An Investigation of Perspectives on Mental Illness Across Race and Ethnicity

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An Investigation of Perspectives on Mental Illness Across Race and Ethnicity

A Thesis
Presented to the Department of Anthropology
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of the Requirements for Graduation Honors

Emily M. Stark
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PART I: Background, Literature, & Methods

The study of mental health has been a passion of mine for many years now, but it was not until I volunteered at the Eskenazi BASE clinic and met patients with Borderline Personality Disorder that I began to realize the pervasiveness of stigma against mental illness. Patients at BASE talked about how they struggled with reaching out for help, getting and keeping jobs, and how their social relationships suffered, all in part due to the negative stigma surrounding their mental illness. Time on social media, particularly reading threads about mental health on Twitter, and conversations with friends brought stigma to my attention in a different way. I found that, depending on their cultural background, individuals had differing kinds of trouble reaching out for help for their mental illness. This realization led me to the idea of conducting a cross-cultural study of mental illness stigma among different racial and ethnic groups in the United States.

As a combined Anthropology and Psychology major, I have a unique perspective when it comes to research. I appreciate the scientific methods of psychological research, but I also think that the anthropological approach is incredibly valuable, especially when studying complex topics like mental illness and race and ethnicity. Uniting the two approaches in this research thesis has proven to be incredibly difficult. I did not want to do a traditional ethnography for a couple of reasons. First, I did not have adequate time with each informant, nor was I able to interview everyone in person. This meant I was not able to engage in extended participant observation with my informants, which is an important part of ethnographic work. Additionally, I felt that for a study based in part on a critique of psychological research, I should have psychological research elements. However, I wanted this study to feel more human than traditional psychological research, which is very data-heavy and focuses more on the big picture rather than the individual. Therefore, I will present descriptive case studies of informants and
quotes from survey respondents, and I have intertwined my own observations and interpretations with the data. For this project, I wanted to utilize my knowledge of both fields to create the most holistic approach I could.

Through a comprehensive examination and analysis of the previous literature on mental illness stigma and race and ethnicity, I demonstrate that a mixed methods approach is the most reasonable and effective approach for this type of research. I argue that research in this arena should incorporate an intersectional approach, as axes of identity and difference affect the beliefs and values of individuals. While I created this study to look at perspectives on mental illness across race and ethnicity, I conclude that it is not race or ethnicity at the root of beliefs about mental illness. Rather, it is cultural norms and values that are influenced by intersectional identity and that shape attitudes about mental illness. The data from my research suggests that there are differences and similarities in beliefs both within and across groups, which supports the premise that beliefs about mental illness are not the result of race or ethnicity. I close with a discussion of the findings and suggestions for future research.

**Stigma**

The concept of stigma is what sparked the idea for this research project; my ultimate goal is to foster a better understanding of how mental illness is conceptualized across a variety of axes, and thereby enable the creation of more effective methods of stigma mitigation. Thus, an understanding of stigma and how it functions was essential. The term stigma originates from the Greek word “stigma,” denoting marks that were put on people to indicate moral inferiority (Goffman, 1963, p. 1). Today the most widely used definition of stigma is that coined by sociologist Erving Goffman in his 1963 book, *Stigma: Notes on the Management of Spoiled Identity*. According to Goffman, stigma is “The phenomenon whereby an individual with an
Stigma is a process by which the reaction of others spoils normal identity” (p. 3). Goffman’s groundbreaking work set the stage for subsequent research on stigma. And, as more has been learned about stigma, Goffman’s classic definition has been edited and amended.

Psychologists Bruce Link and Jo Phelan (2013) add two more critical dimensions to the definition of stigma: power and discrimination. In this perspective, in order for stigmatization to occur, power of one group must be exercised over another (2013). This distinguishes stigma from stereotypes and prejudice: stereotypes and prejudice are a part of stigma, but stigma is a larger concept (Hinshaw, 2007). Stereotypes are generalizing but not necessarily negative beliefs held about an entire group of people; prejudice is an unjustifiable, negative attitude held toward a group of people; and, discrimination is the unfair treatment of a group (2007). Stigma can be conceptualized very broadly as an interaction of all these factors. Link and Phelan (2001) identify the interaction of four factors in acts of stigmatization: differences being labeled; labeled people being negatively stereotyped; labeled people being separated into categories of ‘us’ versus ‘them’; and, finally, the labeled people experiencing discrimination due to the labeling. However, Hinshaw (2007) points out that stigma is more than just that:

From its very definition, [stigma] connotes an internal “mark” of deep degradation to the individual who carries it and a license to the social majority to perpetuate and escalate their judgmental attitudes and responses. It therefore goes beyond the presence of negative attitudes or prejudice per se. Stigmatization may also be extended to those who are merely associated with stigmatized subgroups, such as family members, workmates, or other associates, a process Goffman branded as “courtesy stigma.” Stigma casts a long shadow (24).
The “courtesy stigma” mentioned here is just one type of stigma. There are two main categories of stigma: public stigma and self-stigma. Public stigma is the negative belief system that the public has about individuals with a discrediting mark, like mental illness. Self-stigma occurs when individuals with a discrediting mark internalize negative beliefs about themselves. Not every stigmatized individual experiences public stigma or self-stigma the same way. For instance, in their study of mental illness stigma among youths in outpatient psychiatric facilities, Elkington et al write, “experiences of stigma among youth in treatment are not uniform, varying instead by gender and diagnosis” (p. 381). Stigma results in discrimination (Link & Phelan, 2001), but what that discrimination looks like varies. Possible effects are reduced income (Marcotte & Wilcox-Gok, 2001), social rejection (Feldman & Crandall, 2007) and social withdrawal (Abdullah & Brown, 2011), low self-esteem (Abdullah & Brown, 2011), lower levels of education (Kessler et al., 1995), lower likelihood to seek care (Collins et al., 2014), and other things that are negative for the individual, their families and loved ones, and society as a whole.

Stigma against mental illness is a social problem. It is perpetuated by myths and media (Philo et al., 1994), but precisely because it is a social problem it does not look the same in every culture (Abdullah & Brown, 2011). As someone who wants to pursue a career in clinical psychology and work with people with severe mental illness, it is incredibly important for me to understand stigma. Stigma prevents people from seeking help and can cause complications in the healing process (Corrigan, Druss, & Perlick, 2014). In a society that is a blend of so many different cultures and traditions, it is important to understand stigma in social environments and cultural spaces other than my own to best help any patient with whom I might work.

One thing that needs to be addressed before anything else is how I will be using the term “culture.” This was something that I really struggled with, as it is a broad term and is not to be
thrown around carelessly. One of the arguments I am making is that saying that race or ethnicity cause similarities or differences in beliefs about mental illness is not the full picture – it is race and ethnicity and culture. Culture, as a noun, is a system of shared beliefs, values, artifacts, customs, and behaviors. However, in this paper I will be using it more as an adjective – cultural factors, like norms, values, socialization, ideas shaped by family and institutions, and so forth. Thus, when I say “culture,” this is what I mean, not culture as a singular, identifiable system.

**Literature Review**

After my primary research on stigma, I began to look at what research has been done on mental illness and race and ethnicity to date. This is when my own research idea went through its first evolution. What began as a project aimed solely at seeing what differences there are in perspectives on mental illness across axes of race and ethnicity additionally became a critique of how race and ethnicity are conceptualized and researched. Research on mental illness stigma started as early as the 1950’s in the United States, but it was not until the 1990’s and early 2000’s that it really picked up in popularity. The goal of much of this research is to create a better understanding of stigma and its effects, in order to demonstrate that it needs to be dealt with and to lay the groundwork for how this can be done. In the past decade or so, more research specifically on mental illness stigma and race and ethnicity has been conducted, and the goal of much of this research is to discover how race or ethnicity affects people’s perspectives on mental illness. The current research on mental illness and race and ethnicity makes many generalizations about racial and ethnic groups from the data collected – these generalizations are the result of using broad grouping techniques and nationally representative samples based on these broad groups. The authors of these studies make many suggestions about beliefs about mental illness within racial and ethnic groups, and the differences they find are attributed to race or ethnicity,
rather than cultural norms or values. These weaknesses, which will be further discussed in the following section, can be addressed in part by using a mixed methods approach, as it allows the complexity of both cultural factors and mental illness to be addressed. Additionally, recognizing the intersectionality of identity will make future research on mental illness more thorough and accurate. These are ideas that I will explore in depth in this section.

Generalizations about race and ethnicity can be seen in many of the studies done on race and ethnicity and mental illness. A study done in California by Collins and colleagues (2014) surveyed people over the phone about their willingness to participate in different levels of contact (move next door to, spend an evening socializing with, or start working closely on a job) with people with three different types of mental illness (depression, schizophrenia, and PTSD). The racial and ethnic groupings they used were white, African American, Latino, and Asian American. Their results suggest that white people have the lowest overall concern about interacting with people with mental illness while Asian-Americans have the highest concern.

One quantitative survey study conducted by Whaley et al. (1997) suggests that minority groups like Asian-Pacific Islanders, Black Americans, and Native Americans tend to perceive people with mental illness as being more violent and dangerous than white people perceive them to be. Anglin et al. (2006) looked at racial differences in stigmatizing attitudes towards people with mental illness. Their survey results suggest that African Americans are more likely than white people to believe that people with mental illness are violent, but less likely to believe that they should be blamed for their mental illness (Anglin, Link, & Phelan, 2006). One study on Chinese immigrants in New York City suggests that Chinese-Americans fear that mental illness might threaten their family line (Yang & Purdie-Vaughns, 2013). This study involved participants from various places, including Fuzhou, Taiwan, and mainland China, and used a qualitative method.
Despite their use of interviews, when discussing the individual responses, the researchers did not specify where that person was from or anything about them: “Chinese-Americans” and “East Asians” are treated as homogeneous groups, even when they come from two countries that are quite antagonistic towards each other and have strong senses of national identity. This makes it incredibly easy to generalize beliefs, like those about the ability to work and perceptions of usefulness, to over-simplified groups like “Asian-American.” Additionally, it is problematic that these attitudes are causally attributed to race and ethnicity when a causal relationship cannot be determined.

Beyond the problems of over-generalization and causally attributing attitudes to racial or ethnic difference, research on stigma to date has produced very inconsistent results. These studies suggest that whites have the least amount of stigma and that stigmatizing beliefs in other racial groups differ. Despite the findings shared here, research results on mental illness stigma and race are not always consistent. Collins et al. have conducted several studies pertaining to mental illness stigma, one of which examined race and ethnicity (2014). Their review of the literature on mental illness stigma determined that previous research produced inconsistent results on perceptions of stigma within racial groups (2014, p. 1). For example, one study found that African Americans have greater stigma than whites (Anglin, Link, & Phelan, 2006), but other studies on the same groups did not replicate that finding (Kobau et al., 2010; Whaley, 1997). It is likely that the biggest contribution to these inconsistencies is how samples are chosen for research. Many studies conducted in the United States have used a nationally representative sample, which tends to be small (Anglin, Link, & Phelan, 2006; Whaley, 1997; Elkington et al., 2013; Rao, Feinglass, & Corrigan, 2007). In theory, this is good research practice, but for the
topic of mental illness stigma, using a nationally representative sample could actually hinder getting accurate results representative of the true diversity of a racial or ethnic group.

The variance that exists within groups is lost when the categories are too broad or generalized. For example, clumping all Americans with Asian heritage into one group as “Asian-American” ignores the fact that “Asian” encapsulates all of East Asia, Southeast Asia, South Asia, and Western Asia. Although minority groups in the United States make up a smaller percentage of the population than whites, their numbers in sum are substantial, and within so many groups, there is significant heterogeneity of beliefs (Lewis, 2006). While there might be overlap in the cultural traditions of these groups, there are very significant differences that separate the subcultures within the “Asian” group. When a handful of Chinese-Americans, for example, are used as part of a nationally representative sample, and the beliefs they profess are then applied to every person who falls in the category of “Asian-American,” this perpetuates the idea that every individual in that group holds those beliefs when in reality there exists a wide array of beliefs. To put it simply, the makeup of the sample in a study is important because the heterogeneity of beliefs should be represented.

It is problematic to suggest that race and ethnicity are the dominant factors determining perspectives on mental illness as the current research literature often does. Differences in beliefs that previous research has found could more plausibly be attributed to differences in cultural values, norms, and socialization (Abdullah & Brown, 2011). Additionally, beliefs within groups are not homogeneous (Anglin, Link, & Phelan, 2006), so claiming that one group is more or less likely to stigmatize other than another gives an incomplete picture. It is a mistake to claim that race and ethnicity directly cause differences in perspectives on mental illness. It is important to acknowledge race and ethnicity when looking into mental illness and stigma, but it is just as
important to recognize that race and ethnicity are only a segment of the factors that shape worldview, and that identity is intersectional – an idea that I will explore at length in a subsequent section. Unfortunately, the previous literature on mental illness and race and ethnicity fails to recognize these critical factors.

Cultural norms and values fundamentally shape people’s understandings of what they should think, believe, and do; additionally, they are central to determining that which is marked as abnormal and thus stigmatized. To date, researchers in the United States who study mental illness have primarily focused on gathering information in order to better conceptualize and understand mental illness within a small sphere – they have done a poor job of garnering information that would help people understand mental illness cross-culturally (Abdullah & Brown, 2011). Because the United States is such a large and culturally diverse place, understanding mental illness through a multicultural lens is critical for healthcare providers, social workers, and citizens. For example, for therapists treating mental illness, “Inherent in [individual therapy] is a disregard for the integration of family and community in treating Asian Americans, African Americans, and Latinos in the US with collectivist, interdependent, cooperative traditions. Such an indifference towards cultural traditions likely contributes to stigmatization of mental health services” (Abdullah & Brown, 2011, p. 943). Research on mental illness needs to look deeper into differences across race and ethnicity while also acknowledging within-group differences. Research that garners information, opinions, and viewpoints from people of different cultural backgrounds will help us better understand the range of understandings of and biases against mental illness and hopefully inform more effective anti-stigma campaigns.
The World Health Organization has created an online-accessible guide titled “Investing in Mental Health” in their efforts to increase mental health awareness. In all 52 pages, “race,” “ethnicity,” and “diversity” are not mentioned a single time. They do use the term “socio-cultural factors,” which they define as “age, gender, religion, socioeconomic status” (2003, p. 31), but this is used only twice—once when talking about suicide risk and once when talking about the resources that are available in different countries. WHO is the world’s biggest proponent of health and they work globally with people from radically different backgrounds; the fact that they have very little related to culture or diversity in their guide to mental health is very telling of the current state of the field. The studies that have examined race have looked at racial groups but have not taken cultural factors into account, and few take the time to postulate ideas for why the differences they found exist within racial groups. Culture-conscious research on mental illness is desperately needed if adequate help is going to be provided to those who require it and if stigma is going to be mitigated effectively. Furthermore, the research methods that are used should be chosen carefully, as it is the research on mental illness stigma that inform the procedures used to mitigate stigma.

The traditional quantitative method used for studies on mental illness and race and ethnicity is not adequate, as it does not account for the extent of the effects of identity and cultural factors. Quantitative research is based on the idea that there is a singular reality, while qualitative research is based on the idea that reality differs based on the perspective of the individual (Teherani et al., 2015). This is due to the fact that qualitative research is more person-focused by its very nature: more personal information will come from an interview than from a standardized questionnaire or test. However, quantitative methods give consistent results that can be more easily analyzed, and they can also give the ability to look at larger trends that allow you
to formulate better, more granular qualitative studies. Thus, more appropriate than just one of these methods is a mixed methods approach that combines quantitative techniques with qualitative ones. Some benefits of this approach include the ability to check for consistency of results, the discovery of new and unexpected dimensions of the topic, and an increase in comprehensiveness as qualitative results can be used to explain the quantitative ones (Chow et al., 2010). Research methods should pay closer attention to the concept of identity in order to be complete and representative of people and the complexity of their lives. The best way to do this is to take a mixed methods approach and conceptualize identity in the light of the idea of intersectionality.

Intersectionality, a term first coined by Kimberle Crenshaw in 1991, is an analytical framework used to identify and explain how different axes of identity interact to affect the experience of the individual. Crenshaw originally used the term to talk about the struggles of women of color; these women experience both the problems of being women and of being a person of color, along with other axes of difference involving poverty and sexuality. Having several identities simultaneously leads them to experience problems that white women, men of color, and many others do not and cannot experience. Since its inception, the concept of intersectionality has expanded to refer to the intersection of any and all identities. In the realm of mental illness, intersectionality is important in understanding why people hold stigma, what that stigma looks like, and how to best mitigate stigma. Many racial and ethnic groups have shared cultural norms, but that does not mean that everyone in that group has the same beliefs. Age, gender, and socioeconomic status are just some of the many factors that could influence one’s experience of mental illness and stigma alongside racial or ethnic identity. In a 2012 article published in *Social Science and Medicine*, Olena Hankivsky argues for the value of the concept
of intersectionality in research and writing: “this framework advances more accurate and sophisticated understandings of the multidimensional reality of human lives…intersectionality focuses on examining how social locations and structural forces interact to shape and influence human experiences” (p. 1713). Due to race and ethnicity being so complex, there are many factors that impact an individual’s understanding and conception of mental illness. Therefore, research done on mental illness and race and ethnicity should begin to pay particular attention to identity and take an intersectional approach in addition to using mixed methods.

**Methods**

Due to my background in anthropology, I knew I wanted to conduct qualitative research. Additionally, the limitations of the methods and results of previous studies of mental health stigma strengthened my resolve to combine qualitative methods with quantitative ones. I wanted to get a thorough picture of each informant’s cultural perspective, beliefs, and identity, so I decided to conduct interviews. I recruited 20 participants, ages 20-24. I started off by contacting student groups at Butler University and asking acquaintances if they knew anyone who might be interested in participating in an interview. From there, I used the snowball method for recruiting participants. My participants were not only Butler students, but also students from other Liberal Arts Colleges, from Indiana to Georgia. I gave all participants an informed consent form before the interview began that gave a summary of the study and what they should expect from the interview. I also assigned random numbers to all participants in notes and other documents to ensure anonymity and interviews were not audio or video-recorded. I conducted the interviews face-to-face, over the phone, and over video calls, as not all informants were able to meet in person. At times, this restricted my ability to make observations about facial expressions,
behavior, and other reactions, which would normally enhance fieldwork, but I did my best to note things of this sort.

The interviews consisted of eight pre-written questions focused on beliefs about mental illness held by informant themselves as well as by close family members and friends (complete list of questions can be found in Appendix A). In order to get the most honest and complete information from the informants, I let our conversations develop organically. After asking each pre-written question, I asked follow-up questions where I felt it was necessary and appropriate. Due to the heterogeneity within racial and ethnic groups, instead of having informants select a pre-written option of which race or ethnicity they were, I asked how they would describe their race or ethnicity. This gave each individual the opportunity to define their race or ethnicity in ways they felt were most accurate. One of the drawbacks of conducting interviews is that it is very easy to ask leading questions. When trying to understand an informant’s honest perspective on a topic, leading questions can be detrimental because they plant ideas in the informant’s head. I aimed to make my initial questions as objective and open as possible; for example, one question was “Tell me about how the topic of mental illness is treated in your family and your family’s culture.” I used my own discretion as to what kind of follow up questions were appropriate.

After I conducted the interviews, I went through and picked out concepts and narratives that frequently arose as factors that influence peoples’ perspectives on mental illness. Many informants cited religion, socio-economic status, and age or generation gaps as shaping their personal beliefs about mental illness or influencing the beliefs of their family or members of their community. Considering the fact that I was only able to interview 20 people, I wanted to see if these were actually common themes amongst a larger sample. Thus, for the second portion
of my research, I created and sent out a Qualtrics survey with questions similar to those used in my interviews, but that were more focused around the three central topics I found in the interviews (a complete list of questions can be found in Appendix B). I sent it out through social media, the Butler Connection, and through email to Butler Honors students. Of the 216 respondents, 175 identified as Caucasian or white, leaving only 41 respondents of other races or ethnicities. Despite this lack of diversity in terms of race and ethnicity, which is certainly a weakness, the responses nonetheless proved to be very interesting, although many were not very thorough. While the questions asked for explanations for each response, many participants skipped the sections asking for explanations and provided simply “yes” or “no” responses.

Despite the limitations of my survey, it highlighted some revealing trends. The survey, together with my interviews, support my argument that there are differences of opinion and belief within groups as well as similarities across groups. To varying degrees, religion, age, and socio-economic status do seem to be contributing factors for how people perceive and conceptualize mental illness. Additionally, it underlines the importance of combining quantitative research with qualitative research. The interview portion of the present research project is based on the previous literature that solely used quantitative research, whereas the quantitative survey I created was based on the qualitative interviews. Combining the data is helpful because each method reinforces the results produced by the other. The reciprocal nature of the relationship between the two types of research is very clear.

PART II: Results

In an attempt to intertwine anthropological and psychological methods, I have chosen to present my data in several ways. I have selected four case studies of informants who provided
rich and telling information in their interviews that showcase the three pervasive themes; they also provide a good foundation for comparison. I then present the survey data theme by theme, in context of the case studies. In this way, I hope to demonstrate the value of both the qualitative and quantitative research methods. In the interviews, I asked participants how they would identify their race or ethnicity and also characterize their personal and familial cultural ties. Then I asked about how the topic of mental illness is treated in their family or community and whether or not there is stigma against mental illness in those spheres. In order to better understand what that stigma looks like, I asked each informant why they thought that stigma exists (or does not exist), and what their personal perspective on stigma is. This was the general arc of the interview, but every interview varied depending on which questions the informant connected with the most.

**Case Studies**

*Case Study 1: Kayla*

When we talked, Kayla, an Asian-American, Filipina woman, spoke a lot about efforts to avoid the topic of mental illness in Filipino culture. Filipino culture is centered around family, so anything that is a private matter is kept within the family circle; according to Kayla, mental illness is very private. Within her personal family it is sometimes talked about, but in general it is not believed to be a “real thing,” in part because it is an “invisible illness.” Kayla’s description of mental illnesses as “invisible” was interesting to me because there are invisible physical illnesses as well – thyroid disorders and heart problems, for example. Although mental illnesses can have visible physical symptoms, I think they are often thought of as something that is just “in your head,” and thus cannot be seen. According to Kayla, Filipino culture in general involves always wanting to be happy and thus avoiding talking about problems; when the problem is something
“invisible” like mental illness, it is even less likely to be brought up and it is avoided as much as possible. When I asked why this was, Kayla thought for a moment and said that it’s “not because mental illness doesn’t exist in Filipino culture.” She said that her parents, who grew up in the Philippines, describe symptoms of mental illness but avoid the labels of specific disorders.

Clearly mental illness exists in the Philippines, but, as least in Kayla’s family, people do not want to be labeled with a mental illness. Beyond the cultural norm of having to seem happy all the time, Kayla cited religion as being a large factor behind stigmatizing beliefs about mental illness. Religion is a central part of Filipino culture, and, according to Kayla, those who are devout tend to pray and rely on spirituality when they have problems rather than reaching out for help or getting medication. I did not ask Kayla why she thought this was the case, but this behavior is commonly seen in communities or societies that are highly religious, so it is possible that people just think prayer is more reliable than medicine.

Kayla said that dominant ideas and beliefs about mental illness among Filipino-Americans definitely contribute to the stigmatization of those who are mentally ill. I asked how she thought stigma would be best mitigated in Filipino culture, and she suggested putting the concept of mental illness into terms that would be understandable to people in Filipino culture. She didn’t give specific examples of what this would look like, but she said that it would involve demonstrating to people that mental illness “has always been a thing.” I think the first step in this process would involve teaching people what mental illness looks like, perhaps by supplying diagnoses to the symptoms that people regularly describe. From Kayla’s experience, Filipino-Americans do not like to think about negative or uncomfortable things. She said that the topic of illness in general is avoided – mental illness is just another level because people don’t understand it, partly because it is not always as apparent as physical illness. What I thought was
most interesting about this conversation was that, according to Kayla, the form that stigma takes in Filipino culture is avoidance of the topic. She did not say anything about religion having either a positive or a negative effect on beliefs about mental illness, which did not strike me as unique until after reviewing the other interviews. Kayla described religion merely as a coping mechanism for mental illness.

*Case Study 2: Lisa*

Lisa identified as Black and said, rather emphatically, that there is definitely mental health stigma in Black culture. When I asked how the topic of mental illness is treated in her family and her family’s culture, she said simply, “It’s not.” The first reason she cited was religion, indicating that it is one of the main factors that creates stigma. The way she explained the effect of religion in the Black community is that mental illness and religion are seen as “one or the other:” if you are religious you can’t have a mental illness, and conversely, if you’re mentally ill you’re not adequately religious. In Lisa’s experience, prayer is seen as the key to health because God fixes everything, including mental illness. While Lisa said that religion causes a lot of stigmatization of mental illness because it is sometimes used as a tool to ignore, belittle, and erase mental health issues, she also said she could see how it can be used as a tool to give strength and resilience to people who are suffering. The fact that she brought up both sides of the issue indicated to me that she had actually seen both sides, but her emphasis on the negative influence of religion suggested that that’s the more common effect. She also brought up the experience of being LGBTQ+ and how the religiosity of the Black community results in the condemnation of members of the LGBTQ+ community, which can cause or exacerbate mental illnesses.
The second factor Lisa raised was related to socio-economic status. Lisa said that among Black people she knows there is a perception that “depression and suicide are for white people,” and there is an enduring stereotype that people with mental illness are white and affluent. I was rather surprised by this, perhaps due to my own ego-centrism – I thought the stereotype that I knew of, that mentally ill people are poor and uneducated, was universal. This prompted me to ask me to expand on her thoughts on the influence of the history of Black experience in America on perspectives on mental illness, because there are strong ties between these beliefs about mental illness and Black history. Lisa commented that there is a belief among Black people that Black people do not have time to be depressed because they have so many other things to worry about, and they have already been through so much as a people that mental illness is just seen as an excuse to be lazy and weak. Lisa said that one of the ways Black people have found to survive and cope over the years is by discouraging and not acknowledging weakness, and mental illness is seen as a weakness. In addition, according to Lisa, as each generation “gets better” and gains more rights, there is a tendency for older generations to say, “You have these things I didn’t have, therefore you have to be better.” By this they mean that younger generations have no right to be sad or depressed because the quality of their lives is objectively better in the big picture.

Towards the end of our conversation, we briefly discussed ideas for mitigating stigma in Lisa’s community and culture. She explained that people need to “be met where they’re at.” For her this meant that things that are important to them need to be emphasized and used to explain mental illness. For example, mental illness can be explained in the context of God and religion in a way that does not demonize those who suffer from it. Lisa mentioned religion a lot and she clearly felt it was the most important factor in determining how people in her community and culture view mental illness. She also mentioned factors that are culturally bound, related to the
history of Black people in America, which I did not know much about and really enjoyed hearing her perspective on.

Case Study 3: Lynn

Lynn, a white woman, grew up in a very religious family with strong Southern connections. She was very open about the presence of mental illness in her family, and also noted that the rest of her family is very secretive about it. She confided that her parents have never really accepted the idea that mental illness could be in their family because they believe “mental illness is not in their genes.” They always said “mental differences” instead of “mental illness” when the topic was forced upon them. And, they refused to willingly talk about mental illness until Lynn’s brother was hospitalized after a suicide attempt. To this day they do not accept his diagnosis of bipolar disorder because it is “too severe” and they believe he will “grow out of it.” I know Lynn and her family fairly well, and this surprised me. Her parents are highly educated, but rather conservative. I wondered if this could be part of the reason they hold these views about mental illness, so I asked Lynn to speculate about their reasoning. Lynn surmised part of the reason is because the topic is uncomfortable and is associated with bad things happening; additionally, no parent wants their child to have severe problems. Lynn said her mother is self-made and overcame a lot of hardship to get where she is today. Her struggles led her to view mental illness as a weakness and as something that people “choose to let affect them.” In her eyes, if someone wants badly enough to get better, they will. Neither one of her parents believe in the difficulties people with mental illness experience or in systems of oppression, because they think everything can be changed through the individual. This is a common belief amongst upper class, self-made white Americans, probably partly because they have access to resources and education that other people do not. Lynn’s perspective was the
complete opposite of her parents’. She believes that mental illness is caused by a number of factors, including genetics, and it should be talked about openly. Lynn talked about her personal learning disabilities and anxiety disorder as being factors her mom thought were good for her because she thought they made her a good student. When she had this conversation with her mom, she was shocked – it made her realize the extent of her mom’s denial of the seriousness of mental illness. Lynn’s view could not be more different from her parents’, which I found really interesting. I was surprised that her brother’s struggle with bipolar disorder and Lynn’s struggle with anxiety did not make her parents more understanding. Other informants talked about how they have seen their parents, family members, and peers become more understanding of mental illness after realizing someone close to them struggled with it. This wasn’t the case for Lynn’s parents, and I think that might be because of the life experiences they have had that have led them, particularly her mom, to the mindset that everything can be overcome through hard work. This “bootstraps” philosophy is hard for people to disavow.

Case Study 4: Jared

Jared’s dad is Japanese, and his mom is Thai, but he identifies as Asian-American. In Jared’s parents’ cultures, some mental illnesses aren’t recognized as mental illnesses; instead, according to Jared, they’re seen as a state of mind or a phase. He described the common thought process as, “If they weren’t in that situation then their ‘attitude’ wouldn’t be like that.” This indicates that mental illnesses are context-specific and are the result of people being in bad circumstances. Despite the fact that his own family has always seen mental illness as a legitimate thing, Jared said that he would be more likely to believe someone if they said they had a physical illness rather than a mental illness. He had described his family as understanding mental illness, so this surprised me. I asked him why he holds this belief, and he said it is because people self-
diagnose and will “sometimes say they have a mental illness just to get attention”; and additionally, physical illness symptoms are more concrete or real than mental illness symptoms. I asked if he had ever had someone do this, and he said not that he knew of, so this conjecture struck me as even more odd. I took it as a belief that was started and perpetuated by stereotypes about mental illness. He commented that he would be more likely to believe someone he was really close to if they said they had a mental illness, rather than a stranger. What was even more interesting was that he said he would likely believe a stranger if they said they had a physical illness, so his likelihood to believe a stranger does not depend on his relationship with them, but rather the type of illness.

In regard to the bigger picture, Jared said that, in general, Asian culture is very family-oriented, so if someone suffers from a mental illness it would be seen as an indicator of neglect or a failure in the family. The cardinal rule in Japanese culture, according to Jared, is to never inconvenience anyone, so reaching out for help is shameful for both the individual, as it is a sign of weakness, and the family, because it is a sign of failure. Jared said his sister goes through really highs and lows which has indicated some sort of depression to his family. Due to this, his family has grown more accepting of the idea of mental illness because it has affected them so close to home. The part of this interview that stood out to me so much was Jared’s explanation of accepting physical illnesses over mental illnesses. To me, this clearly indicates an internalization of stigmatic beliefs, despite the fact that he said his family was accepting of his sister’s mental illness.

Cross-Comparison and Significance

When the case studies are conceptualized in the context of intersectionality, we can better understand the layers of rationale for each individual. There was never a single factor that
formed the beliefs of the informants or their families or communities. Whether it was sexuality, history, socio-economic status, or religion, there was always an overlap of multiple axes of difference and this intersectionality resulted in unique perspectives from each informant.

These case studies show us that some beliefs about mental illness are shared across racial and ethnic categories. For example, Kayla and Lisa cited religion as playing a big role in stigmatic beliefs about mental illness. They said it is common to believe that praying will make mental illness go away. Lisa, Lynn, and Jared said that there is a belief that mental illness indicates weakness and that people are in one way or another personally responsible for their mental illness. There is also a tendency to ignore the problem, as Kayla and Lynn shared. Kayla, Lisa, and Lynn talked about how different their beliefs are from their parents or grandparents, indicating a generational or age divide.

Some beliefs were unique among those I interviewed. Lisa, for instance, shared that among her Black friends and family mental illness is seen as being a white people thing. In Jared’s experience, mental illness is often seen as a sign of the family’s failure in Japanese and Thai families. Other beliefs seem to be the same on the surface, but the logics undergirding those beliefs are different. For example, Lisa, Lynn, and Jared all generally shared the belief that mental illness equals weakness. However, according to Lisa it is because of the historic struggle of Black people. In Lynn’s case, it is the personal struggle of her mother, and the narratives of self-determination and personal responsibility that are so central to mother’s understanding of her personal success. For Jared, it is the result of the culturally ingrained rule that one should never inconvenience others or bring shame to the family. The types of weaknesses they talked about differed too. The weakness Lisa mentioned is conceptualized as a kind of selfishness, because from the perspective of the older Black generations, those with mental illness are living
in a much better world than they did and are taking it for granted. The weakness Lynn described is more just a laziness and a lack of resolve to fix the problem. And in Jared’s case, the weakness is of both a selfish and a moral nature, in that being weak brings shame to the family. Despite each person citing a similar belief related to weakness, the whole body of interviews I conducted suggests that this belief varies greatly within and across groups.

Additionally, we see that Kayla and Jared talked about different beliefs that are held within their families and cultures. Kayla said people rely on spirituality and ignore the problem because they want to be happy, while Jared said that mental illnesses are seen as a phase and are ignored because they could reflect poorly on the family image. Despite these clear differences, Kayla and Jared would be put in the same group of Asian-American in a traditional quantitative study. A category such as “Asian-American” is often taken for granted by researchers; they often use it and other racial/ethnic categories as methodologically and empirically meaningful. The differences between Kayla and Jared’s responses demonstrates that differences are found within groups, that standardly used racial and ethnic categories are imperfect frameworks, and that beliefs about mental illness are not solely due to race or ethnicity. Other axes of difference, like social class, religious background, gender, and so forth, must be considered in order to fully understand where stigmatic beliefs come from. It is important to recognize not only the great diversity and difference that exists when it comes to understanding mental illness and mental illness stigma, but also the logics shared across racial and ethnic groups.

**Contributing Factor: Religion**

“There is a fine line between believing in something and allowing that to evolve you and make you better, versus clinging to a set of rules because they make you comfortable or because you feel like it’ll save you.”
Religion has been, and continues to be, central to much of what humans do and how we define ourselves (Bowie, 2006). Religiosity, or the propensity of an individual to be involved in practices and beliefs of structured religion, has been shown to be positively correlated with mental and physical health (Koenig, Larson, & Weaver, 1998; Corrigan et al., 2003). This has been well-established over years of research, but there is a surprising paucity of research on the relationship between mental illness stigma and religion or religiosity. One might hypothesize that religion would be negative correlated with mental illness stigma, due to its positive relationship with mental health. However, the data from my interviews and survey indicate that the relationship between religion and mental illness stigma is much more complex.

In the case studies, informants referred to religion multiple times as something that shaped their and others’ beliefs about mental illness. While Kayla and Lisa both said that they have seen religion invoked when stigmatizing mental illness, Lisa also said she could see how it could be used in a positive manner. This suggestion brings up an interesting dichotomy: religion as a saving grace and source of strength, and religion as a device to hurt and hinder. Beyond the case studies presented earlier, there were other informants who cited religion as being a factor in how people view mental illness. There was a diversity of views about the role of religion in mental illness, and the survey results highlight this intricacy of the impact of religion on beliefs about mental illness.
Of the three factors contributing to perspectives on mental illness that I chose to look at in the survey, people’s opinions about religion were the most divided. It is important to note that not everyone specified their religion, so I am unable to make any inferences about differences in mental illness conceptions across religions. The results for this survey question were split almost exactly evenly: 102 said that yes, religion affects beliefs about mental illness, and 107 said no, it does not. Additionally, the explanations behind the yeses were different – to some, “yes” meant religion was a positive factor, and to others, “yes” meant religion was a negative factor. Others recognized both possibilities. For example, one person responded “Yes, religion promotes acceptance of everyone, weaknesses and strengths together,” while another responded “Yes, coming from an extremely conservative religion, thus affecting my extended family [sic], mental illnesses are not often addressed.” I take the second respondent’s answer here to mean that there is mental illness in their extended family that is not addressed, which they believe is because of their family’s conservative religion. These responses indicate that there is not a universal understanding of how mental illness is treated by or through religion. This could be due to personal experience or either positive or negative stereotypes. Some individuals emphasized how religion emphasizes acceptance while others said religion stigmatized against mental illness because it was unnatural. This is consistent with what several informants said in my interviews. Lisa, mentioned earlier, said she could see how religion could be used in a positive manner as a sort of coping mechanism, but that from her personal experience with the Baptist denomination she had usually seen it used against people with mental illness. Another informant said, in an overtly critical tone, that people pray for suicide victims because they do not want them to go to hell once they die, but they do not do anything to improve their situation while they are still alive. The same informant said that in Islam, mental illness is a sign from God showing the
sufferer that they are on the wrong path and that they need to pray. A different informant said that religion can be a great tool to help people believe in themselves and make them better, but it is all in how it is utilized.

Religious beliefs also informed informants’ ideas and perspectives about treatment of mental illness. One respondent said, “I think so, [religion] definitely opens us up for a kinder, more loving approach. It also makes me feel that [mental illness] should be treated in a more natural way, like prayer rather than pills, but I don’t feel that my religion would have an issue with medicated help if that was decided to be the best treatment.” Another said, “As a strong Christian, I do feel that it is recognized by many, but that there is a stigma surrounding treatment.” While the first respondent here says that their religion would not interfere with treatment, they also say their religious beliefs make them think mental illness should be treated with prayer if possible. This was echoed in the interviews I conducted, as many people who talked about religion said that people in their family or community always said those with mental illness needed to pray about it in order for their problems to go away. This stigma surrounding treatment for mental illness that the second respondent mentions is interesting, because it seems to be unique to mental illness rather than all illness. While there are some denominations of Christianity that reject almost all medical treatment, like Jehovah’s Witnesses and Christian Scientists, most religious people will accept medical treatment for other ailments. What differentiates mental illness from other illnesses is likely that people do not believe it is real or serious, and because it is often perceived as being “all in your head.” There seems to be a commonly held idea that all that needs to happen is the addition of positivity or the rejection of negativity. There is objectively nothing wrong with praying in response to mental illness, but when there is resistance to obtaining empirically supported treatment, problems could arise. I
think this resistance to treatment is likely where the negative opinions of religion in relation to mental illness come from. Many who believe in the power of prayer for healing mental illness seem to also believe that those who are mentally ill are individually responsible for their suffering, perhaps because they themselves are not praying enough. Once again, the impact of religion on people’s perspectives on mental illness depends on how it is utilized.

Although not every respondent or informant specified their religion, if they had, I do not believe there would be much consistency of responses within each religion or across religions. The major world religions like Christianity, Islam, and Hinduism all emphasize acceptance – the important factor in this context would be how the message of each religion is taught and perceived, which varies across denominations. Additionally, the survey data do not support the idea that the effects of religion on perspectives of mental illness differ across race or ethnicity, but there is not much room for cross-group comparison of data here, due to the fact that the majority of responses were white/Caucasian. However, there is a noticeable amount of variance within groups. This supports the argument that racial and ethnic groups are greatly diverse in what they believe. It follows that, in order to understand what people from different groups actually believe, researchers should dig deeper into discovering why the beliefs, the simple yeses and no’s, are held in the first place.

**Contributing Factor: Age or Generation**

“*My grandparents always say things like, ‘I don’t understand why you can’t just be happy.’”*

– Mexican-American, interview informant

“*When children discuss their own mental health with parents, the parents don’t want to call it what it is (anxiety or depression) because they don’t want the label.*”

– Asian/Indian-American, interview informant
It is not uncommon for perspectives on various issues to be different across generations. Part of this is due to environment. Brofenbrenner’s bioecological model proposes that human development is impacted by their genetics as well as their family, social relationships, and society as a whole (Brofenbrenner & Ceci, 1994). As the world changes and new ideas are brought to light, how people think, interact with each other, and raise their children also changes. Social learning theory, or the idea that people learn from watching the adults and other models around them, can be applied to every human belief, value, and behavior (Rosenstock, Strecher, & Becker, 1988). Beliefs about mental illness are no different. If people see those suffering with mental illness shamed and stigmatized by their friends, family, and society, they will be more likely to mirror that behavior and less likely to come forward if they ever begin to struggle with mental illness, because they do not want to have that experience. As more research is done on mental illness and it is more talked about, people have begun to better understand it. However, people from previous generations who grew up being steeped in an environment that stigmatized mental illness are less likely to adapt to this new paradigm of thought. A survey done in 2016 by the Anxiety and Depression Association of America indicates that younger generations have less stigma towards those with mental illness than older generations (Albano, 2018). These results are mirrored in the findings of the present study.

Many of my interview informants mentioned differences between their beliefs about mental illness and those of their parents, grandparents, or older family members. One informant, who identified as Caucasian, said that while her mom is open to conversations about mental illness, her dad is “not comfortable with it – he’s not equipped to deal with it.” Lisa, who identified as Black, said that older generations don’t talk about mental illness because her generation is the first to be educated about mental illness and to have the resources to deal with
it. Another informant, who identified as Latina and European, said that mental illness “generally has not been proactively talked about by adults in my family.” She reiterated the idea that her parents are ignorant about what mental illness really is and said that “mental illness in my parents’ generation isn’t generally talked about – it’s ignored.” Most other informants mentioned differences between their beliefs and older adults’ beliefs, even if they did not directly mention age or generation being a factor in levels of mental illness stigma.

The overwhelming majority (194 yes; 19 no) of survey respondents said age/generation has an impact on people’s perceptions of mental illness, across all racial and ethnic groups. People talked a lot about educational differences, the prevalence of social media and health campaigns, and the simply fact that there is less stigma now. The general consensus was that younger people just understand mental illness better because they are more exposed to it and to information about it – plus more than ever is known about it today. One respondent wrote, “Yes. I’d say that people under the age of 25 or so have been more exposed to the truth about mental illness. Older people often have an inaccurate view of mental illness, especially if they have never been exposed to it.” Another wrote, “Yes. From my experience, older people tend to think that mental illnesses are made up.” Other common responses mentioned older generations’ lack of education on the topic of mental illness and how younger generations are more open to talking about mental illness because it is not as taboo as it used to be. One respondent wrote, “Yes. My dad doesn’t take it seriously because he thinks that people just need to toughen up. That was the general belief of his time.” This was echoed by other survey respondents as well as interview informants. Lynn, whose parents believed that mental illness wasn’t “in their genes,” cited her mom as believing that mental illness is an excuse to be weak and lazy. Lisa, who said that there are striking generational differences in the Black community, commented on how older
generations think the younger generations have it so much better than they did, so they shouldn’t complain.

The belief that age/generation affects understanding of mental illness was present across and within all represented racial or ethnic identities. What might vary across identities is what beliefs older generations hold that younger generations have begun to challenge. For example, Lisa cited the historical oppression of Black people in American and how that influences the beliefs of the older adults in her family. This is not a factor for white people – they are more likely to say that older generations lack the education on mental illness, which is what causes them to have stigma. However, across groups there are similarities in people whose families or parents have been through an exceptionally difficult time, usually financially. I delved into this topic by asking about the contributions of socio-economic status to the understanding of mental illness.

**Contributing Factor: Socio-Economic Status**

“My parents understand [mental illness] is a thing but they don’t think it’s supposed to affect people ‘like us’ – white, middle upper class, educated. The perception is that we don’t have a lot to be sad about."

– White, interview informant

“If you are at the bottom of the socioeconomic food chain, per se, you aren’t concerned about what mental illnesses those around you have or don’t have. You’re more concerned about where your next meal is coming from."

– Asian, survey respondent

Historically, in America, people with lower socio-economic status (SES) have had less access to healthcare. Previous research has found that rates of mental illness are indeed higher in
those with lower SES (Hudson, 2005). Although it wasn’t mentioned as frequently as religion or age/generation, I chose SES as my third variable because it is a subtle thread that wove through every interview. SES is a complex topic because it is very closely related to race: it has been established that Black people tend to have lower SES as well as higher rates of mental illness (Williams, 1999). However, to my knowledge no research has been done on how SES affects understanding of mental illness until the present study. SES turned out to be the factor with the most variance in response, and the reasons people used to support their “yes” responses varied widely as well. I think the best way to address the factor of SES is to mostly look at the survey data first, rather than the interviews. This is because SES was often an unspoken factor in the interviews, and I did not ask about it directly. However, the reasons that people used to support their responses in the survey are also found in the interviews. By going in the reverse order from what I have done for the previous factors, it will be easier to note the instances of SES in the interviews.

When asked if SES is a factor that affects people’s understanding of mental illness, 136 survey respondents said yes and 50 said no, and 18 were unsure. Of the “yes” responses, there were a lot of different reasons for why SES affects understanding of mental illness. Similar to the responses for the factor of religion, there was variance in the meaning of people’s “yeses.” Some meant that low SES has an impact because it prevents people from having access to education and resources, while others commented on how those with high SES are encouraged to ignore their problem because they’re not supposed to have any problems. One person with this latter view wrote, “Yes, people who are in a higher status believe ‘there is no reason to be sad.’” This perspective is supported by the case of Lynn, whose family is very well off. Her mother is self-made and worked very hard to get where she is today, but her success has also caused her to
believe that “if you want [anything] bad enough you can make it happen; mental illness isn’t an excuse.” In contrast, other perspectives on the presence of mental illness in higher SES include “Yes wealthy people tend to get more depressed and it’s possibly because they are more open to share it or the complacency of wealth makes them unmotivated and depressed,” and “I believe that wealthier people often tend to hide their mental illnesses more because they don’t want the public to know about them.” Despite the contrasting views, the common belief throughout these responses is that those with higher SES feel like they shouldn’t have problems, so they do not reach out for help, either because they don’t think they have a problem or because they do not want to admit it for fear of a tarnished public image.

Despite quite a few people saying that high SES has a negative impact on the understanding of or treatment of mental illness, more people wrote about low SES. One respondent commented, “If someone in my family deals with mental illness, they might not have the time or money to get quality care. In my community, both parents are working all day and in many cases there is one parent supporting the household. When you’re living paycheck to paycheck, people are concerned about basic things like food and bills. Not necessarily healthcare.” Many people talked about how people from lower SES lack access to healthcare and resources, which results in them prioritizing other things, ignoring or suppressing problems with mental illness, or pretending the problems don’t exist. Another common factor people cited was lack of education, not just in terms of being uneducated about mental illness, but also how lack of education can affect interactions with healthcare providers. As one informant wrote, “Can be hard for someone with lower health literacy to be able to understand what a doctor is telling them in wrong with their body and the right steps to help it. They might not have the resources to get help too.” From this point of view, a lack of education means not
understanding what mental illness is and not being able to understand treatment. This type of “lack of education” was what people were generally talking about when they mentioned it in relation to low SES.

However, people from high SES can also lack education, as many are uneducated about what mental illness is or how to treat it. In this case, then, access and resources do not necessarily matter, because people do not utilize the resources available to them. Many people recognized that mental illness exists for people in all levels of wealth, but that the treatment varies drastically depending on SES. One person wrote, “Rich crazies and poor crazies are all crazies. The trouble is, poor crazies tend to become homeless, whereas rich crazies are the stars of your favorite movies and shows.” Another wrote “I think so, patients who are of a lower educational background may not understand their condition as well and may struggle when relaying it to their family and community. But I think there may also be a stigma for those who are very wealthy, they don't want those kind [sic] of ‘problems’ out in the public eye.” Again, these informants demonstrate the general belief that less education for those with lower SES and a desire to keep up an untarnished public image in those with higher SES are the main ways that SES affects an understanding of mental illness.

Regarding the interviews, many of these same points were brought up. People most frequently mentioned a lack of education about mental illness as a factor, but it was not necessarily connected to SES. This shows that a lack of education specifically about mental illness is a problem that crosses all levels of SES. Lisa conceptualized the effects of SES in light of race. She said that SES plays into levels of mental illness stigma, because “when there’s an image of a white person with mental illness, it’s an affluent person.” This ties into the belief Lisa cited within the Black community, that Black people do not have time to be mentally ill because
they have other things to worry about. Other informants said that their family was less educated, and as they personally went through college, their beliefs about mental illness changed. These changes are sometimes due to an exposure to information about mental illness, but in other cases it is because during college they met people who personally struggled with mental illness. One informant commented, “In college, I saw people come out with their stories and personal struggles and being more open with how they felt. I realized how serious mental illness is and how many people have it.” This points to the problem not necessarily being a lack of education, but rather a lack of open conversation and exposure.

The way race and ethnicity tie into SES and mental illness is more complex than the factors of religion and age/generation, due to certain races/ethnicities consistently having statistically lower SES than others. However, there were no significant differences in responses about SES between groups in the present data. SES was mentioned directly by several interview informants of various racial and ethnic identities, but it was mentioned indirectly by many others. I think this is because education, the most commonly mentioned factor, is not always considered in the context of SES, or the impact of SES is thought to be obvious and does not need to be directly mentioned. Alternatively, because people tend to be uncomfortable talking about class, class is often coded as education. This discomfort suggests that poverty is connected to what they see as negative behaviors. Thus, the fact that the response types (yes, no, or unsure) for this factor were the most varied of any of the factor could indicate a shaming attitude, or that SES is not as closely connected to mental illness as religion or age/generation, at least in terms of how people think about mental illness.

PART III: Discussion & Future Research
Discussion

Through a thorough analysis of the previous research on mental illness stigma and race and ethnicity, I determined that researchers could be taking a better approach to this type of research, both methodologically and conceptually. A mixed-methods approach used in tandem with the concept of intersectionality enables researchers to better understand the identity of their subjects. Identity is more complex than check-boxes of race or ethnicity on a survey can account for. It involves the interaction of many different factors, including religion, gender, age/generation, sexual orientation, and much more. I took a mixed-methods approach to this study by conducting qualitative interviews as well as a survey. Across all the interviews, the influence of religion, age/generation, and SES on people’s understanding of mental illness were most frequently brought up. Thus, I chose these three topics as the ones I would look at in more depth.

Many interview informants talked about religion having a negative impact on those with mental illness by creating and enforcing stigma against it. In the survey, religion was the factor with the most drastic split in responses. While many people said that religion makes people less tolerant of those with mental illness, others said that it advocates for love and acceptance of everyone and thus makes people more empathetic. Almost every interview informant mentioned age/generation as a factor in understanding mental illness. The common opinion was that people from older generations are less tolerant and understanding of mental illness, in part because they grew up in a world where it was taboo to talk about and they have not received the education about it that younger generations have. In the survey, the vast majority of people echoed this sentiment. SES was the most complex factor to tackle. In the survey, many people said SES does affect understanding of mental illness, but there was a healthy mix of responses. Of those who
talked about low SES, a lack of education and resources were the two most common factors they
cited as having an impact on perspectives on mental illness. Those who talked about high SES
frequently cited the idea that wealthy people don’t believe they should have problems, so they do
not reach out for help. A lack of education specifically about mental illness was a common factor
across all levels of SES.

One of the main goals of this study was to examine how race and ethnicity play into
perspectives on mental illness. What the data show is that there are both similarities and
differences in beliefs within and across racial and ethnic groups. This suggests that it is not race
or ethnicity alone that create these beliefs, but rather cultural values and unique combinations of
other axes of differences. When identity is conceptualized in the framework of intersectionality,
we are able to detect and dissect these differences and the influence of various axes much more
effectively than when identity is looked at as single-dimensional. Additionally, mixed methods
approaches allow for a more thorough analysis of the interaction between cultural values,
identity, and beliefs. Through this lens, we can foster a more complete and accurate
understanding of mental illness, which is critical for mental health care providers and anti-stigma
campaigns alike. As this is just a preliminary study on this topic, I cannot offer direction for how
stigma can be more effectively mitigated. However, I do believe that these results demonstrate
that this topic should be continued to be explored, as doing so will result in better anti-stigma
campaigns in the future.

**Future Research & Reflections**

I learned a lot through the process of this study, both while conducting research and
during the analysis and writing. My skills as an anthropologist improved as I encountered
difficulties in analysis and contradictions in my writing, and there are a few things I would
change for future research. The results of this study have pointed me in a clearer direction for what questions should be asked, so in the future I would make questions more focused on specific factors. I would want to be more detail-oriented in the follow-up questions asked during interviews. Doing so would have provided me with more robust results. For example, asking people what religion they aligned themselves with would have been interesting. I learned a similar lesson in survey construction: open-ended questions on surveys are terribly difficult to glean information from. People often say very little or miss the point of the question completely, but there is the occasional really good response. In the future, I think I would like to use surveys largely, but not necessarily only, for quantitative purposes – this would look like garnering very detailed information from interviews and turning that data into Likert-style questions on a survey. Additionally, it would be important to have a more diverse survey sample. Incorporating these changes would drastically improve the structure of a study like this, which would consequently result in better results. Furthermore, there are several dimensions of mental illness and identity that I did not look at in this study that should be examined in the future.

One factor that people mentioned both in interviews and in the survey is the effect of the media on beliefs about mental illness. I think this is a really important factor, but I chose not to look at it here because it is not a dimension of identity. Additionally, there is already much research being done on the effects of the media on mental illness stigma (McGinty et al., 2016; McGinty et al., 2015). One dimension of identity that I did not look at, but that people occasionally mentioned, was gender. Both gender and sexuality are two areas that future research should examine in light of race and ethnicity and culture, as there are often deeply engrained ideas about what is acceptable and unacceptable, and these ideas are intertwined with mental illness.
Furthermore, future research should look at specific types of mental illness and the variance in what stigma looks like for different disorders. Like race and ethnicity, mental illness is not a monolithic category. Previous research has found that there are differences in stigma levels depending on the type of mental illness (Collins et al., 2014), but this should be reexamined with a mixed methods and intersectional approach in order to understand what the specific beliefs about different mental illnesses are. Additionally, the degree to which people have been exposed to mental illness, specifically whether they have a mental illness themselves, should be accounted for. Having a mental illness is yet another dimension of identity and would certainly impact the perspective one has on mental illnesses.
Appendix A

Interview Questions

1. How old are you?

2. How would you describe your race or ethnicity?

3. How strong are your personal cultural ties? How strong are your family’s cultural ties?

4. Tell me about how the topic of mental illness is treated in your family and your family’s culture.

5. Would you say there is stigma against mental illness in your family and/or culture?

6. Where do you think this stigma (or lack thereof) comes from?

7. What is your personal perspective on mental illness and mental illness stigma? If it differs from that of your culture/family, why is that?

8. What would you say is the best way to mitigate stigma in your culture/community?
Appendix B

Survey Questions (all open-ended)

1. How old are you?

2. How would you describe your race or ethnicity?

3. Do you have any acquaintances, friends, or family members with mental illness? (yes/no)

4. What is your understanding of why people become mentally ill?

5. How do you see people with mental illness treated by members of your family and/or community? Why do you think they are treated that way?

6. How do you think people with mental illness should be treated? Why?

7. Would you say religion affects the understanding of mental illness in your family, community, and/or culture? If so, please explain.

8. Would you say age or generation affects the understanding of mental illness in your family, community, and/or culture? If so, please explain.

9. Would you say socio-economic status affects the understanding of mental illness in your family, community and/or culture? If so, please explain.

10. Are there any other factors you think shape the understanding of mental illness in your family, community, and/or culture? If so, please explain.
References


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