute that is deeply discrediting’ navigate social interaction and manage identities. In relation to persons with stigmatized conditions, Goffman discussed the relevance of three groups, the “own,” the “wise,” and “normals.” The “own” are those who share the stigmatized condition. The “wise” are those who are regarded as ‘normal’, yet due to their relationship with a stigmatized person, have knowledge of that person’s condition. “Normals” are persons who do not carry a stigma. In general, Goffman specifies that the “own” and the “wise” will be more sympathetic to the plight of those stigmatized, compared to “normals.” However, somewhat contradictorily, he also indicates that, because of the possibility for stigma to ‘spread’ (i.e., “courtesy stigma”), and in order to ward off adverse social consequences, the “wise” may attempt to avoid or terminate close connections with stigmatized persons. Remarkably, there has been very little research that

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directly considers the implications of Goffman's conceptualization of the "own" and the "wise" for the social rejection of stigmatized persons.

In the present study, we incorporate the concepts of the "own," the "wise," and "normals" as categories of *stigma status* (proximal stigmatized identity), in a model of desired social distance towards persons exhibiting symptoms of various mental illnesses. Drawing from modified labeling theory and the literature on public attitudes towards mental illness, we examine (1) whether respondents' having a mental illness ("own") or knowing someone with a mental illness diagnosis ("wise") reduces desired social distance from persons exhibiting symptoms of a mental illness, (2) whether perceived dangerousness, in response to persons with symptoms of a mental illness varies by stigma status, and (3) whether the effects of informal labeling and perceived dangerousness on social distance are buffered or exacerbated by respondents' stigma status. We examine these effects using data from a vignette-based survey, administered to a sample of college students, as they constitute a key population of interest for understanding processes of social integration and rejection of those with mental illnesses.

Mental Illness Stigma and Social Distance

Despite advances in public understanding of mental illnesses, they are among the most stigmatized conditions, and are particularly likely to be associated with stereotypes of dangerousness (Link et al. 1999b; Pescosolido et al. 2010). Negative public attitudes towards persons with a mental illness can lead to discrimination, especially in areas such as work and friendships (Corrigan et al. 2002; Link and Phelan 2001). According to modified labeling theory, people also internalize negative public attitudes, leading to demoralization and maladaptive coping efforts (e.g., social withdrawal). Therefore, beyond the debilitating effects of symptoms and direct discrimination, internalized (self) stigma leads to constricted social networks and diminished well-being, inhibiting prospects for recovery (Markowitz 2014).

Following Goffman (1963), mental illness can be considered a 'discreditable' (concealable) attribute, made known to others through revelation of treatment history and the formal labels applied by professionals. Research from the perspective of persons diagnosed with a mental illness shows that, in an attempt to avoid anticipated social rejection by others, concealing one's treatment history or trying to 'educate' others about it, runs the risk of unintentionally increasing their social isolation (Link, Mirotnik, and Cullen 1991).

Mental illness can also be inferred by others through their (informally) labeling deviant (symptomatic) behavior as 'a mental illness'. Studies of public attitudes towards mental illness find, not surprisingly, that symptomatic behavior has a strong effect on social distance that is partly mediated by informally labeling symptoms as 'mental illness', and by perceptions of dangerousness (Martin et al. 2000). This suggests that when encountering persons known to exhibit symptomatic behavior, people invoke stigmatizing conceptions of mental illness and make an assessment of the likelihood of harm, what has been referred to as a "danger appraisal" (Corrigan et al. 2003; Markowitz and Watson 2015). Perceptions that persons with a mental illness are dangerous, while not entirely unfounded, are often

overestimated (Link et al 1999a). Also, symptoms directly affect desired social distance after controlling for labeling and perceived dangerousness. This is because people likely anticipate additional social complications resulting from symptomatic (but not necessarily violent) behavior, such as the difficulty of interacting with someone who is hearing voices or seeing things, dealing with the negativity associated with disorders such as depression, or the unreliability of persons with a substance problem (Karp 2001; Perry 2014).

The “Own” and the “Wise”

Goffman (1963) pointed to two groups of persons who may be more accepting of those who are stigmatized—the “own” and the “wise.” The “own” are those who share the stigmatized condition. In the case of mental illness, these are persons who have been similarly diagnosed. Goffman (1963) stated that “...in being a member of the [“own”] category, an individual may have an increased probability of coming into contact with any other member, and even forming a relationship... (pp. 23-24).” Thus, on the one hand, for the “own,” when encountering someone with a mental illness, there is the possibility of seeing that person ‘as someone like me’, and consequently being more tolerant. This is one of the underlying principles behind support and advocacy groups, where persons are thought to find acceptance among those who share stigmatized conditions. On the other hand, the “own” may not always be more accepting, as some persons, in their efforts to minimize their stigmatization, want to distance themselves from others with a mental illness, to avoid ‘being like them’. For example, persons in mental health self-help groups often leave the groups because of the negativity associated with other people’s problems (Markowitz 2015).

The “wise” are those not marked with the stigmatized condition, but are closely acquainted with those who are. Goffman generally argued that “wise” persons, because of their special proximity to those who are stigmatized, are more sympathetic and accepting. Given the constraints of some relationships, especially in the case of family, one may have less latitude in the choice of whether to interact with the diagnosed person or not. In later work however, Goffman (1971) indicated that, because of the potential for highly disruptive symptoms, the social bond with a family member with a mental illness can be very tenuous.¹

Qualitative studies show there is tremendous strain and ambiguity felt by family members of persons with mental illness (e.g., Karp 2001). Quantitative studies show that family members of persons with mental illness run the risk of being judged less favorably by others and are likely to attempt to conceal their relatives’ mental illness (Mehta and Farina 1988; Phelan, Bromet, and Link 1998). Ostman and Kjellin (2002) also found that stigma by association in relatives of people with mental illness is more pronounced when relatives themselves have mental health problems. At the same time, family members often hold stigmatizing conceptions of their mentally ill relatives (e.g., as dangerous and incompetent) (Markowitz et al. 2011). Together, these findings are consistent with the possibility that persons with a family member or friend with a mental illness might be reluctant to engage

¹-Goffman considers “the wise” as ‘normal’, thus more specifically they would be ‘normal-wise’, in contrast to ‘normal-non-wise’. For the sake of clarity, we simply use the term “wise” to refer to one who is ‘normal-wise’ and “normal” to indicate one who is ‘normal-non-wise’. These distinctions are supported by Smith (2012), who formed clusters based on attitudes towards stigmatized conditions.

with someone with whom they are not already obligated to do so. Similarly, “normals” who do not know someone with a mental illness may also be reluctant to engage with someone with a mental illness to avoid being subject to “courtesy stigma,” whereby their association with a stigmatized person casts them in a negative light. According to Goffman (1963), “In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations either tend to be avoided or to be terminated, where existing (p.30).”

Very little research has directly tested the implications of Goffman’s concepts of the “own” and the “wise.” One exception is Smith (2012), who performed latent-class analysis on college students’ attitudes towards a range of stigmatized conditions (e.g., homosexuals, sexual predators, mentally ill, substance users, and smokers). She found that attitudes can be used to categorize persons into ‘stigma status’ groups of “stigmatizing normals,” “own,” and “wise.” She also found that the “wise” could be further subdivided into “active supporters” (those who encouraged confronting stigma) and “passive supporters” (those who did not). Green (2007), using a sample of college students, found that students with a physical or mental disability (i.e., the “own”) perceived greater devaluation of those with disabilities, in turn affecting their emotional well-being, in line with modified labeling theory. These studies did not, however, examine the effects of one’s stigma status on acceptance or rejection of *others* with a stigmatized condition, or the effects of stigma status with regard to mental illness in particular. Smith (2012) recommended that studies are needed to examine the social network dynamics of stigmatization.²

Some research has applied the “contact hypothesis” of inter-group relations to mental illness (Couture and Penn 2003). In these studies, *contact*, or *familiarity* with mental illness is operationalized broadly. It is measured along a unidimensional continuum, from publically observing persons with mental illness or watching TV portrayals, to working with someone with a mental illness, to having a diagnosis oneself. Findings regarding contact have been mixed. Some studies show that greater familiarity lowers perceptions of dangerousness and social rejection of persons with mental illness, while others show it exacerbates stigma (Corrigan et al. 2001; Pescosolido et al. 2008). For example, one study found that having a roommate receiving mental health services was associated with an increase in stigmatizing attitudes among those without a history of mental illness treatment (Eisenberg, Downs, and Golberstein 2012). As Pescosolido et al. (2008) point out, the effects of contact may be complex, depending on the nature and type of prior relationships persons have with others with a mental illness. Research has not fully examined the effects of particular types of contact, nor has it examined whether the effects of symptomatic behavior, informal labeling, or perceived dangerousness on social rejection are buffered by having a diagnosis (being one of the “own”) or having a close family or friend with a mental illness (being one of the “wise”), compared to not belonging to either of these categories (“normal”). In our analysis, we consider how the categorical distinction of one’s status—as a member of the stigmatized

²Estroff (1981), in her ethnographic account of a community treatment program, found that clients generally made the distinction between “crazies” (known psychiatric patients) and “normies” (persons not known to have a psychiatric disorder). She further noted the distinction made between “inside normals” and “outside normals,” that parallel Goffman’s concepts of the “wise” and “normals.” She found that “outside normals” often avoided, or treated those with a mental illness negatively. At the same time, she found that persons in treatment often avoided “outside normals.”

group, as one closely associated with a member of the stigmatized group, or as one removed from the prospects of stigma—affects the willingness to associate with someone with symptoms of various mental conditions.³

Hypotheses

Several main and interactive effects involving Goffman's concepts of the "own" and the "wise" are possible. In terms of main effects, consistent with the contact hypothesis, the "own" or "wise," because of their greater understanding, could be more sympathetic, and thus perceive those exhibiting signs of mental illness as less dangerousness, and be less rejecting compared to "normals." Alternatively, first-hand experience with the troublesome behavior associated with a mental illness could increase desired social distance from those exhibiting signs of mental illness. In terms of conditional effects, if having a more proximate stigma status fosters 'stigma resistance' (or support), the effects of perceived dangerousness may be less among the "own" and "wise," compared to "normals." Similarly, among those 'in the know' ("own/wise"), the effects of respondents' informally labeling symptomatic behavior as 'mental illness' could be associated with greater understanding, and therefore lower desired social distance, compared to those unacquainted with someone with a mental illness.

Our hypotheses, framed in terms of how more proximal stigma status 'benefits' those with symptoms of a mental illness, are summarized below. In the analyses, we take into account the effects of symptoms of several different types of disorders (schizophrenia, depression, and substance dependence, in comparison to persons exhibiting signs of 'normal distress').

1. *Stigma-status* main effects

- a. The "own" and the "wise" will desire less social distance from persons exhibiting symptoms of mental illness compared to "normals."
- b. The "own" and the "wise" will perceive persons exhibiting symptoms of mental illness as less dangerous compared to "normals."

2. *Stigma-status* conditional effects

- a. The effect of informally labeling symptoms as 'mental illness' on social distance will be less for the "own" and "wise," compared to "normals."
- b. The effect of perceived dangerousness on social distance will be less for the "own" and "wise" compared to "normals."

³Lucas and Phelan (2014), drawing on status characteristics theory, distinguish between *status* and *stigma* processes, with the former referring to 'diffuse' (e.g., gender) and 'specific' characteristics (e.g., musical ability) that affect performance expectations, and the latter associated with conceptions of abnormality (e.g., distinctions between "us" and "them"), activating stereotypes. We use the term *stigma status* to refer to one's position, relative to a stigmatized condition.

Methods

College Student Sample

We test the processes indicated using a sample of college students (details below). There are a number of reasons why a college sample is particularly relevant. A substantial, and increasing number of college students will experience mental health problems, given that many mental illnesses become evident when persons are in their late teens and early twenties (Kessler et al. 2007). Surveys indicate that 17% of college students screened positive for depression, and 10% screened positive for an anxiety disorder (Blanco et al. 2008; Hunt and Eisenberg 2010). Other nationwide data show that about one-third of college students felt, at some time over the last 12 months, “so depressed that it was difficult to function,” 51% reported feeling “overwhelming anxiety,” and 10% reported having seriously considered suicide (American College Health Association 2012; Eisenberg et al. 2007). Studies also show that about 20% of college students meet diagnostic criteria for alcohol abuse or dependence disorders (Blanco et al. 2008; Wechsler and Nelson 2008).

On college campuses, students spend a significant amount of time in close proximity to one another (e.g., dorms, classes), providing considerable opportunities to pursue friendships, working, and romantic relationships. On the one hand, given the prevalence of mental illness among college students and the growth of education and advocacy efforts, fellow students might be somewhat more understanding than others. On the other hand, students may be more sensitive regarding associations of mental illness with dangerousness, given high-profile violent events perpetrated by students with a mental illness on college campuses (Fox 2009). Therefore, socially-rejecting responses from fellow students may be more likely, in the case of some disorders. For students with a mental illness, others’ responses could decrease the likelihood of seeking treatment due to stigma, leading to the loss of social opportunities and sense of belonging, and influence the choice to leave school (Jones et al. 2015).

Experimental studies find that when college student subjects were told their “partners” (presented as fellow students in computer-simulated task situations) had been hospitalized for psychiatric problems, they were less likely to want to meet their “partner,” or continue their partnerships in what they thought was a subsequent phase of the study (Lucas and Phelan; 2012; Kroska et al. 2014). This demonstrates the type of exclusionary processes that may result from mental illness. Task situations are of particular relevance in college settings (e.g., studying, group projects, committees, and organizations). However, since students may not be aware of concealable, formal diagnostic labels that have been applied to fellow students via treatment (including hospitalization), social exclusion may result from non-normative behavior indicative of mental illness, not presented in laboratory simulations.

In the present study, self-administered survey data were collected from a cross-section of students in 26 classes across 6 colleges at a large, public Midwest university. About 75% of all college students are enrolled in public universities. The survey was administered to achieve a sample proportionate to the number of students in each major college within the university. At the beginning of each class, students were given a brief introduction, including assurance of anonymity, and acknowledgement that participation was voluntary. The survey

completion rate was over 95%. A total of 556 cases were used in the analysis, although the sample size drops slightly in the models below due to a small amount of missing data. Comparison of respondent demographics with known characteristics provided by the university's institutional research office indicates the sample closely resembles the students enrolled at the university, as well as students enrolled at public colleges and universities nationwide, in terms of demographics and major colleges (National Center for Education Statistics 2012; National Science Foundation 2012). Fifty-four percent of the respondents were female, 67% white, 11% black, 9% Hispanic, 5% Asian, and 4% multi-racial.

Measures

Respondents were first administered a randomized vignette, describing either "John" or "Mary" ("a student at your university"), who exhibits symptoms of either *schizophrenia*, *alcohol abuse*, *major depression*, or *normal distress*, thus constituting a 2×4 factorial design. The exact wording of the vignette conditions is presented in the Appendix.

Ten *social distance* items measured the willingness to "work closely on the job with," "live next door to," "spend an evening socializing with," "have marry into your family," "have as a friend," "share a dorm room with," "have live on your dorm floor," "have live in your apartment building," "study with," and "date someone like John [Mary]." Responses to each item were coded on a scale from 1 to 4, with 1 = "definitely willing," 2 = "somewhat willing," 3 = "not very willing," and 4 = "not willing at all." The items were added and then averaged, so that higher scores indicate greater social distance (alpha reliability = .93, mean = 2.26, s.d. = .72).

Perceived dangerousness was measured by the question: "In your opinion, how likely is it that John [Mary] would do something violent toward other people?" Responses were coded 1 = "not likely at all," 2 = "not very likely," 3 = "somewhat likely," and 4 = "very likely" (mean = 2.50, s.d. = .80)

Labeling of the vignette character's symptoms as mental illness was measured using a single item: "In your opinion, how likely is it that John [Mary] is experiencing a *mental illness*?" Responses were coded on a scale from 1 to 4 ("very likely," "somewhat likely," "not very likely," and "not likely at all."), so that higher numbers indicate a stronger likelihood of considering the vignette person as having a mental illness (mean = 3.01, s.d. = .87).

Stigma status was established by constructing a three-category variable. Respondents were considered "*own*" if they answered "yes" to the question, "Have you ever been diagnosed with a mental illness (such as depression, panic/anxiety, bipolar disorder, schizophrenia, or substance abuse/dependence)?" Twenty-two percent of the respondents indicate having been diagnosed with a mental illness, similar to estimates from other studies of college students (American College Health Association 2012). They were considered "*wise*" (39%) if they answered "yes" to questions asking whether they "have friends with a mental illness" or "have immediate family with a mental illness (parents or siblings)." If they did not indicate having been diagnosed with a mental illness or knowing someone with one, they were categorized as "*normal*" (39%).

Findings

First, we examined the average social distance scores by stigma status and vignette condition (shown in Table 1), using one-way analysis of variance tests. Here, we see that, despite the prevalence of drinking on college campuses, respondents are most averse to interaction with individuals with persons perceived as “problem drinkers” (2.71). This is followed by persons with schizophrenia (2.44), and major depression (2.14). Social distance scores were lowest for the person described as showing signs of ‘normal’ distress (1.77). These mean differences were all statistically significant from one another ($p < .001$). Consistent with our hypothesis (1a), we find that overall social distance scores vary significantly across stigma status. Average scores for the “own” are lowest (2.12), and progressively increase among the “wise” (2.21) and the “normal” (2.41), in line with the assertion that greater stigma status proximity results in increased social tolerance. Post-hoc tests further reveal that significant differences exist between the “own” and “normals” and between the “wise” and “normals,” but not between the “own” and “wise,” very much in line with Goffman’s theory about the special relationship between the “own” and the “wise.”

Upon closer examination, some special patterns are revealed when examining the relationship between stigma status and social distance by type of symptoms exhibited by the vignette character. Average social distance scores are highest for vignette characters displaying symptoms of alcohol dependence, followed by schizophrenia, depression, and ‘normal distress’. Stigma status does not affect social distance when the vignette character displays symptoms of alcohol dependence, but it does when the vignette character displays symptoms of schizophrenia, depression, and normal distress. The effect is especially pronounced for symptoms of depression. Moreover, note that social distance is lowest for the “own” and “wise” in the case of signs of ‘normal distress’ and for the “own” in cases of depression. This likely reflects depression as among the most common mental disorders, and the ability of respondents to relate to persons going through similar problems (yet not necessarily meeting diagnostic thresholds)

Next, we examined the average level of perceived dangerousness by stigma status and vignette condition (shown in Table 2). Respondents consider individuals with signs of alcohol dependence and schizophrenia most dangerous (2.82 and 2.81, respectively), followed by those with symptoms of major depression (2.38). Perceived dangerousness is lowest for the person described as having ‘normal’ distress (1.99). The mean differences between alcohol dependence and schizophrenia are not statistically significant, but differences between all other conditions are statistically significant from one another ($p < .001$). However, contrary to our hypothesis (1b), for all disorders overall, and for each disorder separately, average level of perceived dangerousness to others does not significantly vary by respondents’ stigma status.

We then estimated two OLS equations (shown in Table 3) to examine the effect of vignette condition, stigma status (“own,” “wise,” compared to “normals”), and informal labeling on social distance, controlling for gender of the vignette character (equation 1). This equation demonstrates the greater preferred social distance from persons showing signs of alcohol dependence, schizophrenia, and major depression compared to the person with signs of

‘normal’ psychological distress. The effect of the vignette character’s gender on social distance is not significant. The effect of respondents’ labeling the vignette character’s behavior as ‘mental illness’ does not have a significant effect on social distance. Consistent with the bivariate analysis above, both the “own” and the “wise” express significantly lower preference for social distance compared to the “normal” respondents, with the effect of “own” being somewhat larger. This is consistent with Goffman’s argument that the “own” and the “wise” will be somewhat more tolerant of persons with a stigmatized condition. Together, the type of symptomatic behavior, respondents’ stigma status, and the other variables account for about 29 percent of the variance in social distance.⁴

The second equation (2) adds the dangerousness variable to examine the extent to which the effects of symptomatic behaviors on social distance are mediated by perceptions of dangerousness of the target person to others. This effect is statistically significant and adds 7% of explained variation in social distance. The effect of alcohol dependence on social distance is reduced by about 20%, the effect of schizophrenia is reduced by about 25%, and the effect of major depression symptoms on social distance is reduced by about 21% when the dangerousness variable is added. Also, the negative effect of respondents’ having been diagnosed with a mental illness on social distance (“own”) is reduced by about 13% and the effect of having close family or friends with a mental illness is reduced by about 4% when dangerousness is added. The effect of informal labeling increases slightly and becomes statistically significant, indicating that respondents that identify the vignette character’s behavior as indicative of mental illness express slightly *less* desire for social distance. Together, these findings suggest that part of the effects of symptoms and stigma status on social distance are mediated by perceived dangerousness.

Next, in order to examine the interactive effect of stigma status, we re-estimate the equation for the effects of symptoms, labeling, and dangerousness separately for the “own” (equation 3), “wise” (equation 4), and “normals” (equation 5). This allows us to examine the extent to which the effects of perceived dangerousness and informal labeling vary by stigma status. Consistent with hypothesis 2a, the effect of labeling the vignette character’s symptoms as “mental illness” results in reduced social distance only for those who have been diagnosed with a mental illness (“own”). Its effect is larger compared to the “wise” and “normals.” Although the negative effect is more pronounced among the “wise” compared to “normals,” it does not quite achieve statistical significance ($p < .10$).

Contrary to hypothesis 2b however, the pattern of results indicates that as respondents’ stigma status is more proximal to mental illness, the effect of perceived dangerousness *increases*. The effect of perceived dangerousness, while significant across the three groups, is somewhat greater among the “own” compared to the “wise” and the “normal.” Moreover, we see that the effects of symptoms of alcohol dependence and schizophrenia on social distance remain substantial for all three groups, but symptoms of alcohol dependence are somewhat less for the “normal” sub-sample, compared to the “own/wise.” The effects of

⁴Initially, we included the effects of respondent’s race and gender. Respondent’s gender did not significantly affect social distance, but social distance scores were slightly higher among black respondents. Inclusion of these variables did not alter the main substantive coefficients in any way, and were thus omitted from the equations shown.

symptoms of schizophrenia also remain substantial, but are most pronounced among the “own.” The effect of symptoms of depression, however, is not significant for the “own,” yet remains significant for the “wise” and the “normal.” Given that depression is a more common mental disorder (especially among college students), it seems that when the vignette character displays those types of symptoms, students who have received a diagnosis of mental illness are perhaps more sympathetic and understanding and less inclined towards social rejection.

Discussion

The results suggest that stigma status affects willingness to interact with persons exhibiting symptomatic behavior in somewhat complex ways. Consistent with our expectations, status as “own” or “wise” is associated with significantly less discrimination. Also, recognizing a person’s non-normative behavior as indicative of a medical condition (i.e., informally labeling symptomatic behavior as ‘mental illness’) results in less discrimination. This effect is more pronounced among those also diagnosed with a mental illness, in line with Goffman’s theory.

Contrary to our expectations however, the socially distancing consequences of perceived dangerousness were more pronounced among the “own,” compared to the “wise” and “normals.” This is perhaps analogous to the way that expectations of devaluation and discrimination operate according to modified labeling theory, in that the “own,” the “wise,” and “normals” hold equal expectations of dangerousness when encountering persons who exhibit symptoms of a mental illness, but those expectations are ‘personally relevant’ among those with greater experience with individuals with mental illness. Persons with a mental illness may especially wish to avoid association with someone thought to be potentially dangerous, as they could have greater awareness of the disruptive potential for symptomatic behavior, and the possibility of a ‘courtesy stigma’ being applied to them.

Perceptions of danger could be enhanced for those with adverse or disconcerting interaction with intimates known to have a mental illnesses. When there is violence among persons with a mental illness, intimates are most likely to be the targets, often due to the ‘conflicted relationships’ that mental illness can create (Estroff et al. 1994; Silver 2002). Families of persons with mental illness experience violence at higher rates than the general population (Solomon, Cavanaugh, and Gelles 2005). One way to examine these processes is to determine the nature of one’s experiences with close associates with mental illness. Generally positive past interactions (or relationships) might not have much of an effect on the decision whether to interact with someone encountered for the first time with a mental illness, but negative past experiences might carry greater weight in the desire for social distance. These types of differences could play a role in determining whether “wise” persons become ‘supporters’ or ‘stigmatizers’ in Smith’s (2012) framework. Further research examining the nature of contact on perceptions of dangerousness and willingness to interact with persons with a mental illness is needed.

A limitation of our study is that while we measured stigma status in relation to proximity to persons with ‘a mental illness’, we did not probe status regarding specific types of disorders.

Having, or knowing someone with depression might, for example, uniquely affect willingness to interact with someone similarly diagnosed. Also, like other studies in this area, the social distance measures are attitudinal, rather than behavioral, and thus may differ in ‘real-world’ situations. However, they represent likely indicators of behavioral intent, especially given the level of choice (i.e., ‘behavioral control’) that students often have, in deciding whether to interact with a fellow student (Azjen 2002). Also, our portrayal of persons with symptoms of mental illnesses did not include information on their treatment engagement, which could affect respondents’ perceptions of dangerousness and willingness to interact (McGinty et al. 2015).

In terms of the practical implications of helping persons with mental illnesses on college campuses (and in general), the findings support continued efforts at “illness reduction” via treatment engagement (Salzer 2012). Unfortunately, the stigma associated with mental illness can reduce the likelihood of voluntary help-seeking (Corrigan 2004). Given that other research shows that program-based, ‘forced’ efforts at contact, and educational efforts at reducing perceptions of dangerousness have limited, short-term effects, we are cautiously optimistic that programs designed to help adults disclose their status as ‘a person with a mental illness’ in ways that dispel others’ concerns, emphasizing competencies and obstacles overcome, may have some potential in reducing stigma and fostering greater social inclusion (Corrigan, Kosyluk, and Rüsch 2013). However, these potential benefits may be contingent upon whether others’ prior interactions with persons with a mental illness have been disconcerting or not.

In sum, the findings suggest some countervailing forces may be operating. On one hand, people experienced with mental illnesses, either first-hand (“own”) or by intimate association with others (“wise”) are more willing to interact with those who show signs of mental illness, compared to others. Moreover, people are less likely to discriminate against those exhibiting troubling behaviors when they recognize such behaviors result from medical conditions. However, to the extent that stigmatizing perceptions of dangerousness are invoked, this leads to an increased likelihood of discrimination towards those with a mental illness.

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Appendix

Schizophrenia

John [Mary] is a student at your university. Up until a year ago, life was pretty okay for John [Mary]. But then things started to change. He [she] thought that people around him [her] were making disapproving comments, and talking behind his back. John [Mary] was convinced that people were spying on him [her] and that they could hear what he [she] was thinking. John [Mary] lost his drive to participate in his usual work and family activities and

retreated to his [her] home, eventually spending most of his [her] day in his [her] room. John [Mary] was hearing voices even though no one else was around. These voices told him [her] what do and what to think. He [She] has been living this way for six months.

Alcohol Dependence

John [Mary] is a student at your university. During the last month John [Mary] has started to drink more than his usual amount of alcohol. In fact, you have noticed that he [she] needs to drink twice as much as he used to get the same effect. Several times, he [she] has tried to cut down, or stop drinking, but he [she] can't. Each time he [she] has tried to cut down, he [she] became very agitated, sweaty and he couldn't sleep, so he [she] took another drink. His [Her] friends have complained that he [she] is often hung-over, and has become unreliable, making plans one day, and canceling them the next.

Major Depression

John [Mary] is a student at your university. For the past two weeks he [she] has been feeling really down. He wakes up in the morning with a flat heavy feeling that sticks with him all day long. He [she] isn't enjoying things the way he normally would. In fact nothing gives him [her] pleasure. Even when good things happen, they don't seem to make John [Mary] happy. He pushes on through his [her] days, but it is really hard. The smallest tasks are difficult to accomplish. He finds it hard to concentrate. He [She] feels out of energy and out of steam. And even though John [Mary] feels tired, when night comes he [she] can't go to sleep. John [Mary] feels pretty worthless, and very discouraged. His [Her] family has noticed that he hasn't been himself for about the last month and that he has pulled away from them. John [Mary] just doesn't feel like talking.

Normal Distress

John [Mary] is a student at your university. Until a year ago, life was pretty okay for John [Mary]. While nothing much was going wrong in his [her] life he sometimes feels worried, a little sad, or has trouble sleeping at night. John [Mary] feels that at times things bother him more than they bother other people and that when things go wrong, he [she] sometimes gets nervous or annoyed. Otherwise John [Mary] is getting along pretty well. He enjoys being with other people and although he [she] sometimes argues with his family, John [Mary] has been getting along pretty well with his [her] family.

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Table 1.

Social Distance by Stigma Status and Symptoms

Symptoms	Respondent's Status				F	Sig.	n
	Total	"Own"	"Wise"	"Normal"			
Alcohol	2.71	2.73	2.70	2.72	.04	.964	134
Schizophrenia	2.44	2.18	2.40	2.57	3.76	.026	140
Depression	2.14	1.73	2.07	2.37	12.76	.000	142
Normal distress	1.77	1.65	1.65	2.00	5.81	.004	137
Average	2.26	2.12	2.21	2.41	7.69	.001	553

Table 2.

Perceived Dangerousness by Stigma Status and Symptoms

Symptoms	Respondent's Status				F	Sig.	n
	Total	"Own"	"Wise"	"Normal"			
Alcohol	2.82	2.82	2.92	2.66	1.76	.176	136
Schizophrenia	2.81	2.56	2.78	2.93	2.28	.106	141
Depression	2.38	2.20	2.37	2.47	1.30	.275	147
Normal distress	1.99	2.10	1.95	1.96	.54	.586	137
Average	2.50	2.44	2.51	2.52	.43	.650	561

Table 3.

Relationships Between Symptoms, Stigma Status, Dangerousness, and Social Distance

	Social Distance				
	(1)	(2)	(3)	(4)	(5)
	Total Sample		“Own”	“Wise”	“Normal”
Alcohol dependence ^a	.996 *** (.074)	.796 *** (.076)	.840 *** (.139)	.930 *** (.122)	.579 *** (.139)
Schizophrenia ^a	.706 *** (.085)	.530 *** (.084)	.461 ** (.155)	.720 *** (.140)	.421 ** (.141)
Depression ^a	.370 *** (.075)	.294 *** (.072)	.088 (.139)	.398 ** (.116)	.311 * (.121)
Female vignette	-.086 (.053)	-.048 (.050)	-.010 (.099)	-.044 (.075)	-.092 (.086)
Label as “mental illness”	-.053 (.035)	-.085 ** (.034)	-.138 * (.063)	-.085 (.056)	-.050 (.058)
“Own”	-.329 *** (.070)	-.285 *** (.069)	-	-	-
“Wise”	-.229 *** (.059)	-.219 *** (.056)	-	-	-
Danger to others	-	.256 *** (.035)	.390 *** (.066)	.199 ** (.057)	.194 * (.059)
R ²	.288	.355	.543	.386	.196
n	550	545	123	217	205

Note: Unstandardized regression coefficients shown with standard errors in parentheses

^aNormal distress is the reference category*
 $p < .05$ **
 $p < .01$ ***
 $p < .001$