Public stigma is the social process of upholding negative stereotypes about a certain group of individuals and subsequently distancing from that group and limiting their rights (Corrigan & Watson, 2002a). One particular group of people who have been subjected to public stigma for many years are those living with mental illness. People not only have to cope with their illness but also tolerate social exclusion and prejudices because of the negative stereotypes held by others (Rössler, 2016). These stereotypes, such as being labeled as dangerous, result in an exceeding number of people distancing themselves from and holding negative attitudes toward this group of people. They are then considered to be part of an out-group, which restricts the opportunities they have in society. Therefore, it is important to understand the impact of these stigmatizing attitudes toward people with mental illness and how they can be prevented.

To delineate this multifaceted phenomenon of mental illness stigma, Corrigan et al. (2000) applied Weiner’s (1972) attribution theory to the way society views people with mental disorders as unstable and disruptive. Controllability becomes a factor as people with mental illness are more likely to be seen as responsible for both causing their illness and for the presumed lack of effort they put in to improve their condition. Discomfort may be experienced by others when people with mental illness exhibit behaviors that are regarded as a violation of social norms.
norms, and this may result in negative stereotypes and avoidance behaviors.

Fostering negative stereotypes creates an inaccurate perception of people with mental illness, making them less socially desirable. These stereotypes, such as being less intelligent, mentally disorganized, and dirty, diminish almost all aspects of a person (Link et al., 1997; Newheiser & Barreto, 2014). Another common belief is that those with mental illness are dangerous, leading others to desire distance from them (Rüscher et al., 2005). These negative stereotypes, such as being incompetent and untrustworthy, are preconceived notions that can lead to active discrimination (Corrigan & Kleinlein, 2005).

Discrimination toward people with mental illness can limit their resources and opportunities in areas like housing, healthcare, employment, and education. They are less likely to find proper housing as people are less likely to lease apartments to them (Padgett, 2007). They are also less likely to receive adequate health care and generally report having a lower quality of life (Couture & Penn, 2003; Link & Phelan, 2001). Discrimination in the workplace may exist when employers attempt to circumvent the hiring of these people, resulting in fewer job opportunities (Couture & Penn, 2003; Link & Phelan, 2001). In academic settings, students may socially exclude peers with mental illness when they display emotional and behavioral problems, which becomes a risk for educational underachievement (Woodward & Fergusson, 2000).

**Mental Illness Stigma in College Students**

Many undergraduate students show symptoms of mental illness for the first time during their college years. According to the National Institute of Mental Health (NIMH, 2001), one in four young adults between the ages of 18 and 24 have a diagnosable mental illness. Out of these young adults who attend college, more than 25% have been diagnosed or treated by a professional for a mental health condition (NIMH, 2001). These young adults encounter ineluctable difficulties when transitioning from high school to college, as they are exposed to new challenges and have to adjust to significant life changes. During this critical period, students are likely to experience personal and emotional problems, global psychological distress, somatic distress, anxiety, low self-esteem, and depression (Shim et al., 2012). The combination of students’ genetic predisposition, pre-existing vulnerabilities, and psychological health issues, in conjunction with college environmental factors, can influence the onset of mental disorders.

Students are not only coping with the onset of mental illness but with quotidian college stressors as well. Ross et al. (1999) established the most common stressors as leaving one’s hometown and family, leaving one’s old friends behind to settle down in an unfamiliar institution with strangers, attempting to interact and/or living with these strangers, adapting to a new teaching system, and learning how to appropriately exercise autonomy. These common challenges have been found to induce more stress in students with pre-existing or evolving psychological disabilities (Weiner, 1999). As a response, students form maladaptive coping mechanisms, which can inadvertently make them more vulnerable to these stressors. One common maladaptive coping mechanism is withdrawal from active participation in college, which can lead to loneliness and subsequent depression (Kenyon & Koerner, 2009; Nicpon et al., 2006).

Students with mental illness who cannot appropriately cope with their symptoms may experience significant impairment in academic success. They may face more challenges with class assignments, exams, concentration, managing their time, and class participation (Knis-Matthews et al., 2007). Thus, they are also less likely to receive high grades (Dusselier et al., 2005). For example, even after controlling for prior academic performance, symptoms of depression have been shown to be a significant predictor of lower GPA, resulting in higher student attrition rates (Eisenberg et al., 2009). Mental illness also has a pronounced effect on social interactions, influencing academic success (Salzer, 2012).

Positive peer interactions can serve as a protective factor against severe mental illness symptoms in students. Social support has been demonstrated to buffer and counteract the negative impact of stress (Feldman et al., 2004). Suldo et al. (2008) found that students with above-average anxiety are more likely to view social interactions as helpful. Social support can also act as a buffer against alcohol consumption—a common coping mechanism—by making it seem less functional and useful (Pauley & Hesse, 2009). Additionally, peer support can prevent loneliness, which has caused well-documented problems, such as comorbid depression among students with mental health disorders (Perese & Wolf, 2005). Furthermore, Knis-Matthews et al. (2007) found that peer support within classes improved self-confidence and gave students with mental illness a sense of accomplishment.
Mental Illness Stigma and Social Distance

Although students attempt to socialize with their peers, they often experience social distance—a major component of the definition of stigma. Stigma is a multifaceted concept because it can be measured in different ways, with the desire for social distance being a common measurement (Jorm & Oh, 2009). Social distance has been defined as the relative willingness of one person to participate in relationships of varying degrees of intimacy with a person who has a stigmatized identity (Bowman, 1987). In this context, it reflects how society behaviorally approaches people with mental illness as different from and inferior to themselves. Social distance has been utilized as a measure of discrimination toward adults with mental illness in many studies (Baumann, 2007; Link & Phelan, 2001; Marie & Miles, 2008). Participants in these studies responded to the Social Distance Scale (Bogardus, 1933), which is a validated measure of one’s implicit attitudes toward people with mental illness and the desire to avoid them.

Greater social distance is desired more from people with mental disorders than from people who suffer from minor troubles or physical illnesses (Jorm & Oh, 2009). People seem to disapprove of those with psychiatric disabilities more than those with physical illness (Teachman et al., 2006). Among psychology undergraduates, Monteith and Pettit (2011) found that implicit associations regarding the underlying psychological causes of mental illness were found with more negative evaluation compared to physical illness. Social distance has been greater toward people with mental illnesses in comparison with someone with “normal” behavior, such as stress or physical illnesses like asthma, skin cancer, or a herniated disc (Martin et al., 2007).

As students with mental illness experience social isolation, they may begin to internalize these negative public attitudes and identify as a part of a stigmatized group. This self-discrimination and social exclusion can undermine a person’s identification as a student and lessen their motivation to achieve academically (Corrigan & Watson, 2002b). Along with internalized self-stigma, these “failures” result in low perceived self-esteem and self-efficacy (Watson et al., 2007). For example, people who anticipate and fear rejection—in addition to having been hospitalized for mental illness—may act less confidently or more defensively, or they may just completely avoid contact with others (Link et al., 2001). This can further increase isolation and conflicts in existing relationships.

Stigma as a Barrier to Mental Health Care

Most college students with mental disorders in the United States do not receive mental health care (Dusselier et al., 2005). In 2006, among students with a mood disorder, only between 34% and 36% received any mental health services (Eisenberg et al., 2007; Wu et al., 2007). Drum et al. (2009) found that, in 2008, more than half of college students who seriously considered attempting suicide had not received professional help. The underutilization of mental health services among students at higher risk for suicide is problematic, as seeking help has been shown to decrease the likelihood of a suicidal attempt (Brownson & Burton, 2007).

One explanation for the underutilization of mental health services by college students may be the fear of disclosure. Self-stigmatizing students may resist seeking help from others who were labeled for using counseling services (Sibicky & Dovidio, 1986). Furthermore, in a study by Ben-Porath (2002), hypothetical individuals described as seeking assistance for depression were rated as more emotionally unstable, less interesting, and less confident than both students who were
In-Group Identity on Mental Health Stigma | Mustafiz and Dugan

described as seeking help for back pain and those who had depression but chose not to seek help. Seeking help compels students to disclose a disability, which can make them feel vulnerable as they are voluntarily subjecting themselves to these stigmatizing attitudes. Collins and Mowbray (2005) conducted a study in which one participant suggested that schools should get rid of the self-identification model and instead rely on admissions staff to disseminate information and make referrals. This may make it easier for colleges to provide services and support to students who “hide” their disability.

Mental Illness Stigma and Perceived Similarity

To reduce stigmatizing attitudes, perceived similarity can be strengthened to create a bridge between people with and without mental illness. Research over the years has shown that taking a narrative approach when introducing a stigmatized person allows people to learn more about that person’s life experiences and multiple social identities. This can facilitate emotional immersion into that person’s world and elicit empathy, immersion into their perspective, and a temporary adoption of their desires, motivations, challenges, successes, and failures as their own (Miller & Brewer, 1986; Smith, 2007). Perspective taking from this narrative engagement has the potential to encourage social acceptance by increasing perceptions of similarity, increasing social attraction, and decreasing social distance for highly stigmatized people (Busselle & Bilandzic, 2008; Chung & Slater, 2013).

Many researchers have examined this phenomenon of increasing perceived similarity through a narrative approach to reduce social distance and ultimately stigma among college students. In a study by Norman et al. (2017), three groups of college students watched different videos: one group saw Andrew who was a person recovering from schizophrenia, the second group saw a different video of Andrew describing acute symptoms of schizophrenia, and the third group did not see any video. The researchers measured the reduction of stigma over a 2-week period and found that the recovery-focused presentation led to greater perceived similarity. Li et al. (2017) also conducted a study in which participants were assigned to the same videos of Andrew used in the study mentioned above. Participants were asked prior to the video to either “keep thinking of what you have in common with this person and try to find as many similarities as possible” or to “keep thinking of ways you are different from this person and try to find as many dissimilarities as possible” (Li et al., p. 119).

Watching Andrew describe his recovery led to more positive impressions, greater perceived overlap in personal characteristics, and less preferred social distance toward him than when the video focused on his symptoms.

Another study by Gay (2016) looked strictly at whether perceived similarity with someone with mental illness can reduce stigma among college students. College students were given information to think either abstractly or concretely and completed self-report and behavioral measures of stigma toward people with mental illness such as the Attribution Questionnaire. Additionally, these participants completed the Inclusion of Self in the Other Scale to rate their perceived similarity with a person with mental illness. Participants who were primed to think abstractly showed more stigmatizing attitudes toward a person with mental illness than participants who were primed to think concretely; abstract primes increased the activation of similar goals, leading to a similarity focus. Ultimately, the perception of similarity with a person with mental illness explained the relationship between construal level and stigmatizing attitudes and behavior; participants who rated themselves as being highly similar to a person with mental illness were less likely to endorse stigmatizing attitudes toward people with mental illness.

In-Group Favoritism and Out-Group Discrimination

Endorsing stigmatizing attitudes toward peers with mental illness can create in-group versus out-group separation. In-group favoritism is the tendency to favor members of one’s own group over those in other groups (Everett et al., 2015). Those who do not have mental illness may displace peers with mental illness into their out-group and choose to limit their interaction with them (Huggett et al., 2018). Grouping the out-group members together encourages negative stereotyping and prejudice. Research shows that this stigma creates an instinctive desire to socially distance oneself from members of out-groups (Brown et al., 2003; Dovidio et al., 2000). This is due to the perception that out-group members are inherently undesirable and defective. They are viewed as threatening or hostile (negative bias), whereas individuals perceived as in-group members are more likely to be seen as trustworthy or friendly (positive bias; Reihl et al., 2015). Separation leads to the belief that “they” (people with mental illness) are fundamentally different from “us” and that “they” are only defined by their label (Rusch et al., 2005).
Conversely, when people perceive someone as a part of their in-group, they are more likely to include them in their social group based on perceived similarities. When in-group and out-group members work toward common, superordinate goals and foster an expanded sense of in-group identity, stigma is likely to diminish (Gaertner & Dovidio, 2000; Sherif & Sherif, 1953). The perceiver’s already-formed and favorable impression of their peer, in conjunction with the positive stereotype of their shared in-group, might enter into and adjust the stereotypes held about the stigmatized group on a more general level (Major et al., 2000).

Although in-group identification has been shown to reduce stigma, it has not conclusively eliminated it toward people with mental illness compared to people with physical illness (Martin et al., 2007). People with mental illness continue to experience more stigma than those with relatively minor health problems like stress. However, amplifying perceived similarity through a common identity may eliminate inter-group differences and reduce social distance among the groups (Smith, 2007).

Current Study

Based on these previous findings, the current study aimed to examine the effect of high group identification versus low group identification on the level of stigma held toward a college peer with a mental health state of stress compared to a peer with mental illness. It was hypothesized that (a) high in-group identification with a peer, irrespective of their mental health state (stress versus mental illness), would lead to more perceived similarity and less social distance than low in-group identification, and (b) less perceived similarity and more social distance will be rated toward a peer with mental illness when compared to a peer with stress, but high in-group identification with the peer will still lead to a more favorable perception than low in-group identification.

Method

Participants

Participants (N = 152) were composed of undergraduate college students from a large public college—Hunter College, The City University of New York (CUNY). They were recruited through the Psychology Department Research Pool and completed the study as a requirement for the Introduction to Psychology course. Of the 152 participants, there were 100 women (66%), 48 men (32%), and 4 others (2%). See Table 1 for a detailed sample description.

Materials

Participants were asked to fill out a short questionnaire online on Qualtrics. All of the students first responded to the 4-item Group Identification Scale (GIS; Sani et al., 2015) which measures someone’s sense of belonging to a group, coupled with their sense of commonality with its members on a 7-point Likert-type scale from 1 (strongly agree) to 7 (strongly disagree). Stronger group identification measured by this scale has been shown to be valid and reliable in predicting properties of social relationships such as stronger perceived support, which is known to produce positive effects on mental health (Lincoln & Chae, 2012). Previous studies measuring group identification with various social groups, such as family, friends, and community members, have established the GIS’ reliability, with Cronbach’s α ranging from high .80s to low .90s (Sani et al., 2015). Additionally, the scale also has shown convergent validity by strongly correlating with two other measures of the same construct: Doosje, Ellemers, and Spears’s (1995) 4-item group identification measure and Postmes, Haslam, and Jans’ (2013) single item group identification measure. Divergent validity has also been shown with the GIS being correlated with Postmes’ (2003) perceived group distinctiveness scale, which is a scale that has been shown to be related to group identification. For

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Descriptive Characteristics of the Sample</th>
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<tbody>
<tr>
<td></td>
<td>Stress Condition Condition</td>
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<tr>
<td>n</td>
<td>%</td>
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<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>51</td>
</tr>
<tr>
<td>Man</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>24</td>
</tr>
<tr>
<td>White/European American</td>
<td>18</td>
</tr>
<tr>
<td>Black/African American</td>
<td>6</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>10</td>
</tr>
<tr>
<td>Mixed race/ethnicity</td>
<td>5</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>1</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td>History of mental illness</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>No</td>
<td>65</td>
</tr>
</tbody>
</table>
this study, participants’ group identification was measured with their college peers after they heard an audio clip of a hypothetical peer describing their typical Hunter College, CUNY experience. The overall score ranged from 4 to 28 with the lowest score indicating high in-group identification. Consistent with prior literature, average scores were computed to assign high in-group identification to participants whose average score was less than 5 and low in-group identification to participants whose average score was 5 or higher (Sani et al., 2015). Some items included in this scale were, “I feel a bond with Hunter College, CUNY students” and “I feel similar to the other Hunter College, CUNY students.”

The next scale utilized was the Inclusion of Other in the Self Scale (Aron et al., 1992). This 1-item scale assesses how close/similar the respondent feels with another person or group. It has exhibited convergent and divergent validity (Aron et al., 1992; Gächter et al., 2015). It has been significantly and strongly correlated with several scales that measure dimensions of relationship closeness such as the Relationship Closeness Inventory, the Loving and Liking Scales, and the Personal Acquaintance Measure Scale (Gächter et al., 2015). This scale was utilized in this study because interpersonal similarity is a component of social distance (Heider, 1958; Miller et al., 1998). In-groups are perceived as socially closer than out-groups (Fiske et al., 2002). Thus, this scale reassessed participants’ desired closeness after the peer’s mental health state was revealed. Participants saw seven pairs of circles that ranged from just touching to almost completely overlapping. One circle in each pair is labeled “self,” and the second circle is labeled “other.” Participants chose one of the seven pairs to respond to this item. They were instructed to click the diagram that best represented how close they felt to Jennifer, the Hunter College, CUNY student. The lower the score, the less similarity is perceived with the hypothetical student.

The final scale utilized is the Social Distance Scale (Link et al., 1987), which was originally adapted from the Bogardus Social Distance Scale. This 11-item scale measured the participants’ likelihood to engage in varying levels of intimacy with the hypothetical student on a 7-point Likert-type scale from 1 (strongly agree) to 7 (strongly disagree). The overall scores of this scale range from 11 to 77, with higher scores indicating greater social distance from the hypothetical student. To avoid social desirability bias associated with explicit measures of stigma, this scale has been used as a validated measure of implicit attitudes of stigma toward people with mental illness (Rüsche et al., 2010; Wang et al., 2012). Using the SDS, a recent population-wide study has also found significant stigma towards people with mental illness and identified specific groups who hold more stigmatizing attitudes (Subramaniam et al., 2017). The 11 items that make up the Social Distance Scale score showed good internal consistency with Cronbach’s α = .85, good construct validity, criterion validity, convergent validity, discriminant validity, and factor analysis (Link et al., 1987). For this study, items included in the scale were how likely the participant would be to: “Sit next to this person in class?” and “Feel comfortable being in the same classroom as this person?” Following this scale, all participants answered questions on gender, race, age, and history of mental illness.

Procedure

Prior to data collection, the manuscript received approval from the institutional review board. The Qualtrics survey was advertised on the Psychology Department online Research Pool. On Qualtrics, recruited participants were directed to first read a consent script that informed them of confidentiality, potential risks, their right to withdraw while still receiving credit, and deception. They were told that the full purpose of the study would be revealed at the end of their participation. They had to acknowledge that they are of 18 years or older and a Hunter College, CUNY student to confirm eligibility.

A between-participants experimental design with random assignment to two conditions was utilized. Initially, all 152 participants read the following direction at the beginning of the questionnaire: “We are looking to have people talk about their Hunter College, CUNY experience. Please listen to this student’s experience to determine whether or not this is a typical Hunter College, CUNY experience:” They were directed to an audio recording of Jennifer, a 20-year-old hypothetical Hunter College, CUNY student. The 18-second recording contains the following description of a typical Hunter College, CUNY college experience:

To describe my experience as a Hunter College, CUNY student, I am able to obtain quality education for an affordable price. It offers a variety of majors. It has a diverse student body, so I get to meet people from
different states and countries. Since it is in the heart of the city, there are a lot of places to go to nearby such as Central Park.

The first measure to be completed was the 4-item GIS, which assessed in-group versus out-group identification with other Hunter College, CUNY students like Jennifer.

Then, Qualtrics randomly assigned 74 participants to hear an audio clip of Jennifer revealing her experience of having stress while the other 78 heard Jennifer reveal her mental illness. In the stress condition, participants heard 8 seconds of the following vignette: “I don’t know if this is relevant or not, but last fall, I felt really stressed, and I struggled to complete my classwork. I had to miss a couple of classes.” In the mental illness condition, participants heard 10 seconds of the following vignette:

I don’t know if this is relevant or not, but last fall, I had kind of a nervous breakdown and had to be hospitalized for a while. I’ve been seeing a psychiatrist ever since and have been diagnosed with a mental illness.

Then, participants completed the 1-item Inclusion of Other in the Self Scale to rate their desired social closeness and perceived similarity to Jennifer. Finally, participants completed the adapted 11-item Social Distance Scale to rate their level of willingness to engage with Jennifer, followed by general demographic questions.

At the end of the survey, there was a debriefing section where the actual purpose of the study was disclosed, which is to look at attitudes toward students with mental illness. The participants also learned about the two different types of mental health conditions that participants were randomly assigned to.

Results

A factorial multivariate analysis of variance (MANOVA) was conducted to evaluate the effects of the two variables on the two dependent variables. Results from descriptive analysis indicated that there were no substantial violations of normality in all dependent variables. Among the 74 participants who were randomized to listen to Jennifer reveal stress, 41 rated low in-group identification with her and the other 33 rated high in-group identification. Among the 78 students who were randomized to listen to Jennifer reveal mental illness, 36 rated low in-group identification with her and the other 42 rated high in-group identification. The means and standard deviation values are shown in Table 2.

**Table 2: Descriptive Statistics and Effect Sizes for the Experimental and Control Groups**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Low In-Group Identification (n = 77)</th>
<th>High In-Group Identification (n = 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress (n = 41)</td>
<td>M(SD) = 3.10, 1.62</td>
<td>M(SD) = 3.06, 1.23</td>
</tr>
<tr>
<td>Mental Illness (n = 36)</td>
<td>M(SD) = 2.53, 1.34</td>
<td>M(SD) = 2.69, 1.11</td>
</tr>
<tr>
<td>Stress (n = 42)</td>
<td>M(SD) = 4.06, 2.11</td>
<td>M(SD) = 3.42, 1.90</td>
</tr>
<tr>
<td>Mental Illness (n = 42)</td>
<td>M(SD) = 3.21, 1.98</td>
<td>M(SD) = 3.22, 1.98</td>
</tr>
</tbody>
</table>

**Note:** IOS = Inclusion of Self in the Other Scale. SDS = Social Distance Scale.

**Group Identification**

Results of the factorial MANOVA indicated a significant effect for in-group identification, F(2, 147) = 8.01, p < .001, partial η² = .10. This variable was significant on the dependent variables of perceived similarity, F(1, 148) = 8.04, p = .005, partial η² = .05, and social distance, F(1, 148) = 12.52, p = .001, partial η² = .07. The means and standard deviation values displayed in Table 2 show that participants who rated high in-group identification with Jennifer perceived her more favorably by rating more perceived similarity and less social distance than the participants who rated low in-group identification with her.

**Peer’s Mental Health State**

Results of the factorial MANOVA indicated a significant effect for the peer’s mental health state, F(2, 147) = 8.00, p = .001, partial η² = .10. This variable was significant on the dependent variables of perceived similarity, F(1, 148) = 5.92, p = .02, partial η² = .04, and social distance, F(1, 148) = 11.28, p = .001, partial η² = .07. The means and standard deviation values displayed in Table 2 show that participants who rated Jennifer with stress perceived her more favorably by rating more perceived similarity and less social distance toward her than participants who rated her with mental illness.

**Group Identification and Peer’s Mental Health State**

The multivariate interaction effect of the two independent variables (group identification and the peer’s mental health state) on the dependent variables (perceived similarity and social distance) together was not significant, F(2, 147) = 2.66, p = 0.07, partial η² = .04. However, as indicated in Table 2, meaningful differences were observed between these variables. Among participants who initially reported low in-group identification with
In-Group Identity on Mental Health Stigma

Jennifer, those who heard her disclose stress rated more perceived similarity and less social distance toward her. On the other hand, the participants who heard her disclose mental illness rated less perceived similarity and more social distance toward her.

Likewise, among participants who reported high in-group identification with Jennifer, those who heard her disclose stress rated more perceived similarity and less social distance toward her compared to those who heard her with mental illness and rated less perceived similarity and more social distance toward her.

Discussion

The results of the present study suggest that high in-group identification can shape an individual’s implicit stigmatizing attitudes by eliciting a more positive perception of a peer with mental illness. Rüscher et al. (2009) established that the common identity of being a student at the same college alone may be inadequate to reduce stigma—one must exhibit higher levels of in-group perception and feel attached to their group to feel similar to other members. Thus, as hypothesized, students perceived more similarity and less social distance from the hypothetical student—regardless of their mental health state—when they identified strongly with them. Similarly, Major et al. (2000) found that, when students exhibited higher in-group perception with a peer from a stigmatized group, they expressed less stigma toward them because they identified more with them.

As expected, high in-group identification did not lead to a more positive evaluation of the peer with mental illness compared to the peer with stress. This finding is congruent with previous studies, which found that people with minor problems such as stress are less stigmatized than people with mental illness (Teachman et al., 2006). Therefore, this study supports existing literature by indicating that less social support is offered to these students (Livingston & Boyd, 2010). However, when examining the role of group identification, the current study found that students who identified more with their peers showed the smallest difference between the scores for the peer with stress and the peer with mental illness. This suggests that group identification had a significant impact on one’s stigmatizing attitudes toward peers with mental illness. This is supported by research from Gaertner and Dovidio (2000) and Sherif and Sherif (1953) who found that stigma is likely to decrease when people work toward similar and significant goals, as this increases an expanded sense of in-group identity.

Limitations and Strengths

A limitation of this study is that participants were recruited from an introductory course. Most were first-year or transfer students in their first semester at Hunter College, CUNY. Additionally, the 4-item GIS may not have been strong enough to detect in-group/out-group identity within this group of college students. The college is known for being a commuter school where very few students live in housing provided by the college or near the college. Thus, they might not have yet established a bond with other students at their college or a strong identification with being a student of their college. Another limitation could have been the significant difference in the number of participants who identified as men versus women, with 66% identifying as women; the participant’s gender could have influenced how they rated the hypothetical student, who was a woman. Furthermore, the mental illness audio script might have been perceived as more severe than the stress audio script, which could have contributed to the unfavorable perception of the peer with mental illness. However, the hypothetical peer’s hospitalization was considered to be an essential component of their college experience, as many young adults first experience mental illness at this age and are subsequently hospitalized.

Implications and Future Directions

The overall implications for this study are significant and applicable when targeting stigma because, although stigma could not be removed toward peers with mental illness, it decreased when students strongly identified with their peers. This conveys that, if an atmosphere can be created in a college climate where students have a strong sense of college community, it could reduce the extent to which students stereotype those with mental illness. Because many students have mental illness, increasing awareness of this shared identity in educational institutions can help students reframe their perception of people with mental illness. This idea is consistent with research by Gaertner et al. (2000), who established the common in-group identity model to explain that people of different groups can modify their perceptions to see themselves as members of a common larger group that includes previously labeled in-group and out-group members. Students can recategorize themselves to be a part of a superordinate group of peers instead of labeling and separating other students with mental illness as “them.” This is also
supported by research from McGrea et al. (2012), who found that increasing people’s focus on group generalization leads to less stereotypical social categorizations. Inter-group bias between students who have mental illness and those who do not have mental illness can potentially be diminished through the emphasis of the common identity of being a student of the same institution.

Educational institutions can take advantage of the enhanced awareness of this shared student identity to promote help-seeking behaviors. Stigma from peers can demotivate students from utilizing the counseling services at their college (Jennings et al., 2015). However, our findings suggest that creating this environment where the emphasis lies on common identities and goals, rather than one’s mental health state, can potentially increase social support, which has been shown to have a positive relationship with the number of students who seek help (Hartman-Hall & Haaga, 2002; Keum et al., 2018; Sibicky & Dovidio, 1986). A large body of research shows that the implementation of mental health literacy programs in educational institutions may also be effective in preventing mental health problems, decreasing mental health stigma, and increasing help-seeking behaviors (Jung et al., 2017, Kim et al., 2020, Kutcher, et al., 2016; Whitley et al., 2013). Furthermore, programs can take a narrative approach when introducing someone with mental illness to increase awareness about that person’s life experiences and multiple social identities (Miller & Brewer, 1986; Smith, 2007). This approach may not only reduce prejudice and promote perceived similarity but also pre-empt any negative inter-group expectations of people with mental illness who are currently around these students, such as peers with mental illness (Busselle & Bilandzic, 2008; Chung & Slater, 2013).

As students’ level of mental health knowledge increases, they can begin to apply this knowledge when interacting with peers who may have mental illness. Educational institutions may consider increasing contact between students through group education to promote any shared common identities and similarities in addition to the common identity of being members of the same institution. Additionally, researchers of a recent study were the first to show that college students who became involved in a student peer organization, developed to increase mental health literacy and decrease mental health stigma, were more likely to take action to support peers with mental health issues (Sontag-Padilla et al., 2018).

In conclusion, this study suggests that increasing this awareness of shared in-group identification reinforces a more positive view of someone with mental illness, which can potentially reduce stigma and lead to less hostility toward them. Although high in-group identification does not entirely eliminate stigma, it can narrow the gap between inter-groups because peers with mental illness were stigmatized to a smaller degree in this study. Nevertheless, reducing stigma is important because stigma from peers can become a barrier in accessing care, but fostering a sense of similarity by emphasizing the shared student identity and goals may potentially increase the number of students who seek help (Keum et al., 2018, Hartman-Hall & Haaga, 2002; Sibicky & Dovidio, 1986). Creating a college environment where the emphasis lies on a common identity and goals, rather than one’s mental health state, may potentially increase the number of students who seek help (Keum et al., 2018). Educational institutions may increase in-group awareness with peers with mental illness by implementing mental health literacy programs and increasing any in-group contact through group education and student peer organizations. Future research should continue to explore the efficacy of these interventions in helping to combat overall stigma by targeting those who are more prone to holding stigmatizing attitudes and opinions about people with mental illness and subsequently increasing social support and help-seeking intentions among those with mental illness.

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