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Breaking the Cycle of Stigma: The Role of Majority Group Stigmatization in Contributing to Internalized Stigma Among Racial Minorities

Camryn Harris

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by

Camryn Harris.

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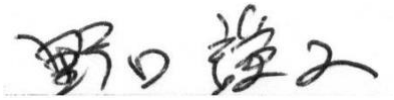

Kenji Noguchi, Ph.D.Ph.D.Ph.D.Ph.D., Thesis Advisor,
School of PsychologyPsychologyPsychologyPsychology

Sara Jordan., Ph.D.Ph.D.Ph.D.Ph.D., Director,
School of PsychologyPsychologyPsychologyPsychology

Sabine Heinhorst, Ph.D., Dean
Honors College

ABSTRACT

This study investigates whether individuals hold more stigma against minority group members with mental health issues based on race. Individuals are more susceptible to the negligence of treatment and further assistance due to increased stigmatization associated with mental health. Internalized stigma is more prominent within marginalized communities due to various co-existing factors such as socioeconomic status, inadequate resources, aversive health experiences, and low education levels infiltrated by systemic discrimination and structural inequality. In addition, minority group members are also more at risk for mental health disorders due to these factors.

Past research has shown that stigmatization against individuals with mental health issues is prevalent, leading to social polarization and worsening symptoms. Therefore, it is critical to understand how stigmatization manifests among different racial groups to promote equitable mental health treatment and reduce the burden of stigma on marginalized communities.

To gather data on stigmatization, the researchers presented college students with a series of vignettes describing individuals, some identified as African American and others as White, with various mental health conditions. Participants were asked to rate their level of comfort interacting with the individual to examine their perspectives regarding mental health, as the results will highlight majority group contribution to stigmatization. Studies have shown that majority group's attitudes towards mental health issues can also influence how services are provided, which can impact the quality and accessibility of care for minority group members. Investigating the role of the majority group members in perpetuating stigma against minority group members with mental health issues can

provide essential insights into the root causes of mental health stigma and how it can be addressed. This study will have significant implications for policymakers, mental health professionals, and advocacy groups working to reduce stigma against individuals with mental health issues, especially among minority group members.

Keywords: stigma, race, socioeconomic status, ethnicity, mental health

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In addition, I would also like to extend my thanks to the School of Psychology for allowing me the privilege of sharing my work and growing academically.

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LIST OF ABBREVIATIONS

ANOVA	Analysis of Variance
IRB	Institutional Review Board
SDS	Social Distance Scale
SES	Socioeconomic Status
USM	The University of Southern Mississippi

CHAPTER I: BREAKING THE CYCLE OF STIGMA

It is well known that in many areas in the United States, a fair share of disadvantaged communities receives far fewer resources than others. At a higher rate, these despaired communities experience food deserts, inadequate education systems, subsidized housing, and simply, unstable living environments. One of the most significant disparities in these communities is the privilege of sufficient health care and resources, specifically as it relates to mental healthcare. People in these communities do not receive adequate care due to the lack of resources and substandard treatment in their neighborhoods. Not only are they deprived of helpful tools, but they are also put at a greater disadvantage due to the lack of awareness and education on important mental health topics. Many marginalized groups continue to face discriminatory circumstances in healthcare and other professional settings. A meta-analysis by Schmitt et al. (2014) displayed evidence of discrimination in public health settings with regards to its effects on the health of minority groups. Data showed that the relationship was stronger for disadvantaged groups ($r = -.24$) than for more advantaged groups ($r = -.10$). Schmitt et al. (2014) concluded that racial discrimination is positively associated with poor health while utilizing correlating variables, racial prejudice and overall health of minority groups. Perceived stigma and discriminatory experiences in healthcare settings create uncertainty in marginalized individuals, which causes many to reject treatment options and partake in unhealthy, non-medical coping mechanisms. Consequently, stigmatized individuals are placed into a never-ending cycle as they ultimately become players and contributors to stigma.

This study aims to examine if people will hold more stigma against minority group members who have mental health issues than against majority group members. This study is important because stigma against minority group members may contribute to the lack of regard held within marginalized communities. In the study, we examined whether there is a stigma against African Americans with mental health issues and whether people may react differently to someone with mental health issues depending on their race. To gain perspectives regarding stigmatization, college students were presented with a series of vignettes describing individuals, identified as African American or White, with various mental health conditions,. Participants were asked to rate their level of comfort interacting with the individual, their likelihood of offering professional help, and their overall perception of the individual's mental health. Given the disproportionate prevalence of mental health issues among African Americans, these results will highlight the urgent need for increased support and communal resources. In the introduction, I will discuss the key concepts that are relevant to the current study and review the past findings on these key issues.

Stigma

Stigma refers to a negative and unfair label or stereotype attached to a group of people, often due to a characteristic or behavior perceived as different from usual societal standards. Throughout the years, researchers have employed stigma based on the sociological theory of labeling (Scheff, 1984). The labeling theory suggests that societal labels and classifications can influence an individual’s behavior without thorough review and limited contextual information. Scheff (1984) indicated that the labeling theory would be the main contributor to stigma against those who have mental health issues.

When discussing psychological stigma, labeling can be observed through the negative connotations people possess upon others with mental health difficulties. When individuals express their disdain, they utilize stigmatization by signifying that individuals challenged by mental health illnesses are ‘dangerous’ and ‘unruly.’ These negative implications contribute to the lack of understanding and neglect for mental health. Many individuals use such words as insults while simultaneously describing those suffering from a mental health disorder, which can significantly impact the confidence and growth potential of others. It is discovered that labeling, along with initial stigma, contribute to persistent illness. This signifies that labeling and stereotypical opinions can cause residual effects, such as self-fulfilling prophecies and engaging in behaviors that prevent further social rejection (Markowitz, 1998).

Stigmatization of mental health is a phenomenon that arises from incomprehension and lack of education on mental health, since it may not be as easily recognized as physical illness. It has been found that the stigma of mental illness is more profound in individuals diagnosed with depressive-anxiety symptoms than those with psychotic symptoms (Markowitz, 1998). Many people are influenced by external social conditions that perpetuate the myth that people with mental health disorders are dangerous or morally deficient, which can have significant negative effects on individuals who are mentally challenged, such as internalizing fear and stigma towards others. Labeled individuals and others who experience mental health symptoms often reap the effects of anticipated criticisms due to several aversive experiences of stigma from others (Markowitz, 1998). They are, ultimately, discouraged from obtaining treatment and isolate themselves socially due to the fear of unacceptance. Research shows that the

majority of individuals within minority groups decline treatment or physician assistance. Stigma is observably prevalent within those communities that do not receive proper education and resources regarding mental health issues and care (Lancet, 2016).

Stigma can be separated into three categories, 1) public, 2) self, and 3) institutional (Oudejans et al., 2021). The presenting stigmas can be further explained and applied through various examples of stereotypical and discriminatory circumstances that individuals with mental health disorders encounter daily in public and/or institutional settings. As stigma is envisioned it has three different constructs: "knowledge (ignorance), attitudes (prejudice), and behavior…" which can be observed in personal interactions (Evans-Lacko et al., 2010, p. 441). Due to the lack of mental health education, attitudes and opinions are extracted from assumptions regarding unknown and unresearched topics. Stigma, therefore, can ultimately lead to the allowance of discriminative actions in an individual's familial, social, work, and personal and professional environments. These actions can further contribute to the lack of assistance and absolute disregard for an individuals' psychological well-being, causing them to hold on to internalized, unhealthy stigma. Many individuals even describe stigma as being "worse than those of the condition itself" (Lancet, 2016, p. 1027).

Public Stigma

Public mental health stigma is the dismissal of mental health and the negative attitudes of those who hold stereotypical and discriminatory views towards people with mental disorders. People with stigmatized opinions of mental health see those with mental illness as dangerous, incompetent, unpredictable, and so on. These negative beliefs correlate to the biased behaviors and prejudicial actions of the public policy,

which can be possessed by those working in professional environments, such as schools, healthcare, and housing. These ideals are also portrayed in some laws and additional policies that decrease the opportunities available for these individuals, specifically identified as institutional stigma.

Stigma is profoundly directed towards persons labeled as different and undesirable by the majority. As a result, individuals labeled as such do not receive the same status and opportunities as those considered normal. These discriminatory experiences based on negative labeling can lead to social, political, ethical, and economic disadvantages (Oudejans et al., 2021). People of higher social and economic status have greater autonomy than those who are negatively labeled, and those with mental health disorders can be further stigmatized.

The main components and determinants of stigma, include, "poverty, housing status, education, access to resources, institutionalization, social determinants of equity, stress, and physical health status." Without the application of these devices within ethnic/minority communities, various individuals neglect mental health treatment, such as medication and counseling (Primm et al., 2009, p. 3).

Self-Stigma

The effects of public and institutionalized stigma directed towards individuals challenged by mental health disorders may lead to the internalizing self-hate and the negligence towards care, which can lead to effects on self-perception. Additionally, stigma can cause low self-esteem and an increased likelihood of discontinuing of treatment (Corrigan et al, 2014). As discovered, dealing with stigma while handling challenging mental illness symptoms can lead to emotional stress reactions and aversive

cognitive coping responses. More specifically, the stress of stigma on individuals with mental health disorders can increase the intensity of the illness, leading to long-term negative effects. However, these implications can be seen differently considering how individuals deal with stress due to stigma.

As the individual discontinues treatment and ignores proper diagnosis, they will subsequently participate in self-coping mechanisms that do not positively affect their mental well-being. For instance, individuals who engage in aversive coping skills, such as secrecy, withdrawal, and substance abuse, are highly susceptible to self-stigmatization (Lancet, 2016). Thornicroft and Mehta (2016) conducted a longitudinal study using the perspectives of 200 individuals with a mental health disorder. They found that self-stigma increased after a lack of treatment and recovery after internalized applications of stigma derived from public and institutionalized barriers.

When individuals internalize stigma, they may also begin to project these negative attitudes onto others who identify under similar circumstances. Individuals can use discriminatory tactics towards their group as a way to dissociate themselves away from that identity. A study of African American participants concluded that those who reported experiencing discrimination were more likely to endorse negative attitudes towards mental illness (Keyes et al., 2014). They explained that internalization of shame and embarrassment can manifest as reluctance to seek help, ultimately contributing to the projection onto others. Some individuals may also feel increased pressure to conform to cultural norms and expectations around mental health within their communities due to additional barriers regarding access to mental health resources, which can create a culture

of silence, inattention, and shame around mental health issues within minority communities.

Institutional Stigma

Institutional stigma, in the context of mental health, refers to the systematic injustice and discrimination experienced by individuals with mental health conditions in various institutions such as healthcare systems, social services, and legal systems. The stigma is perpetuated by institutional policies and practices that prevent individuals with these conditions from accessing services or receiving adequate treatment. A quantitative research study conducted an examination of various stressors and coping resources from the homeless population (Lippert et al, 2015). The article displays the sociological theory of cumulative disadvantage, which indicates the accumulation of early-life disadvantages and inequalities, such as poverty and additional trauma, can possibly lead to long-term consequences. These long-term conditions can involve a lack of access to resources, limited opportunities and negative health outcomes. It was found that 30-40% of homeless people are challenged with psychiatric disorders. The most common disorders were depression, schizophrenia, and suicidal ideation, which can co-exist with other substance abuse disorders. Homelessness can worsen psychiatric symptoms due to dangerous environments and economic instability. As individuals face multiple and intersecting forms of disadvantage over time, it can ultimately compound and lead to further aversive effects, creating a cycle of cumulative disadvantage which can be difficult to overcome (Lippert et al, 2015).

Stigma of Public Health

Rössler (2016) interviewed both mental health professionals and members of the public to assess their attitudes towards individuals with psychiatric symptoms, such as depression or schizophrenia. The study found that those who are more familiar with psychiatric illnesses tend to have a greater stigma towards such individuals. Additionally, it was concluded that psychiatrists ranked the highest in terms of the degree of stigma due to multiple influences such as personal experiences, societal attitudes, and cultural beliefs.

Suresh and Bhui (2006) found that Black patients were four times more likely to be forced to inpatient facilities on the account of criminal activity, whereas other majority groups are offered the option to volunteer themselves. In addition, Asian counterparts are more susceptible to not being referred to additional specialists (Suresh & Bhui, 2006). It has also been identified that most South Asians under-utilize mental health resources, and Black patients are more permitted to being over-represented in involuntary forensic psychiatric facilities, and they do not receive further specialty medical assistance such as diagnosis, treatment plans, and referrals. Suresh and Bhui (2006) mentioned that "[Blacks] are particularly under-represented in outpatient mental health settings." Therefore, they are more liable to engage in fewer therapeutic sessions and withdrawing prematurely (Alvidrez et al., 2008).

Minority racial groups often face challenges in accessing adequate healthcare and mental health services due to systemic inequalities in the healthcare system. This exacerbates the various circumstances and experiences that contribute to the dissociation and negligence of mental health disorders in marginalized communities. As a result,

disadvantaged individuals are highly susceptible to self-stigma and the internalization of aversion. Therefore, they may view themselves and others as unworthy of care or shameful, rejecting treatment and refusing to see a physician concerning their illness.

Cultural and racial differences

Lancet (2016) suggests that mental health stigma is prevalent in multiple environments, but it is most susceptible in ethnic communities due to indifferent cultural, environmental, and institutional factors. The various interactions in patient-physician relationships have been heavily influenced by the cultural backgrounds of both parties. This leads to barriers of communication in health and presumptions of diagnosis and treatment options, ultimately contributing to negative perception. Previous research expresses the connection between culture and a sense of self-worth for individuals in these communities, which emphasizes the importance of subjective influence and the considerable impact of public stigma upon oneself (Suresh & Bhui, 2006).

Lancet (2016) discussed that Asian and other non-western cultures tend to overlook mental health illnesses to uphold strong and emotionally restrained characteristics. This can be also a barrier in seeking out help and shows how difficulties with stigma in ethnic communities ultimately contribute to a disproportionate number of mental health problems and aversive coping mechanisms used. It is suggested within the review that a person's culture can influence coping mechanisms and impact whether an individual seeks help for mental health issues. For example, some cultures may value prayer or alcohol consumption as a means of coping, signifying the coping skills that are influenced within ethnic communities as substitution for medical assistance such as therapy, medication, and positive practices.

Monoculturalism, a lack of ethnocentric studies included in the healthcare system, leads to a lack of cultural and personable understanding between patient and provider (Alvidrez et al., 2008). The absence of inclusion for alternative medicine and cultural beliefs seen in mostly western societies, further stigmatize public health and the mental health system among ethnic minority groups. While interviewing individuals who belonged to a specific racial group and had also been diagnosed with a mental illness, Alvidrez et al. (2008) required participants to recall their experiences with stigmatized views towards their condition. The researcher found that some individuals counteracted these communal stigmas by placing importance on their well-being rather than the opinions of others. In comparison, other subjects reverted to internalization and were deterred away from treatment. Alvidrez et al. (2008) found that the exposure to stigmatizing beliefs held by family and community members are significant in Black groups and 29% of mental health consumers found it hard to discuss these matters within their family. It was concluded that 35% of the participants were taught that mental illness was shameful. Alvidrez et al. (2008) concluded that the many beliefs endorsed by minority groups signifies that mental illness is a personal weakness and are the results of an improper and immoral lifestyle.

It is seen that Black communities in the U.S. heavily stigmatize mental health and assistance due to reoccurrences of adverse external and internal circumstances, causing themselves and others to deter from treatment. Research indicates that Black and other minority populations hold more negative connotations towards individuals with mental illnesses compared to White groups. It is further discussed that Whites are more

susceptible to quality treatment and make more declarations of mental illness than African Americans (Alvidrez, Snowden, & Kaiser, 2008).

Socioeconomic status

There is a significant connection between socioeconomic status and mental health stigma. Various surveys have found that having a lower socioeconomic status implies opposing views towards mental illness (e.g., McManus et al., 2016). Another study suggests that individual responses to treatment vary by socioeconomic status and income. For example, Cohen et al. (2008) found that more citizens within middle- and higher-income groups were more susceptible to take part in treatment and respond actively than lower income counterparts due to stigma. The meta-analytic review indicated that lower status groups received poorer treatment. This is due to a combination of low income, employment status, and education level which ultimately withholds access to adequate health services and familiarity.

Recent research conducted by Foster (2021) indicated that those with higher levels of income were found to stigmatize those with mental health illnesses due to prominent social advantages. Individuals with high income status have taken away certain opportunities from those positioned in lower status. The just world belief (Lerner & Lerner, 1980) suggests that those with a higher socioeconomic status are also more positioned to place the blame on irresponsible circumstances in finance, career, and education of those with low incomes. These individuals become the main contributors to public stigmatization, views and negative indifferent group ideas, which "perpetuate the existing hierarchical structure of society." (Foster, 2021, p. 288). Individuals who have

socioeconomic stability exhibit negative attitudes and prejudices towards the mental health care of others because they possess economic superiority and social dominance.

Because of deficit resources and opportunities in low-income communities, a scarcity of education on psychological concepts are also observed in these communities. Studies suggest that higher education levels are associated with increased levels of mental health education and decreased scale of self-stigma (Foster, 2021). Therefore, differing degrees of occupation and education intertwine and contribute to stigmatization of others. This further supports the discriminative and unfortunate factors experienced by lower-class citizens and the systematic impact on stigma within different communities.

It has been found that minorities in the United States tend to have lower socioeconomic status levels than non-minorities. A report from the Pew Research Center in 2016 displays the relationship between social and economic well-being and minority race and ethnic group status. Analysis of data shows that African Americans are twice as likely to be unemployed and in a lower SES group than Whites. Living in poverty-stricken districts, which are associated with lower SES can also indicate education level and accessibility. Due to the expensive qualities of therapy, people within lower economic and social statuses hold negative views towards mental health and treatment due to the lack of accessibility, exposure, and familiarity. Secondly, the lack of exposure is highly connected to the absence of awareness and familiarity of mental illnesses in subjected communities.

CHAPTER II: PRESENT STUDY

In the study by Oudejans et al, 2021 they presented 16 vignettes to participants to measure their perspectives on individuals with mental health disorders. The vignettes in the study described a fictional male with a mental illness, and each scenario contained one of the four manipulated variables; diagnosis, age, noise disturbance, and employment. The social distance scale was utilized to measure perceived stigma by examining the degree of social distance the participants place between themselves and the target character. For example, they might be unwilling to live in the same neighborhood or be a co-worker.

The current study uses a similar strategy to examine the stigma toward racial minorities; however, I manipulated race and socioeconomic status to see if these variables influence the distance toward those with mental disorders. By modifying these variables, we aimed to comprehend how societal perceptions of race and SES shape attitudes toward individuals who have mental illnesses. The study explores whether certain groups are more susceptible to stigmatization for their mental health status due to external circumstances concerning the manipulated variables. This approach allows the identification of new insights into how social, economic, and cultural factors intersect the influence of opinions. The results of this study have the potential to inform the public and additional policies to reduce stigma while promoting more inclusive attitudes towards mental health across different racial and economic groups.

In the current study, participants are presented with a vignette describing the characters of different races, socioeconomic statuses, and treatment plans regarding mental health status. After the scenarios were presented to the subjects, a series of

surveys inquired about their level of possible interaction with the character, mental health knowledge, and personal background information. The participants were drawn from a sample of college students at the University of Southern Mississippi. Past research showed mental health stigma towards minority groups due to racial and socioeconomic hierarchy. Therefore, it was hypothesized in this study that marginalized groups such as targets who were described as a Black and having a low socioeconomic status (SES), and receiving an unfair treatment would be given more social distance than their counterparts. The study also included the ethnic background of the participants. Past research discussed that marginalized groups may produce self-stigma because of a lack of education regarding mental health issues. Thus, participants with minority ethnic backgrounds would give more social distance toward individuals with mental health issues than participants with majority ethnic backgrounds. The combination of race, SES, and the quality of treatment would be additive; therefore, it was predicted that the target who is Black with low SES and received an unfair treatment would be more stigmatized (more social distance) than any other targets. Statistical analysis and data observation are predicted to show connections between racial and economic minority groups and their perceived views on mental health.

CHAPTER III: METHODS

Participants

The participants were recruited from the University of Southern Mississippi via SONA system and student chat rooms. In the SONA system the participants were given an incentive of a class credit towards a class in a psychology course. The total number of participants were 200 students (108 female, 21 male, 7 others, and 2 preferred not to answer) with a mean age of 21.36 and a standard deviation of 5.28. To ensure ethical requirements, prior to the study, the students were asked to sign and read a consent form as this study is approved by the university's Institutional Review Board (see Appendix C). To be eligible to participate in the study, individuals were 18 years or older, currently enrolled at the university, and had completed the consent form.

Procedure

A between factorial design was utilized with the manipulations of race (White, Black), socioeconomic status (High, Low), and the quality of treatment (Fair, Unfair treatment). Participants were presented with scenarios describing fictional characters with mental illnesses. Each participant was randomly assigned to one of the scenarios based on the combination of the manipulated variables. Participants were asked to fill out the Social Distance scale to measure their sense of distance from the target person in the scenario. Participants would create more distance from the person if they did not desire to interact with the target person. The scenarios described the situation of a college graduate returning home and experiencing heightened feelings and symptoms of depression and anxiety (see Appendix A). The manipulations in the vignettes consisted of race and socioeconomic status to measure the proposed distance seen between minority groups

and majority groups with mental illness. Manipulation of the character's treatment plan was also displayed to gain further opinions regarding mental health treatments.

Measures

The SDS (Social Distance Scale)

The Likert point scale utilizes a range of response options from 1-5, which includes five distance levels, 1 indicating 'strongly disagree' and 5 indicating 'strongly agree,' and a middle category of 'neither agree nor disagree.' Each level represents a different degree of social distance. Subsequent to reading a randomized vignette, respondents rated their willingness for the character to engage in varying levels of social interaction (e.g., willing to live in the same neighborhood, have as a coworker). The scale scores are reverse-coded (e.g. 1 is converted to 5, 2 is converted to 4) and averaged. Therefore, higher scores indicate greater social distance. The scale allows researchers to observe the distance the participant will position between themselves and the individual displayed in their assigned scenario.

Demographic Questionnaire

The survey inquired about additional background information such as mental health history, gender, age, race, ethnicity, location, and present household income. These questions allowed researchers to draw conclusions on the subjects and the answers they provided in the previous questions, while also placing them in ethnic minority and majority classifications.

CHAPTER IV: RESULTS

To test the hypothesis that participants would show more social distance as a sign of stigma toward marginalized groups with mental illness, a mixed model of within and between subject analysis of variance (ANOVA) was conducted using a four-way factorial design. A 2 (Race: Black, White) x 2 (SES: high, low) x 2 (Treatment quality: fair, unfair) x 2 (Ethnicity of participants: majority, minority) design was utilized, and the ethnicity of participants was a between-subject factor, while the rest of the factors were within-subject factors. The Social Distance Scale (SDS) mean score was the dependent measure. In this study, the dependent variable was computed to assess the amount of social distance the subject would position between themselves and someone with a diagnosed mental illness using SDS. Higher SDS scores indicate more negative reactions and increased social distance towards the target in the vignettes.

A significant main effect of the participants' ethnicity was found in the scale measuring the amount of social distance implied by the subjects, $F(1, 122) = 4.29$, $p = .040$ (see Figure 1). It was observed that participants who identified as an ethnic minority group member ($M = 2.43$, $SD = 0.63$) were susceptible to create more social distance between themselves and the character displayed in the scenario than participants who identified as an ethnic majority group member ($M = 2.08$, $SD = 0.79$. There was no other main effect seen with the other variables, including; race, SES, and quality of treatment.

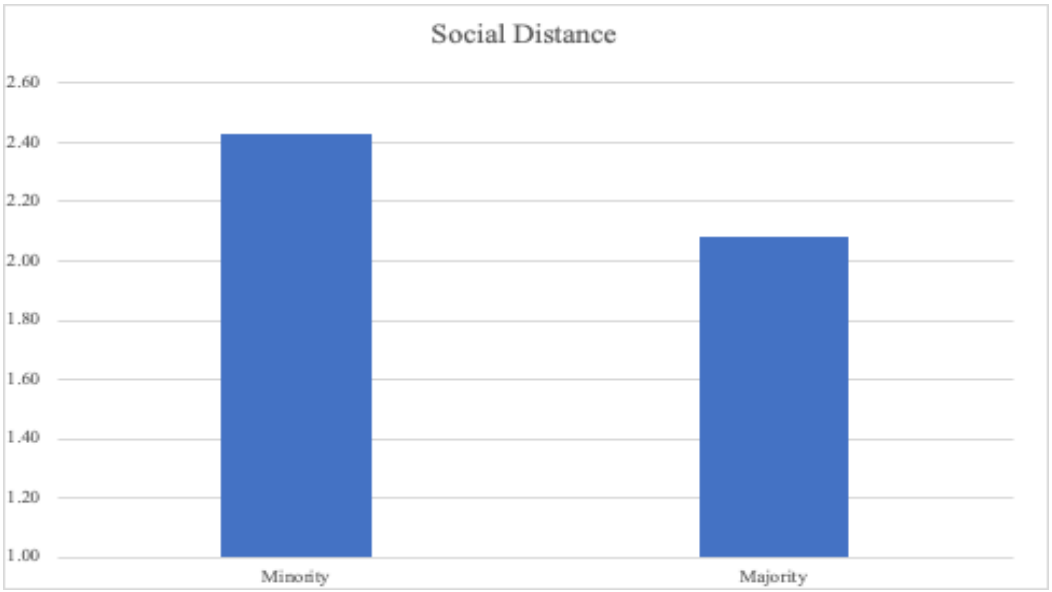

Figure 1: Significant Effect for Social Distancing in Ethnic Groups

Additionally, most of the interactions between the independent variables were not significant. However, the three-way interaction between Race, SES, and Ethnicity was significant on the social distance score, $F(1, 122) = 5.35$, $p = .022$ (See Figure 2). The results suggest that the effect of social distance on race is influenced by the levels of SES, and the participants' ethnicity. Posthoc analyses showed that significant mean differences were found only between low and high SES in the White condition by the minority group, $p = .047$ and between the minority and the majority group in the White/high SES condition, $p = .017$. Thus, none of the mean differences between the race conditions were significant. However, Figure 2 shows different directions of mean differences between the race conditions and shows that majority group members applied the least space toward Black characters when they were in low SES; however, when the character displayed higher SES the distance to the Black target by the ethnic minority was increased. It is possible that members were more sympathetic towards the low SES and Black character or they did not want to be deemed as racially biased. This point is

explored further in the discussion. The figure also displays that minority members rated more social distance when the target was Black and low SES. Moreover, minority group members also held more social distance towards high SES targets, regardless of race, which implies that they were less sympathetic.

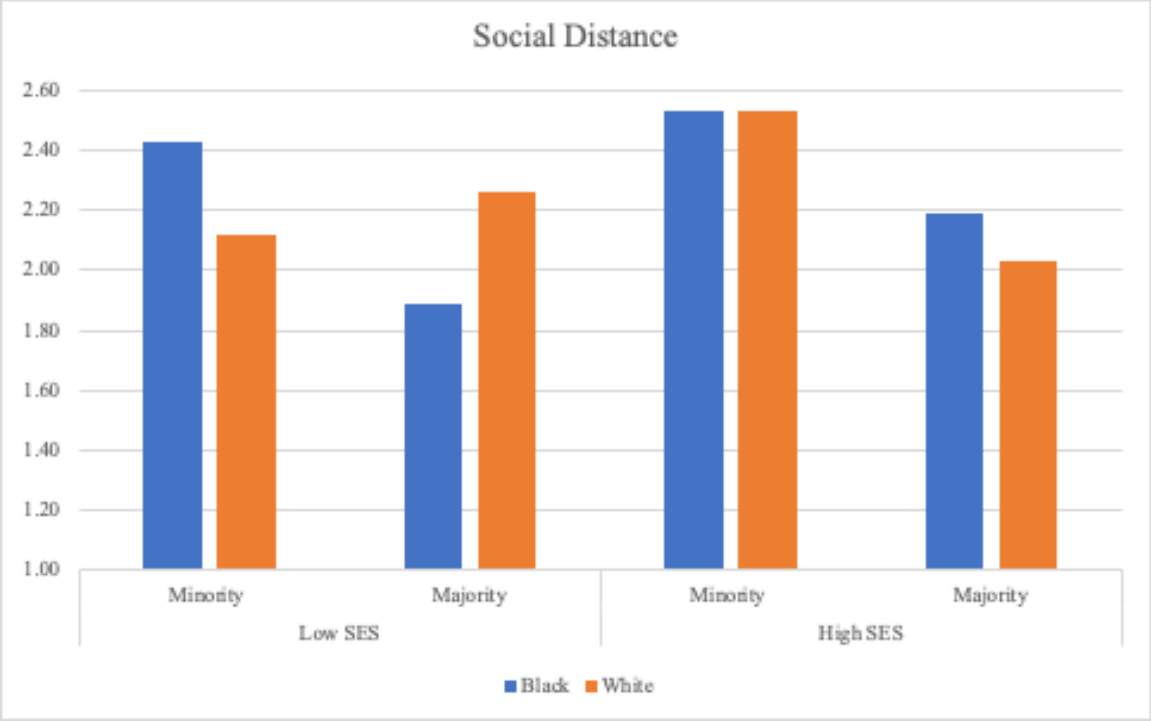

Figure 2: Significant Effect for Social Distancing between interactions of race, SES, quality of treatment, and ethnicity

The results of the study did not support the hypothesis that marginalized groups (minorities) with mental illness receive higher stigmatization. However, the data supports the idea that the effects of stigmatization are present within minority groups. Participants who identified as minority group members were more susceptible to create more social distance between themselves and the character displayed in the scenario when the target was Black.

CHAPTER V: DISCUSSION

The present study aimed to examine the relationship between race, SES, and mental health stigma, along with the exhibition that marginalized groups experience higher stigmatization and public stigma than majority groups, which can also result in increased self-stigma. The study used vignettes describing the main characters with different racial backgrounds, different SES levels, and receiving different quality of treatment. The study utilized a factorial design, with manipulations of race, socioeconomic status, and quality of treatment and the Social Distance Scale that measures the distance participants position themselves against the character displayed in their assigned scenario as the dependent measure. The results supported the notion that stigmatization of mental illness is present within minority groups. However, the results did not support the hypothesis that marginalized groups experience higher levels of public stigma overall due to non-significant effects of race. The main result of ethnicity implies that the members of minority groups tend to exhibit more negative reactions and increased space towards characters with mental illness than the majority group members. Since stigma is more significant in certain minority groups, members may often internalize the stigma surrounding mental health issues, leading to shame and self-blame for their struggles. The negligence seen can be incorporated as the fear of being judged or discriminated against.

The three-way interaction between race, SES, and ethnicity was also significant, further indicating that a combination of SES level and ethnicity influences the effect of race. The significant interaction suggests that the impact of race on the stigma people place toward those with mental health issues is not general but somewhat influenced by

other factors, such as the ethnicity of those who perceive the target and the SES level of the target. As mentioned, in the introduction, previous research has exhibited that individuals who identify within minority groups are more likely to experience socioeconomic disadvantages such as poverty, lower education levels, and inadequate resources. In addition, the lack of education and resources seen within low-income and mostly ethnic communities is a primary contributor to stigma. Without proper education, individuals may not understand the nature of mental health problems, leading to misunderstandings and negative attitudes toward those who suffer from them. As displayed in the results, it is seen that minority groups were more susceptible to creating distance within the interaction rather than what was hypothesized.

Due to social hierarchy and privilege, majority group members have more access to resources, adequate education, and the ability to afford said opportunities. This increased exposure can lead to greater understanding and empathy for others diagnosed with mental health conditions, decreasing the probability of self-stigma. This is relevant as individuals identifying as a part of the majority group viewed the Black and low SES character with more empathy as the social distance was reduced. However, majority group members positioned more space within the interaction with the Black and high SES character provided in the vignette. These results may be due to the phenomenon "Black-SES paradox," which suggests that individuals withhold more negative attitudes towards minority groups perceived as more economically privileged than what stereotypes and biases impose (Keyes, 2009). Therefore, these individuals presume that high-SES Black individuals have more opportunities than others and are at a lower risk of mental health issues.

Additionally, individuals within marginalized groups associated with ethnicity and low SES can often experience discrimination and criticism due to their condition. Combining these demographics can exacerbate poorer mental health outcomes, which is not experienced as frequently by majority group individuals. Furthermore, the lack of resources and access to services can also perpetuate the stigma and promote the belief that these issues are not severe or require professional attention.

Limitations

One potential limitation of this study is the need for more reflection and simulation of real-world situations as vignettes were provided to the subjects. It is assumed that participants may have responded differently if they were in a real-life circumstance. As stated previously, another study limitation is the possibility of social desirability bias. Participants of each group may have answered questions to avoid racial bias and responses to appeal to society rather than their actual attitudes towards mental illness. This can be seen in the results regarding the responses of majority group members, as individuals favored the low SES and Black character. To improve future research, it may be beneficial to use more diverse measures of stigma and mental illness, such as using real-life scenarios. Future researchers can utilize more anonymous surveys by removing identifying information and enhance privacy to minimalize social desirability seen in participants. Future research could explore additional factors that may influence mental health stigma, as the current study's variables are quite limited. Additional factors that can be expanded upon can be involved or substituted in future studies, such as age, gender, and religion.

Conclusion

In conclusion, the findings of this study highlight the importance of understanding the complex nature of stigmatization towards mental illness and further research to address this phenomenon. By better understanding the factors that influence stigma, we can develop more effective interventions and policies to combat mental health stigma and improve the lives of those affected. These unfortunate components can be detrimental when considering various communities' mental well-being and education. It has been found that using methods such as social marketing to spread public health information may aid in reducing the negative perceptions and discrimination towards mental illness within certain racial and ethnic minority groups. Implementing education resources within communities can encourage engagement with mental health resources and the pursuit of treatment (Primm et al., 2009). The results of previous studies show that greater familiarity and education are associated with decreased levels of stigma. Lower education rates are more susceptible in lower-income neighborhoods due to the lack of adequate resources and tools, therefore increasing opposing attitudes and the tendency to maintain social distance towards individuals with mental illnesses. With greater access to education and services, lower-income communities can ultimately promote the engagement of health resources.

APPENDIX A: A SERIES OF PRESENTED VIGNETTES

Black, low SES, unfair treatment

Caleb is a 25-year-old Black male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, his parents' home is placed within a predominantly minority and more ethnic environment than his college town. And he feels he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He has expressed these feelings to his parents, but they disregarded him and told him they could not give him a solution to things they did not understand. His siblings, however, advised that he seek therapy from available resources within their community. Shortly after, Caleb scheduled a therapeutic appointment where he felt he was pushed into seeking expensive medications, didn't connect well with the presented therapist, and was charged an unaffordable co-pay. Having little to no other options, Caleb decided to reconnect with some of his old friends in the neighborhood to express his discernment and unhappiness in life. His friends told him he was crazy for experiencing these feelings because "… Black people don't have depression. Only White people experience that." Conclusively, they disregarded and invalidated his perspectives of hopelessness and worry. And Caleb began to invert these assumptions upon himself; he began to suppress his emotions and take up aversive coping mechanisms, such as drugs and alcohol.

Black, low SES, fair treatment

Marshall is a 25-year-old Black male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, his parents' home is placed within a predominantly minority community and a more ethnic environment than his college town. And he feels he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He has expressed these feelings to his parents, but they disregarded him and told him they could not give him a solution to things they did not understand. His siblings, however, advised that he seek therapy from available resources within their community, and Caleb was subsequently introduced to a cost-efficient therapeutic team, where his insurance was applicable. Caleb met with his therapist and worked on a few coping mechanisms, including breathing techniques and practicing self-monitoring and stress reduction techniques. Soon enough, Caleb began to notice a change in his mindset as he and his therapist began to connect. Ultimately, Caleb found the encouragement and confidence to apply for several local jobs. He also became a part of the local advocacy program to inform many people about mental health education and the various cost-efficient opportunities for treatment within his community.

Black, high SES, fair treatment

Miguel is a 25-year-old Black man living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, Miguel's parents' home is located within a safe community in the suburbs where most physicians, lawyers, and other professionals reside. And he feels as if he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He expressed these feelings to his parents, and they suggested that he seek help from a therapist and comply with any treatment indicated, as they wanted to help their son. His mother advised him to see the same therapist his father was visiting weekly. At his parents' expense, Miguel began seeing a therapist and working on a few coping mechanisms they discussed during sessions, such as breathing techniques and practicing self-monitoring and stress reduction techniques. Miguel's family was so proud of their son's progress through therapy that they decided to finance an apartment for him and allow him the independence she sought. Ultimately, Miguel found the encouragement and confidence to apply for several jobs in his hometown and even some positions out of state.

Black, high SES, unfair treatment

Gabriel is a 25-year-old Black male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, Gabriel's parents' home is located within a safe community in the suburbs where most physicians, lawyers, and other professionals reside. And he feels he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He has expressed these feelings to his parents, but they disregarded him and told him they could not give him a solution to things they did not understand. However, Gabriel reached out to his past high school counselor and confided in her. Shortly after, Gabriel's counselor scheduled a therapeutic appointment with a local therapist. Within his sessions, he felt he was pushed into seeking expensive medications and didn't connect well with the presented therapist. As he was discouraged, Gabriel decided to abandon the idea of therapy and reconnect with some of his old friends to express his discernment and unhappiness in life. His friends told him he was crazy for experiencing these feelings because he had everything he could want and need in life, and "… Black people don't have depression. Only White people experience that." Conclusively, they disregarded and invalidated his perspectives of hopelessness and worry. And Gabriel began to invert these assumptions upon himself; he began to suppress his emotions and take up aversive coping mechanisms, such as drugs and alcohol.

White, high SES, fair treatment

Michael is a 25-year-old White male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, Michael's parents' home is located within a safe community in the suburbs where most physicians, lawyers, and other professionals reside. And he feels as if he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He expressed these feelings to his parents, and they suggested that he seek help from a therapist and comply with any treatment indicated, as they wanted to help their son. His mother advised him to see the same therapist his father was visiting weekly. At his parents' expense, Michael began seeing a therapist and working on a few coping mechanisms they discussed during sessions, such as breathing techniques and practicing self-monitoring and stress reduction techniques. Michael's family was so proud of their son's progress through therapy that they decided to finance an apartment for him and allow him the independence he sought. Ultimately, Michael found the encouragement and confidence to apply for several jobs in his hometown and even some positions out of state.

White, high SES, unfair treatment

Jayden is a 25-year-old White male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, Jayden's parents' home is located within a safe community in the suburbs where most physicians, lawyers, and other professionals reside. And he feels as if he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He expressed these feelings to his parents, and they suggested that he seek help from a therapist and comply with any treatment indicated, as they wanted to help their son. His mother advised him to see the same therapist his father was visiting weekly. At his parents' expense, Jayden scheduled a therapeutic appointment. Within his sessions, he felt he was pushed into seeking expensive medications and didn't connect well with the presented therapist. As he was discouraged, Jayden abandoned therapy and reconnected with some of his old friends to express his discernment and unhappiness in life. His friends told him he was crazy for experiencing these feelings because he had everything he could want and need in life, and "… depression is for 'crazy' people. You are not 'crazy.'" Conclusively, they disregarded and invalidated his perspectives of hopelessness and worry. And Gabriel began to invert these assumptions upon himself; he began to suppress his emotions and take up aversive coping mechanisms, such as drugs and alcohol.

White, low SES, unfair treatment

Carlton is a 25-year-old White male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, his parents' home is placed within a predominantly poor and more ethnic environment than his college town. And he feels he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He has expressed these feelings to his parents, but they disregarded him and told him they could not give him a solution to things they did not understand. His siblings, however, advised that he seek therapy from available resources within their community. Shortly after, Carlton scheduled a therapeutic appointment where he felt he was pushed into seeking expensive medications, didn't connect well with the presented therapist, and was charged an unaffordable co-pay. Having little to no other options, Carlton decided to reconnect with some of his old friends in the neighborhood to express his discernment and unhappiness in life. His friends told him he was crazy for experiencing these feelings because "… depression is for ‘crazy’ people. You are not ‘crazy’." Conclusively, they disregarded and invalidated his perspectives of hopelessness and worry. And Carlton began to invert these assumptions upon himself; he began to suppress his emotions and take up aversive coping mechanisms, such as drugs and alcohol.

White, low SES, fair treatment

Ben is a 25-year-old White male living with his parents and younger siblings in his hometown. Last year, he graduated with his bachelor's degree in business and communications. He is having trouble finding a job within his major and had to move back in with his immediate family after living with his best friends in his college town. In addition, his parents' home is placed within a predominantly poor and more ethnic environment than his college town. And he feels he is putting a burden on his parents and expected to have a job by now, increasing his feelings of anxiety, discouragement, depression, inability to focus, and some suicidal ideations. He has expressed these feelings to his parents, but they disregarded him and told him they could not give him a solution to things they did not understand. However, his siblings advised that he seek therapy from available resources within their community, and Ben was subsequently introduced to a cost-efficient therapeutic team that accepted his insurance. Ben met with his therapist and worked on a few coping mechanisms, including breathing techniques and practicing self-monitoring and stress reduction techniques. Soon enough, Ben began to notice a change in his mindset as he and his therapist began to connect. Ultimately, Ben found the encouragement and confidence to apply for several local jobs. He also became a part of the local advocacy program to inform many people about mental health education and the various cost-efficient opportunities for treatment within his community.

APPENDIX B: SOCIAL DISTANCE SCALE

On a scale from 1-5 starting from ‘strongly disagree’ to ‘strongly agree.’

1. Would you be willing to have someone with a mental illness as your neighbor?

2. Would you be willing to spend a whole evening socializing with someone with a mental illness?

3. Would you be willing to have someone with a mental illness as your personal friend?

4. Would you be willing to have someone with a mental illness as your coworker?

5. Would you be willing to marry into a family with someone with a mental illness?

APPENDIX C: IRB APPROVAL LETTER

Office *of*
Research Integrity

THE UNIVERSITY OF SOUTHERN MISSISSIPPI

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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident submission on InfoEd IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER:	23-0037
PROJECT TITLE:	The perception of mental health and treatment quality survey
SCHOOL/PROGRAM	Psychology
RESEARCHERS:	PI: Camryn Harris Investigators: Harris, Camryn~Noguchi, Kenji~
IRB COMMITTEE ACTION:	Approved
CATEGORY:	Expedited Category
PERIOD OF APPROVAL:	22-Feb-2023 to 21-Feb-2024

Donald Sacco Jr.

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

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