Ethnic Differences in Perceptions of Mental Illness: Examining Intergroup Relations

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ABSTRACT

People with mental illness are often stereotyped as dangerous, unstable, or unreliable, and these stereotypes perpetuate prejudice against those who are already vulnerable. However, many of these stereotypes are Eurocentric due to a lack of diversity within psychology. The present, pre-registered research investigates whether depictions of mental illness are idiosyncratic to various racial/ethnic groups, or if these perceptions generalize across groups. Participants reported their endorsement of a series of mental illness descriptions (e.g., "This person spontaneously explodes in outbursts of anger") as they apply to African Americans, Asian Americans, Hispanic/Latinxs, Caucasians, as well as to individuals with unspecified race/ethnicity. Exploratory factor analyses of these descriptions revealed three factors that describe mentally ill people — ashamed, self-destructive, irresponsible — and participants' perceptions of mental illness on these three factors varied by racial/ethnic groups. Participants rated Asian Americans as more ashamed, but less self-destructive and irresponsible than other racial/ethnic groups. Conversely, participants rated Caucasians as less ashamed but more self-destructive and irresponsible than other racial/ethnic groups. Perceptions of mental illness did not differ between Hispanic/Latinxs and African Americans. Additional analyses indicate that, compared to Caucasian participants, non-Caucasian participants rated mentally ill members of their ingroup as more ashamed but less self-destructive and irresponsible. This research indicates that participants from different racial/ethnic groups vary in the extent to which they ascribe different facets of mental illness to their ingroup versus outgroups. Implications for Eurocentric versus more diverse perceptions of mental illness are discussed.

KEYWORDS: *Bias, Cross-Cultural, Intergroup Relations, Mental Illness, Perceptions, Stereotypes, Stigma*

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INTRODUCTION

People with mental illness are often stereotyped as dangerous, unstable, or unreliable (Abdullah & Brown, 2011; Corrigan et al., 2014; Link et al., 1987). Such stereotypes are a precursor to discrimination (Eagly & Chaiken, 1993), and perpetuate prejudice against people who are already vulnerable (Corrigan & Bink, 2016). One way in which prejudice can manifest is stigma, where an individual is devalued based upon unfavorable group stereotypes (Hinshaw, 2007). In the context of mental illness, stigma refers to negative perceptions of an individual because they have mental illness symptoms or have been labeled as possessing a mental illness (Corrigan et al., 2014; Link et al., 1987). Once stigmatized as 'crazy,' 'psycho,' or 'sick,' individuals struggling with mental illness may become resistant to seeking assistance (Abdullah & Brown, 2011). More broadly, stigma is defined as a negative label of an outgroup, in the context of stereotypical differences that separate "us" from "them" (Link & Phelan, 2001).

Though existing racial/ethnic dynamics likely exacerbate mental illness stigma, the extent to which mentally ill people are stigmatized may be underestimated because stereotypes about mental illness are primarily Eurocentric, in that mental illness is conceptualized to reflect Caucasian views and perspectives (Katz, 1985). Prior stigma research assumes that perceptions of mental illness are viewed universally, such that individuals of different cultures and racial/ethnic backgrounds are all stigmatized in the same way (Abdullah & Brown, 2011). This restricted focus reflects the lack of psychological research among minorities with mental health conditions, and may not represent stereotypes about mental illness when applied more broadly across different cultures and ethnic/racial groups. Moreover, perceptions of mental illness symptoms, and approaches to treatment, are typically viewed from a Eurocentric perspective, such that the fundamental concept of mental illness reflects a middle-class Caucasian value system (Joseph, 2015; Katz, 1985; Naidoo, 1996).

Further exacerbating the Eurocentric perspective on mental illness, Caucasians have greater representation in media, which includes both stigmatizing (i.e., negative) and de-stigmatizing (i.e., positive) portrayals of mental illness (Frisby, 2017). Taken together, Eurocentrism is pervasive throughout psychological research and mental health and impedes non-Caucasians from seeking help. Mental health professionals are not immune to the effects of stigma (Stubbs, 2014; Hanafiah & Bortel, 2015). Professionals who are not culturally competent may inadvertently adopt a Eurocentric perspective in their treatment of minority patients. These negative, Eurocentric stereotypes of racial/ethnic minority patients' conditions may obstruct minorities from seeking help (Hanafiah & Bortel, 2015; Horsfall et al., 2010).

Contemporary research on mental illness highlights the importance of understanding stigma cross-culturally by acknowledging the values, norms, and social contexts in which diverse individuals operate (Abdullah & Brown, 2011; Corrigan et al., 2014). Additionally, examining mental illness stereotypes through a multiracial/ethnic lens provides the opportunity to ask novel questions. For example, to what extent do mental illness stereotypes depend on the intergroup relationship between perceiver and target? The possibility that intergroup relationships moderate intergroup perceptions (such as stereotypes) has precedent: The ultimate attribution error (Pettigrew, 1979), proposes that people will attribute negative behaviors of outgroup members to internal factors, but attribute negative behaviors of ingroup members to external factors. In other words, when members of the ingroup have negative behaviors, people attribute it to the situation rather than blaming the individual (Pettigrew, 1979). Building on this perspective, given that mental illness stereotypes are negative (and, thus, stigmatizing), this study proposes that people will differentially ascribe descriptions of mental illness to ingroup versus outgroup members.

THE PRESENT RESEARCH

The goal of this research is to examine mental illness stereotypes from the perspective of race and ethnicity. In doing so, two questions arise: the first question focuses on ethnic and racial differences in mental illness stereotypes, and the second question focuses on whether mental illness stereotypes depend on the intergroup relationship (i.e., ingroup versus outgroup) between the mentally ill person and the perceiver.

PARTICIPANTS AND METHODS

In the interest of clarity and open research, our hypothesis, methods, and exclusion criteria were pre-registered and are available at https://osf.io/4yn56. A total of 315 undergraduate participants were recruited from the University of California, Riverside. Of these, 26 were excluded for the *a priori* exclusion criteria of missing or incomplete data, leaving a final sample size of 289 (M age = 19.6, *SD* = 2.83; 83 men, 206 women; Participant Ethnicities: 8 African Americans, 103 Asian Americans, 106 Hispanic/Latinx, 32 Caucasian, 40 other). Participants completed five 20-item scales that measured perceptions of mental illness towards different racial/ethnic groups. All five scales shared the same basic structure, such that participants indicated how strongly each item (e.g., "This person is aggressive and spontaneously explodes in loud outbursts of anger.") described a mentally ill person on a 7-point Likert scale (1 = not at all representative, 7 = very representative; see Appendix A).

Table 1. Note: Average mental illness endorsement ratings by target group race/ethnicity.

	Ashamed		Self-Destructive		Irresponsible	
	Mean (*SD*)	*SE*	Mean (*SD*)	*SE*	Mean (*SD*)	*SE*
General	5.35 (0.96)	.057	4.85 (1.06)	.062	4.26 (1.23)	.072
African American	5.12 (0.97)	.057	4.61 (0.95)	.056	4.05 (1.10)	.065
Asian American	5.59 (0.90)	.053	4.28 (1.04)	.061	3.70 (1.21)	.071
Hispanic/Latinx	5.37 (0.99)	.058	4.68 (0.95)	.056	3.95 (1.19)	.070
Caucasian	4.60 (1.05)	.061	4.98 (1.00)	.059	4.57 (1.05)	.062

All participants began by reporting their perceptions of a general (i.e., not race-specific) person with mental illness. The next four scales, measuring perceptions of African American, Asian American, Hispanic/Latinx, and Caucasian people with mental illness, were presented in random order.

RESULTS

Exploratory factor analysis utilizing maximum likelihood was conducted on general mental illness perceptions, which revealed three factors: *ashamed* ($\alpha = .81$), *self-destructive* ($\alpha = .89$), and *irresponsible* ($\alpha = .84$). Because the items that comprised each of these three factors demonstrated good reliability, items were then averaged into indices reflecting each factor (see Appendix A for factor loading for each item). Three subsequent mixed-model ANOVAs were conducted, with target race/ethnicity (African American, Asian American, Hispanic/Latinx, Caucasian) as a within-participants factor and participant race/ethnicity (African American, Asian American, Hispanic/Latinx, Caucasian) as a between-participants factor. These ANOVAs were employed to predict perceptions on each of the three factors that emerged in the exploratory factor analysis. The main effects of target race/ethnicity emerged (**Table 1**), such that Caucasian targets were rated as less ashamed, more self-destructive, and more irresponsible than the other target groups, and Asian American targets were rated as more ashamed and less self-destructive and irresponsible than the other target groups. Perceptions of mental illness between Hispanic/Latinxs and African Americans did not differ. No other reliable main effects emerged.

In order to examine the interaction between participant and target race/ethnicity, targets were re-coded as either 'ingroup' or 'outgroup' to each participant for ease of interpretability (**Table 2**). This analysis revealed that African Americans, Asian Americans, and Hispanic/Latinxs rated mentally ill members of their ingroup as more ashamed than did Caucasians. Hispanic/Latinxs and Caucasians rated mentally ill members of their ingroup as more self-destructive than did African Americans and Asian Americans. African Americans and Caucasians rated mentally ill members of their ingroup as more irresponsible than did Hispanic/Latinxs and Asian Americans. No other reliable interactions emerged.

DISCUSSION

The present research examined mental illness stereotypes across different races and ethnicities. Caucasians were perceived as less ashamed, more self-destructive, and more irresponsible than other groups. In contrast, Asian Americans were perceived as more ashamed, less self-destructive, and less irresponsible than other groups. Additionally, non-Caucasians rated members of their ingroup as more ashamed compared to Caucasians who rated ingroup members as less ashamed, but more self-destructive and irresponsible. Hispanic/Latinxs and Caucasians rated members of their ingroup as more self-destructive than did African and Asian Americans. In contrast, African Americans and Caucasians rated mentally ill members of their ingroup as more irresponsible than did Hispanic/Latinxs and Asian Americans. Notably, the ratings of Caucasians as low in ashamed, but high in self-destructive and irresponsible, provide support for Eurocentric perceptions of mental illness by illustrating the pervasiveness of Caucasian representation within mental health.

IMPLICATIONS

This work aids literature on mental health stigma by examining depictions of mental illness as they vary by race and ethnicity. These findings add to a growing body of work that highlights the need for diversity and representation within mental health. These results shed light on how individuals stereotype other's behaviors, highlighting a need for greater intergroup communication surrounding mental health. The lack of accurate, de-stigmatizing representation within the media perpetuate negative perceptions of people struggling with mental illness, discourages vulnerable people from seeking help (Abdullah & Brown, 2011). In turn, this underscores

Table 2. Note: : Average mental illness endorsement ratings by participant groups for the ingroup and outgroups

	INGROUP	OUTGROUP	TEST OF DIFFERENCE		
	Mean *(SD)*	Mean *(SD)*	*t*(df)	*p*	Cohen's *d* [95% CI]
ASHAMED					
African American	5.61 (0.83)	4.88 (0.88)	3.04 (7)	.019	0.85 [-0.27, 1.97]
Asian American	5.71 (0.96)	4.90 (0.87)	9.41 (102)	<.001	0.88 [0.59, 1.17]
Hispanic/Latinx	5.81 (0.88)	5.12 (0.73)	9.27 (105)	<.001	1.97 [1.05, 2.88]
Caucasian	4.88 (0.93)	5.36 (0.76)	-3.41 (31)	.001	-0.56 [-1.07, -0.05]
SELF-DESTRUCTIVE					
African American	4.33 (1.40)	4.56 (0.63)	-0.62 (7)	.56	-0.20 [-1.28, 0.87]
Asian American	4.47 (1.06)	4.74 (0.95)	-4.04 (102)	<.001	-0.27 [-0.55, 0.003]
Hispanic/Latinx	4.70 (0.88)	4.59 (0.74)	1.64 (105)	.10	0.13 [-0.14, 0.41]
Caucasian	4.98 (1.07)	4.56 (0.96)	3.90 (31)	<.001	0.41 [-0.09, 0.92]
IRRESPONSIBLE					
African American	3.47 (1.72)	3.33 (0.76)	0.34 (7)	.75	0.10 [-0.97, 1.17]
Asian American	3.83 (1.33)	4.29 (1.01)	-3.94 (102)	<.001	-0.39 [-0.66, -0.11]
Hispanic/Latinx	3.76 (1.14)	4.08 (0.78)	-3.84 (105)	<.001	-0.33 [-0.60, -0.05]
Caucasian	4.30 (1.15)	3.79 (1.04)	3.29 (31)	.002	0.47 [-0.04, 0.97]

the importance of raising awareness for a better understanding of non-Caucasian mental illness populations regarding research and approaches to treatment.

Our findings may help mental health professionals in understanding how mental illness symptoms are perceived among different races and ethnicities and, in turn, adjust their approach to treatment. Although it is well understood that treatment approaches are Eurocentric and inappropriate for various minority groups (Katz, 1985; Naidoo, 1996; Sue, 1994), what is not understood is how the Eurocentric perceptions influence this. Understanding stereotypical perceptions versus well-documented symptoms among different minority groups may enhance cultural competency among clinicians and researchers.

LIMITATIONS

One possible limitation of the present research is that the items used to depict mental illness descriptions may not fully capture the breadth of mental illness symptoms across races and ethnicities. Participants may have felt that none of the twenty items could reasonably be applied to certain racial/ethnic groups, or that one description may apply equally well to all racial/ethnic groups. More broadly, the present research may paradoxically be Eurocentric, in that people from non-Caucasian cultural backgrounds might not understand the concept of mental illness in the manner it is presented here. If a concept is not discussed in one's culture, there would be no logical explanation to ascribe a behavior to mental illness.

Another limitation of our findings is that they reflect only the perceptions of undergraduate participants. The racial/ethnic breakdown of our particular undergraduate sample included few African Americans – corresponding to the racial/ethnic composition of our campus – which is insufficient to draw strong conclusions about their perceptions of mental illness. Future research should seek to include more African Americans, as well as diverse participants on other dimensions, in order to build a more comprehensive and externally valid understanding of mental illness perceptions across races and ethnicities.

Additionally, the three factors – ashamed, self-destructive, irresponsible –were derived based on perceptions of a general (not race-specific) mentally ill person. This method was operational-

ized so that it equally compares all racial/ethnic groups across a common framework. Different factors may have emerged if they were operationalized in terms of specific races/ethnicities. Future research should build upon the foundation laid by the present research to examine the extent to which these three factors persist versus vary across mentally ill people of different races/ethnicities.

CONCLUSION

The present research indicates that perceptions of mental illness vary across racial/ethnic groups and that racial/ethnic groups vary in the extent to which they ascribe different facets of mental illness to their ingroup versus outgroups. Future research should clearly define stereotypical portrayals of mental illness within minority racial/ethnic groups as members of those groups understand them. Not only does this work extend the existing literature on cross-cultural stigma within intergroup relations, but it also highlights the lack of diverse representation, and emphasizes the importance of recognizing non-Caucasian mental illness symptoms regarding mental health.

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APPENDIX A – EFA SCALE ITEM LOADINGS

ITEM	Ashamed	Self-Destructive	Irresponsible
Tries their best to hide mental illness from others	**0.71**	0.16	-
Afraid of disappointing their family due to others' knowledge of their MI	**0.59**	-	0.16
Feels as though they have no right to talk about it; others have it worse	**0.56**	0.17	0.16
Hasn't told their family about mental illness	**0.54**	0.22	-
Experiences sleep disruption, either too much or too little	**0.52**	0.11	0.36
Feels pressure to act 'normal'	**0.49**	-0.14	0.13
Experiences frequent chest pains, stomach pains, and/or body aches	**0.46**	-	0.36
Has thoughts of attempting suicide	0.17	**0.68**	0.18
Aggressive, and spontaneously explodes in loud outbursts of anger	-	**0.63**	0.35
Dependent on drugs and alcohol	-	**0.60**	0.31
Experiences "blackouts" or "shuts down" when they're very upset or angry	0.30	**0.48**	0.26
Can still do well in school, work, and/or extracurriculars (reversed)	0.24	**-0.44**	-
Has many crying spells	0.31	**0.38**	0.28
Is Unproductive	0.18	0.21	**0.56**
Spends money recklessly	-	0.24	**0.53**
Calls off of work a lot	0.28	0.27	**0.49**
Is unpredictable and unreliable	-	0.33	**0.44**
Thinks that their MI is a punishment*	0.41	0.38	-
Copes with difficulties by overeating or undereating*	0.37	0.41	0.38
Prays and attends church more frequently to deal with difficulties ‡	0.27	-	0.24

Note: Items indicated (*) were removed from factor loadings due to double loading.
Items indicated (‡) were removed from factor loadings due to not meeting 0.35 criterion.