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# The Psychological Effects of Racial Discrimination and Internalized Mental Illness Stigma on a Community Sample of Blacks and Latinos

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The Psychological Effects of Racial Discrimination and  
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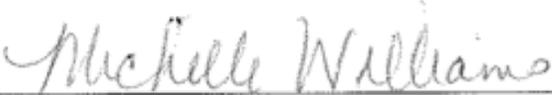
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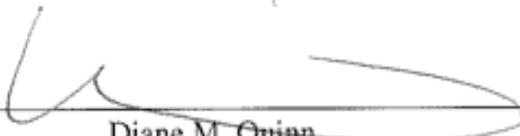
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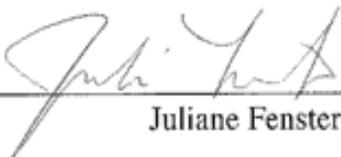
The Psychological Effects of Racial Discrimination and Internalized Mental  
Illness Stigma on a Community Sample of Blacks and Latinos

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## Introduction

A number of studies have considered the effects of having multiple minority statuses on psychological well-being (Bowleg, Huang, Brooks, Black, & Burkholder 2003; Connor & Rosen, 2008; Nabors, 2012; Reid & Comas-Diaz, 1990); however, fewer studies have directly addressed the psychological implications of having both a marginalized identity that is visible (e.g. race, gender) and a devalued identity that is concealable (e.g., mental illness, HIV status) (Quinn, Williams, Overstreet, & Weisz, 2014a). More specifically, there is a dearth of literature that examines the mental health outcomes of being subjected to routine, negative, racial slights (Sue et al., 2007), experiencing major events of racial discrimination throughout the lifespan (Kessler, Mickelson, & Williams, 1999), and experiencing mental illness as a stigmatizing identity. Whereas studies have examined mental health outcomes associated with racial discrimination, relatively few studies have also incorporated beliefs about, experiences with, or perceptions of mental illness as a stigmatizing identity. Conversely, the literature on mental illness stigma generally examines race in the context of group-based comparisons (e.g., Black-White differences in stigma) rather than racialized experiences such as discrimination, which can also impact mental health outcomes. This study aims to investigate the psychological outcomes of experiencing both external and internal devaluation; it examines the effects of both racial discrimination and mental illness stigma internalization on psychological distress in a community sample of Black and Latino adults who identify mental illness as a primary identity.

*Prevalence of Racial Discrimination Among Blacks and Latinos*

Racial discrimination has been defined as unequal treatment, motivated by racial prejudice, that can occur on individual, social, and institutional levels (Williams, 1999). Racial prejudice may be implicit (internalized via socialization and/or unconsciously motivated) or explicit (fully understood and clearly expressed). Thus, racial discrimination may manifest as inadvertent, subtle, or overt behaviors (Sue et al., 2007). Racial discrimination can be experienced as discrete, major lifetime events such as being fired from a job or victim of a hate crime and as recurrent, habitual, or chronic experiences such as being treated with less courtesy or ignored due to one's race/ethnicity. Among racial and ethnic groups, reports of racial discrimination have been and continue to be frequent and of great concern (Lewis, Cogburn, & Williams 2015; Byrd & Mirken, 2011). Prevalence data from the Midlife Development in the United States survey (MIDUS) found that 60.9% of adult respondents report experiencing some type of day-to-day discrimination with 24.8% of Blacks reporting frequent experiences (Kessler, et al., 1999). The National Survey of African Life (NSAL) data revealed that Black and Caribbean youth report at least one experience of discrimination within the past year and perceive more discriminatory events as they progress through adolescence (Seaton, Caldwell, Sellers, & Jackson, 2008). Similarly, data from the National Latino and Asian American Study (NLAAS) reported that almost half of U.S.-born Latinos report exposure to day-to-day discrimination (Pérez, Fortuna, & Alegría, 2008), and a survey conducted by the Pew Research Center revealed that 61% of Latinos surveyed describe discrimination against their ethnic group as a "major problem" (Lopez, Morin, & Taylor, 2010). Among racial and ethnic minorities, and specifically with Black and Latino Americans, the experience

of racial/ethnic discrimination on a day-to-day basis occurs with a high degree of frequency and is perceived to be a major problem faced by racial minorities.

### *Racial Discrimination and Mental Health Outcomes*

The majority of the literature examining the association between racial discrimination and health has focused on mental health outcomes; however, racial discrimination has been shown to predict physical and behavioral health conditions as well, such as alcohol use (Blume, Lovato, Thyken, & Denny, 2012; Borell et al., 2010; Hurd, Varner, Caldwell, & Zimmerman, 2014), smoking (Borell et al., 2010), emotional-eating (Johnson, Risica, Gans, Kirtania, & Kumanyika, 2012), and elevated systolic blood pressure (Ryan, Gee, & Laflamme, 2006). For the purposes of the current investigation, however, the focus will be on psychological and mental health outcomes and not physical health.

A number of studies have linked racial discrimination with unfavorable mental health outcomes among ethnic/racial minorities (Brondolo et al., 2011; Jackson, Knight, & Rafferty, 2010; Lewis et al., 2015; Williams & Mohammed, 2009). For example, self-reported racial discrimination has been associated with psychological distress (despite the perceived stressfulness of the event) (Huynh, Devos, & Dunbar, 2012), state and trait anxiety, depression, and suicidal ideation (Hwang & Goto, 2008), depressive symptoms (English, Lambert, & Ialongo, 2014; Gibbons et al., 2014; Keith, Lincoln, Taylor, & Jackson, 2009; Miranda, Polanco-Roman, Tsypes, & Valderrama, 2013; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), poorer self-ratings of mental health (Karlsen & Nazroo, 2002), as well as academic, interpersonal, emotional, and existential distress (Chao,

Mallinckrodt, & Wei, 2012). In addition, racial discrimination has been shown to predict diagnosable psychological outcomes, such as generalized anxiety disorder (Soto, Dawson-Andoh, & BeLue, 2011) and social anxiety disorder (Levine et al., 2014), along with psychological symptoms like anxiety, hostility, and anger (Gibbons et al., 2014), general psychiatric symptoms (Klonoff, Landrine, & Ullman, 1999), perfectionism and suicide risk (Chao et al., 2012). Negative mental health outcomes such as depression and psychological distress are robust for adults as well as adolescents (English et al., 2014; Sellers & Shelton, 2003) and across racial minority groups.

Huynh, Devos, and Dunbar (2012) investigated the impact of both frequency and intensity of stress associated with experiences of racial discrimination on reports of psychological distress. Using a sample of 168 Latino/a undergraduate students, the researchers assessed racial discrimination using the Schedule of Racist Events, which measures the frequency of racial discrimination in the past year and lifetime as well as the perceived stressfulness of those events. The study findings indicate an interaction between the frequency and stressfulness of racist events, such that experiencing numerous, low stress events was associated with greater psychological distress, while high stress events predicted greater distress, regardless of frequency. The study findings provide additional evidence that there is an association between experiencing racial discrimination and psychological distress, and that experiencing habitual discrimination has a cumulative effect on psychological distress. This cumulative impact of lower stress events has been found to be consistent with chronic and traumatic stress models (Carter, 2007; Sue, Capodilupo, & Holder, 2008).

In another study, Hwang and Goto (2008) examined how racial discrimination affected reported levels of psychological distress, anxiety, suicidal ideation, and clinical depression in a sample of Asian American and Latino college students. Their results indicate that risk for psychological distress does not vary based on ethnicity, but that higher endorsement of racial discrimination was significantly associated with higher levels of psychological distress, suicidal ideation, state anxiety, trait anxiety, and clinical depression.

In sum, there is broad agreement within the literature that experiencing both habitual and major event-related racial discrimination is significantly associated with negative psychological outcomes. Notably, the literature most often recognizes the association between discrimination and distress as present, and sometimes as stronger, in the context of day-to-day or chronic racial discrimination as opposed to lifetime racial discrimination (Keith, Lincoln, Taylor, & Jackson, 2009; Kessler et al., 1999; Levine et al., 2014; Ryan, Gee, & Laflamme, 2006; Sellers & Shelton, 2003; Williams et al., 1997). Moreover, while there may be some racial/ ethnic differences in the kinds of discriminatory experiences reported (Hwang & Goto, 2008; Nadal et al., 2014), the association between racial discrimination and negative mental health outcomes has been shown to hold true for multiple racial/ ethnic groups that are the targets of systemic racial discrimination, and these findings are consistent in different populations: college/ high school (Blume et al., 2012; Chao et al., 2012; Hurd et al., 2014; Huynh et al., 2010; Hwang & Goto, 2008; Miranda et al., 2013), community samples (Brondolo et al., 2011; English et al., 2014; Gibbons et al., 2014; Klonoff et al., 1999), and national samples (Karlsen & Nazroo, 2002; Keith et al., 2010; Kessler et al., 1999; Levine et al., 2014; Soto et al., 2011). Some of this research has combined college and community participants (Nadal et al., 2014), but

the majority of the research has focused on college samples. Although mental health outcomes were the focus of most of these studies, relatively few, if any included mental health constructs beyond assessment of symptoms or diagnoses. The degree to which racial discrimination results in negative psychological outcomes may depend in part on beliefs about mental illness. The stigma associated with mental illness especially among racial and ethnic minorities may be an important factor to consider in understanding the effects of racial discrimination on mental health.

The present study adds to the literature by examining the association between racial discrimination and psychological outcomes in an urban, ethnically diverse, and predominantly low income, community sample and will include mental health constructs such as stigma in addition to racial discrimination.

### *Barriers to Adequate Mental Health Care Among Blacks and Latinos*

Despite the consistent association between racial discrimination and poorer mental health outcomes for Blacks and Latinos, research shows that racial and ethnic minorities are less likely to utilize specialty mental health care services in comparison to Whites (Alegría et al., 2002). This finding may be particularly true for mood and anxiety disorders in comparison to substance abuse disorders (Keyes et al., 2008). Lack of mental health treatment and follow-up warrants both national and global concern, as untreated mental health conditions place a large national economic burden in terms of both direct and indirect costs (Insel, 2008), with depression alone cited as the third leading contributor to the global disease burden (Collins et al., 2011). Thus, it is particularly important to examine barriers to mental health treatment and retention for racial and ethnic minorities

and to understand both the health and economic consequences. Furthermore, it is important to consider this incongruence in service utilization considering that Blacks and Latinos are documented as having similar rates of mental health conditions (Alegría et al., 2007; Robins & Regier 1991) and perhaps even lower rates of affective disorders for Blacks compared to Whites (Kessler et al., 1994). These comparable rates of psychiatric disorders and lower utilization rates occur despite these groups reporting frequent experiences and perceptions of racial discrimination (a social stressor) (Ancis, Sedlacek, & Mohn, 2000; Lewis, Kravitz, Janssen, & Powell, 2011; Williams, Jackson, & Anderson, 1997). One reason for the racial/ ethnic disparate mental health service use may be due to coping responses which can be healthy (such as seeking social support and cultural engagement) as well as unhealthy (such as substance use or avoidance/denial), both of which might mitigate more acute mental distress (Jackson et al., 2010); however there are also both historical and cultural factors that may bear an impact on mental health service utilization.

Racial/ ethnic minority group membership has been historically linked with barriers to healthcare treatment, subpar treatment, and distrust of medical professionals and institutions. For example, in a study comparing racial/ ethnic differences in both access to and quality of care for depression among Blacks, Latinos, Asians, and Whites, Alegría et al. (2008) found significant differences in treatment accessibility, with racial/ ethnic minorities reporting significantly less access to quality care compared with Whites. Similarly, in a study assessing disparities in mental health treatment, Cook et al. (2014) found that Blacks and Latinos were less-likely to initiate treatment, had shorter treatment sessions (many of which solely consisted of psychotropic prescription fills), and overall

fewer prescription fills compared with Whites. A study by DePetris and Cook (2013) found that information regarding health risks associated with prescribed psychotropic medication was slower to diffuse into healthcare systems treating Blacks and Latinos compared with Whites, and studies have shown that physicians treating Blacks are less likely to be board-certified and more likely to report difficulties providing quality care to patients compared with physicians treating White patients (Bach, Pham, Schrag, Tate, & Hargraves, 2004). Such healthcare disparities persist even when influences related to healthcare access are controlled (Smedley, Stith, & Nelson, 2009).

Racial/ ethnic minority group membership has also been historically associated with unconsented and deceptive medical experimentation (e.g., Tuskegee Syphilis Study conducted on Black men in Alabama and STD Inoculation Study conducted on Latinos in Guatemala) (Washington, 2007). These medical abuses and others that preceded them (e.g., surgical experiments conducted on Black slaves (Gamble, 1997)) and followed them (e.g. sterilization abuse of women of color (Davis, 2003; Suite, La Bril, Primm, & Harrison-Ross, 2007)) likely contribute to an undercurrent of cultural distrust of both medical professionals and health care institutions. Regarding mental health discrimination, racist, fabricated psychological disorders such as drapetomania (describing Black slaves' desires to resist conditions of slavery and escape (Suite et al., 2007)), along with "the Puerto Rican Syndrome" (characterized by "agitation," "violent movements," and "bizarre detached uncommunicative violent attitudes," (Mehlman, 1961)), contribute to cultural mistrust as they invalidate the humanity of individuals subjected to systemic and institutional dehumanization, and pathologize their reactions to and rejection of those experiences. Thus, the collective memory (Gamble, 1997) of medical injustice, along with

actual experiences of poorer quality care compared with Whites, likely contributes to the under-utilization of mental health services by racial/ ethnic minorities and the stigma associated with mental health treatment.

More contemporary manifestations of subpar mental health care and medical mistrust are evidenced in the differential diagnosis of more severe mental disorders for Blacks and Latinos compared with Whites when comparable symptoms are presented. For instance, Blacks and Latinos with bipolar disorder are more likely to be misdiagnosed with schizophrenia compared with Whites (Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983); Blacks who present with both psychotic and mood symptoms are more likely to be admitted with a diagnosis of schizophrenia rather than affective disorder whereas Whites are more likely to be admitted with a mood disorder diagnosis (Snowden & Cheung, 1990); there is a general over-diagnosis of schizophrenia for Blacks compared with Whites despite comparable prevalence rates in both groups (Baker & Bell, 1999). The fear of being diagnosed with a severe mental health condition may further prevent racial/ ethnic minorities from seeking much needed health services and from completing mental health care treatment (Gary, 2005; Snowden, 2001). The negative stereotypes that perpetuate public stigma around mental illness are often tied to misperceptions and beliefs about individuals with serious mental illness (e.g., dangerous, violent, threatening).

#### *Mental Illness Stigma and Stigma Internalization Among Blacks and Latinos*

It follows that a history of being denied ethical and adequate medical care, along with the stigma associated with being diagnosed with a severe mental illness, may be of greater concern for racial/ ethnic minorities in comparison to Whites. The following

section will address the concept of stigma, internalized mental illness stigma, and its implications for racial and ethnic minorities.

Stigma has been defined in the literature as the convergence of interrelated components, reflecting a process of both differentiation and devaluation. Labeling, stereotyping, separation, status loss, and discrimination are identified as the concurrent components, originating from within a power dynamic in which those who “possess social, cultural, economic, and political power” have the ability to differentiate groups and stigmatize some as “less than” (Link & Phelan, 2001). The consequences of stigma are both perpetual and pervasive, affecting wage earnings, access to education, housing, health care, criminal involvement, and mental health outcomes (Link & Phelan, 2001) and occur at the individual and societal levels. Thus, the ramifications of stigma exist inextricably on institutional, interpersonal and intrapsychic levels.

Internalized stigma, self-stigma, or private stigma, occurs at the individual level and describes the process by which an individual accepts adverse stereotypes about the group, attributes these stereotypes to the self, and endorses a devalued social status (Park, Bennett, Couture, & Blanchard, 2013; Rüsch, Angermeyer, & Corrigan, 2005).

Internalized stigma is often the result of public stigma, (i.e. the negative stereotypes and discrimination about a group, widely endorsed by external sources), that devalues the group and affects the marginalized individual (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Corrigan & Watson, 2002). Public stigma is the negatively held beliefs about a group whereas self-stigma is the application and internalization of those beliefs to the self. This paper uses the terms internalized stigma and self-stigma interchangeably.

Regarding mental illness stigma internalization, several studies have indicated that internalized stigma is associated with poorer psychological outcomes, such as depression (Park et al., 2013; Sharaf, Ossman, & Lachine, 2012), suicide risk (Sharaf et al., 2012), low levels of self-esteem, self-efficacy, recovery orientation (Drapalski et. al., 2013), and low levels of psychological well being (Norman, Windell, Lynch, & Manchanda, 2011). The majority of these studies have examined the effects of internalized stigma among individuals with psychotic disorders and serious mental illnesses such as schizophrenia and bipolar disorder (Drapalski et al., 2013; Link 1987; Livingston & Boyd, 2010; Norman et al., 2011; Park et al., 2013; Sharaf et al., 2012). The aforementioned studies were conducted at outpatient mental health centers, which are more typically frequented by individuals who have a severe or chronic mental illness and/ or substance abuse disorders. It is also the case that individuals diagnosed with a more severe mental illness (e.g., psychotic disorders, bipolar disorder) experience greater mental illness stigma, are more likely to be the targets of discrimination, and experience more negative consequences as a result of their mental illness (Rusch, Angermeyer, & Corrigan, 2005). It is, however, important to explore the overall pervasiveness of mental illness stigma internalization, especially as early intervention for less-severe mental health conditions may mitigate the onset of a more severe trajectory. The literature shows that Blacks in particular have the highest rates of emergency room mental health visits compared with other racial/ ethnic groups (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005), indicating that service seeking may occur when symptoms are most acute and severe. Mental illness stigma, among other socioeconomic factors, may play a role in the delayed onset of treatment and in a potentially more severe treatment course. The present study

contributes to the literature by examining the contribution of internalized mental illness stigma on psychological distress in a population with a spectrum of severity regarding mental illnesses.

There is evidence that mental illness stigma internalization is of particular concern for racial/ ethnic minorities compared with their White counterparts. In a study comparing the impact of both internalized and perceived public stigma on 248 elder African American and White adults with depression, researchers found that African Americans have higher levels of internalized stigma, less positive attitudes toward seeking treatment, and lower levels of intention to seek treatment than Whites (Conner et al., 2010). Though there is a dearth of research focusing on mental illness self-stigma among other racial/ ethnic groups, the aforementioned findings coincide with research indicating that: African Americans are significantly more likely to raise concerns about mental illness stigma as an impactful barrier to help-seeking behavior than Whites (Cooper-Patrick et al., 1997), Blacks and Latinos are more resistant to both advice from health care providers and to psychiatric diagnoses (Carpenter-Song, 2010), as well as psychotropic medication consumption (Cooper et al., 2003) than Whites (Carpenter-Song et al., 2010). In addition, Blacks and Latinos have higher mean levels of public stigma for mental illness than Whites (Eisenberg, Downs, Golberstein, & Zivin, 2009), Latinos report more shame about having a mental illness than Whites (Jimenez, Bartels, Cardenas, & Alegría, 2013), and Blacks and Latinas are more likely to endorse the belief that problems should not be talked about outside of the home (Alvidrez, 1999). Although some studies suggest that mental illness stigma concern may be greater for Blacks compared to Latinos (Carpenter-Song et al., 2010; Nadeem et al., 2007; Rao, Feinglass, & Corrigan, 2007), overall findings

suggest that there are similarities in levels of mental illness stigma between Blacks and Latinos, and that both groups report greater mental illness stigma than Whites. It is conceivable that internalized mental illness stigma, when coupled with experiences of racial discrimination, may amplify the negative mental health outcomes that are associated with each experience alone; this magnified psychological burden may occur if a mental health condition, unlike one's race/ ethnicity, is viewed as self-inflicted, and an additional devalued status. The present study addresses a gap in the literature by focusing on mental illness self-stigma in a multi-racial/ ethnic sample.

In sum, the current study endeavors to integrate the bodies of literature concerning the mental health outcomes of Blacks and Latinos who experience both racial discrimination and internalized mental illness stigma. This study will add to the literature by exploring the potential multiplicative effects of racial discrimination and internalized mental illness stigma on psychological distress. Hypotheses include:

1. Both day-to-day and lifetime racial discrimination will have a direct effect on psychological distress.
2. The effect of day-to-day racial discrimination on psychological distress will be stronger than that of lifetime racial discrimination.
3. Internalized mental illness stigma will have a direct effect on psychological distress.
4. Internalized mental illness stigma will moderate the association between racial discrimination and psychological distress.

Thus, we expect that the multiplicative effects produced by racial discrimination and mental illness stigma internalization will produce significantly greater effects on psychological distress than either racial discrimination or internalized stigma on its own, or their additive effect.

## Method

### Participants and Procedure

Analyses were conducted using extant data collected between 2009 – 2011 as part of a larger Concealed Stigmatized Identity (CSI) study funded by the National Institutes of Health (NIH). The aim of the broader research project was to examine the effects of five different concealable stigmatized identities or experiences (mental illness, substance abuse, experience of domestic violence, experience of sexual assault, and experience of childhood abuse) on treatment, physical, and mental health outcomes. All of the study measures and procedures for the CSI study were approved by the Institutional Review Board of the University of Connecticut.

Participants were recruited by trained research assistants from three centers in and surrounding Hartford, Connecticut: a community college with a high representation of non-traditional students, a privately-run agency offering a host of services, including parenting, employment, school-readiness, juvenile prevention, housing, mental health, etc., and a state-operated mental health center providing an array of behavioral health services. Participants were provided with a broad description of the study, informed of the approximate study length being 30-50 minutes, and notified of their rights to confidentiality. Those who chose to participate were taken to a quiet area and provided

with Netbook PCs to complete the questionnaire; the questionnaire was created in MediaLab, and participants had the option of completing it in English or Spanish. Participants were paid \$5, \$10, or \$20 dollars based on how much of the study they completed, and were debriefed after survey completion. Of the 751 participants recruited for the full study, 67 met criteria for inclusion in the current study. Inclusion criteria were: being at least 18 years old, being literate, indicating mental illness as one's primary concealable stigmatized identity, and completing all of the relevant study measures.

The final sample consisted of 37 Black (55%) and 30 Latino (45%) participants. Of the 67 participants, 45 were male (67%) and 22 were female (33%). Fifty-four participants (82%) elected to complete the survey in English, while 12 (18%) chose to complete the survey in Spanish. The mean age of participants was 36 years ( $SD = 11.0$ ), 7 participants indicated that they were employed (10%), and the overall median income was less than \$5,000 per year. Most participants had some high school experience ( $n = 16$ ; 24%), 14 indicated that they had completed high school (21%), and one had earned a B.A. at the time of the study (1.5%). The majority of participants were recruited from the state agency ( $n = 39$ ; 58%), 16 participants were recruited from the private agency (24%), and 12 were recruited from the community college (18%). Notably, a series of one-way ANOVA analyses revealed that there were no significant differences between Blacks and Latinos on any of our main variables of interest. For a complete summary of these analyses, please refer to Table 1.

Participants in the overall study were asked to indicate if they had a mental illness diagnosis. If so, they were asked to specify their diagnosis and were able to check-off multiple diagnoses if they had co-morbid conditions. Major depressive disorder and

anxiety disorders were the most frequently endorsed diagnoses in the sample, comprising between 30-70% of sample. For a full list of endorsed mental illness diagnoses, please refer to Table 2.

## Measures

### *Day-to-Day Racial Discrimination*

Day-to-Day Racial Discrimination was measured using the nine-item Day-to-Day Perceived Discrimination scale developed by Kessler, Mickelson, and Williams (1999). The original scale was designed to capture the frequency of exposure to chronic, daily discrimination, without stipulating that the basis for the discrimination be attributable to race, gender, or socioeconomic status. For the current study, the items were modified to reflect the frequency of experiencing each event as a consequence of one's race/ethnicity. Sample items include, because of your race/ethnicity, "People act as if you are inferior to them," "People act as if they are afraid of you," "You are called names or insulted," or "You are threatened or harassed." Participants were asked to report the frequency of exposure to unfair treatment according to a four-point scale, of often (1) to never (4). Kessler's Day-to-Day Perceived Discrimination measure has a Cronbach's alpha ranging between .85 and .93 in most studies, and a Cronbach's alpha of .91 in this study.

### *Lifetime Racial Discrimination*

Lifetime Racial Discrimination was measured using the eleven-item Major Lifetime Perceived Discrimination scale developed by Kessler, Michelson, and Williams (1999). The scale was designed to capture the frequency of exposure to major lifetime experiences of discrimination, without stipulating that the basis for the discrimination be

attributable to race, gender, or socioeconomic status. The scale was modified for the current study to reflect lifetime discrimination as a result of one's race/ethnicity. Sample items requested participants to check off if due to their race/ethnicity, they believe they were ever, "Not hired for a job," "Hassled by the police," "Prevented from renting or buying a home," or "Denied (or received poorer) medical service." Kessler's Major Lifetime Perceived Discrimination measure has a Cronbach's alpha ranging between .86 and .88 across studies, and a Cronbach's alpha of .62 in this study; however, Williams, Neighbors, and Jackson (2003) note that internal reliability statistics are not appropriate for checklists of major experiences of discrimination, as the occurrence of one event does not necessarily predict the likely occurrence of another. Participants were asked to indicate yes or no to the sequence of items and the total number of events were summed.

#### *Mental Illness Stigma Internalization*

Stigma Internalization was assessed using four, modified items (Eisenberg et. al., 2009) from Link's Devaluation-Discrimination Measure (Link, 1987). Within the context of the larger Concealable Stigmatized Identity (CSI) study, questions were modified to reflect one's internalization of his or her CSI, and this study includes those participants who identified mental illness as a primary CSI. Modified questions, rated on a strongly disagree (1) to strongly agree (7) scale, include: "I feel that my CSI is a sign of personal failure," "I would not want to date someone with my CSI," "Most of the negative things people think about my CSI are true," and "I don't blame people for wanting to keep their distance from me when they find out about my CSI." Link's full scale includes 12 items that reflect both experiences of devaluation and discrimination. Of those items, five are

more reflective of devaluation, which is more consistent with the construct of internalized stigma than discrimination. One item reduced the internal consistency of the scale and was removed, resulting in the four-item measure.

Link's abbreviated and modified measure has a Cronbach's alpha of .71 in this study, compared to an alpha of .78 in a study by Quinn et al. (2014b); the full measure is the oldest measure of internalized stigma for those with a mental illness, is psychometrically sound, and is one of the most widely used internalized stigma measures (Livingston & Boyd, 2010).

### *Psychological Distress*

Psychological Distress was measured using a composite scale comprised of depression and anxiety. Depressive symptoms were measured using the Center for Epidemiological Studies- Depression Scale (CES-D; Radloff, 1977) and anxiety symptoms measured using the Spielberger Trait Anxiety Scale (STAI-T; Spielberger, Vagg, Barker, Donham, & Westberry, 1980). The CES-D is a 20-item scale which instructs participants to indicate the frequency of experienced depressive symptoms on a 0 – 3 scale, where 0 indicates rarely or none of the time (less than one day) and 3 refers to most or all of the time (5-7 days). Scale items include: “I felt depressed,” “My sleep was restless,” and “I had crying spells.” Due to a programming malfunction in the original CSI study, a small number of participants only received 19 of the 20 CES-D items, thus rather than using sum scores as is typically the case, mean scores were calculated (Quinn et al, 2014b). Regarding the STAI-T, participants were instructed to indicate the frequency of anxiety symptoms based on how they “generally feel,” where 1 indicates almost never and 4 indicates all of the time. Scale items include: “I feel inadequate,” “I make decisions

easily,” and “I feel that difficulties are piling up.” Mean scores were calculated for the STAI-T. The CES-D has been found reliable for multiple ethnic groups (Roberts, 1980) and to have both high internal consistency and test-retest reliability (Radloff, 1977). The STAI-T has also been found to be a highly reliable and valid measure (Quek, Low, Razack, Loh, & Chua, 2004), and is able to differentiate between high and low stress conditions (Metzer, 1976). For this study, the two scale means are correlated at .75. Both scales were standardized using z-scores and a composite psychological distress scale was created.

### Data Analytic Procedure

Prior to analyses both tolerance and variance inflation factor (VIF) levels were inspected to ensure that cases high on both leverage and distance would not skew the data, and to assess the distribution of variables. Bivariate correlations were conducted to determine correlations among the predictor and outcome variables.

Our hypotheses were tested using hierarchical regression. To test the research question of a potential multiplicative effect, an interaction term combining the two predictor variables was added to the hierarchical regression to determine the magnitude or direction of an interaction.

## Results

### Descriptive Statistics

Descriptive statistics for all primary continuous variables are shown in Table 3. Additionally, the following summary statistics were calculated: Approximately 66% of participants (n = 44) reported high levels of day-to-day racial discrimination (indicating

“often” or “sometimes” on questions pertaining to experiences of day-to-day racial discrimination. Conversely, about 34% of the sample ( $n = 23$ ) indicated experiencing low levels of day-to-day discrimination (indicating “rarely” or “never” on sample items). Approximately 19% of the sample ( $n = 13$ ) did not check off any major lifetime events of racial discrimination, about 45% of the sample ( $n = 30$ ) checked off one event, approximately 27% ( $n = 18$ ) indicated two – four events, and about 9% ( $n = 6$ ) indicated five - eight events. About 43% of participants ( $n = 29$ ) had lower levels of stigma internalization (indicating a range of responses from strongly disagree to disagree), and about 21% ( $n = 14$ ) indicated high levels of stigma internalization (ranging in responses between agree to strongly agree). (Participants who selected “neutral” as their response with regard to their level of stigma internalization (36%;  $n = 24$ ), were omitted from the aforementioned statistics).

With the exception of sex and language, there were relatively few significant associations among the demographic variables and the outcome measures. Men were more likely to have taken the questionnaire in Spanish ( $r = -.24, p < .05$ ), reported more lifetime racial discrimination ( $r = -.29, p < .05$ ), and reported greater internalized stigma ( $r = -.29, p < .05$ ) compared with women. Day-to-day racial discrimination and lifetime racial discrimination were positively and significantly correlated with each other ( $r = .42, p < .001$ ) and both were significantly and positively correlated with internalized mental illness stigma ( $r = .41, p = .001$  and  $r = .25, p < .05$ , respectively). Higher endorsement of minor and major racial discrimination experiences were associated with greater mental illness stigma internalization. Day-to-day racial discrimination and psychological distress were positively and significantly correlated ( $r = .27, p < .05$ ). The correlation between stigma

internalization and psychological distress was in the positive direction and approaching significance ( $r = .22, p = .07$ ). A greater endorsement of both day-to-day racial discrimination and stigma internalization corresponded with greater distress. For additional information regarding correlations between the covariates and the primary variables of interest, please refer to Table 4.

### Multiplicative Model

To explore a potential interaction between internalized stigma and racial discrimination, we conducted a hierarchical regression and added an interaction term as a proxy for the combined effect of racial discrimination and stigma internalization. Language, age, sex, income, and education level were entered in Step 1 of the regression to control for the impact of these demographic characteristics on psychological distress. In Step 2, both day-to-day and lifetime discrimination were entered into the model. Day-to-day discrimination significantly accounted for an adjusted 11.1% of the variance in psychological distress ( $\Delta R^2 = .11, F(7,57) = 3.29, p = .01, \beta = .32, p = .01$ ), however lifetime racial discrimination did not significantly predict psychological distress ( $\beta = .05, p = .74$ ). In Step 3, internalized mental illness stigma was added to the model, and did not significantly account for variance in psychological distress ( $\Delta R^2 = .00, F(8,56) = 2.88, ns$ ). An interaction term of day-to-day discrimination x internalized stigma was added to Step 4 of the model. The interaction was not significant ( $\Delta R^2 = .00, F(9,55) = 2.52, ns$ ). For a full depiction of standardized beta weights, please refer to Table 5.

## Discussion

This study utilized a community sample of predominately low income Blacks and Latinos to explore whether or not experiencing both racial discrimination and internalized mental illness stigma pose an amplified risk for endorsing psychological distress. We hypothesized that the two marginalized experiences would create an amplified burden, resulting in compounded psychological distress. We also hypothesized that day-to-day racial discrimination would have a stronger effect on psychological distress than that of lifetime racial discrimination. We did not detect a significant interaction effect in our results, which does not support the proposed multiplicative model. In fact, day-to-day racial discrimination proved to be the only significant predictor of psychological distress in our sample, whereas major lifetime racial discrimination and internalized mental illness stigma were not significant predictors of distress. Our results suggest that experiencing day-to-day racial discrimination may be a better predictor of psychological distress than internalized mental illness stigma in a diverse, low income, community sample. However, a larger sample size and perhaps a more comprehensive measure of internalized mental illness stigma may detect findings not found in the current study.

Notably, our sample endorsed relatively high levels of prominent day-to-day racial discrimination (66%) and moderate levels of noteworthy events of lifetime racial discrimination, with about 45% of the sample indicating that they had experienced one major event of racial discrimination in their lifetime. While explicit racism may be somewhat less common in the Northeast than in other regions of the United States, implicit racism remains an undercurrent of American culture that is harder to eradicate, is often below an individual's level of awareness, and continues to manifest on daily basis

(Sue et al., 2008). Thus, it is unsurprising that racial/ ethnic minorities report higher levels of smaller-scale forms of racial discrimination as opposed to major discriminatory events. Additionally, some of the events on the lifetime racial discrimination scale, such as “Not hired for a job,” “Not given a promotion,” “Fired from a job,” and “Denied a scholarship,” may have an ambiguous connotation, such that an individual might not be sure whether or not to associate the event with race-based discrimination or to other devalued statuses, such as being female, having a marginalized sexual orientation, less educational attainment, or being a low wage earner. In addition, the vast majority of the sample (90%) was unemployed at the time of data collection and reported an annual income of \$20,000 or less (93%), thus the opportunity to experience some of the major discrimination experiences (e.g., fired from a job, denied bank loan, denied scholarship) would be less likely.

Our sample did not widely endorse high levels of mental illness stigma internalization (21%). This finding was surprising, given the strong association between mental illness stigma and psychological distress in previous studies. These low self-stigma levels likely reflect the fact that our participants may have been somewhat desensitized to mental illness stigma due to their potentially regular exposure to mental health services; two of our three recruiting sites offered outpatient mental health services, and it is probable that our participants had been utilizing these sources both leading up to and at the time of study participation. Perhaps mental illness service utilization and being around others who also identify with having a mental illness contributed to decreased stigma regarding mental illnesses, and by extension, decreased internalized mental illness stigma. Similarly, the time period following an initial mental health diagnosis may have been a

related contributor to reduced internalized mental illness stigma; it is conceivable that those who have had a mental health diagnosis for longer periods of time may also feel less internalized stigma compared with individuals who more recently received their first mental health diagnosis. Future studies may benefit from assessing the time period following the first mental health diagnosis. Another explanation that may account for the lower levels of internalized mental illness stigma is the symptom severity within our sample. If participants were experiencing symptoms that weren't severe enough at the time of the study to warrant inpatient treatment, it is possible that they might have a less severe illness course, which may in turn be associated with a decreased likelihood of internalizing mental illness stigma. Future studies should account for both diagnosis and symptom severity in analyses of internalized mental illness stigma. Yet another explanation for the low endorsement of internalized mental illness stigma in our sample is the way that we measured it. It is possible that the four items used to embody self-stigma might not have adequately captured the construct for our outpatient sample. Black and Latino cultures also tend to place a greater emphasis on social roles, family, and extended social connections, and thus the role of public stigma may be an important factor to consider in evaluating the impact of internalized stigma on mental health outcomes (Brown et al., 2010).

### *Strengths*

This study draws from a number of strengths. One methodological strength is that we utilized two scales to assess both chronic and major lifetime events of racial discrimination, which affords insight into how both types of experiences are associated

with psychological distress. Additionally, we utilized a racially and ethnically diverse sample, which allows us to examine mental illness self-stigma in populations that have been noted in the literature to harbor heightened stigma regarding mental illness in comparison with Whites (Alvidrez, 1999; Conner et al., 2010; Eisenberg et al., 2009; Jimenez et al., 2013). Also, this study adds to the body of literature exploring mental illness stigma by utilizing a community sample as opposed to a psychiatric, inpatient sample which is likely to report more psychological distress, or a college student sample which is likely to report less psychological distress. Finally and importantly, our study considered the complexity of people's experiences by studying how both negative experiences associated with a concealable identity and a visible identity may interact to contribute to psychological distress. Future studies should continue to explore how multiple identities converge, and particularly how having multiple marginalized statuses may affect psychological, physical, and behavioral health outcomes.

### *Limitations*

This study also had several limitations. First, our research is cross-sectional, which doesn't allow us to draw conclusions about the causal relationships among our variables. Second, our relatively small sample size did not allow us to maximize our chances of finding significant differences that might truly exist. Future research would benefit from recruiting more racially and ethnically diverse participants, and thus having results which may be more reflective of subpopulation mean levels of these variables. Third, our four-item measure of internalized mental illness stigma might not have adequately captured the construct for our sample. Fourth, our study would have benefited from knowing the symptom severity of the specific diagnoses of our participants, which

would have allowed us to account for condition severity in our analyses. This information would be important for allowing us to draw conclusions about how experiences of racial discrimination might interact with more severe and debilitating diagnoses as well as less severe and debilitating diagnoses. Additionally, future studies may also benefit from understanding the level of insight that participants have concerning their mental illness, as insight could potentially moderate the relationship between internalized mental illness stigma and psychological distress.

### *Future Directions*

Future studies should continue to explore the psychological, behavioral, and physical health outcomes of experiencing multiple devalued statuses, taking into account a breadth of identities and factors, such socioeconomic status, gender, sexual orientation, gender expression, etc. Future research should also continue to examine the ways in which these marginalized statuses and experiences may create additive and multiplicative burdens on an individual's health status. With regard to racial discrimination, studies may benefit from using measures of racial microaggressions (Nadal, 2011; Torres-Harding, Andrade, & Romero Diaz, 2012), along with measures of day-to-day racial discrimination and lifetime racial discrimination, to specifically account for the impact of implicitly harbored racial prejudice on the part of the perpetrator and perhaps attributions of more ambiguous racial discrimination on the part of the subject; racial microaggressions may be more prevalent and common on average than experiences overt racial discrimination (Sue, et al., 2007). Regarding mental illness stigma internalization, future research should broaden the scope of study around both public and cultural stigma to consider the impact

of mental illness stigma and other cultural factors such as treatment experiences, cultural mistrust, and cultural coping. Studies measuring internalized mental illness status should aim to do so in diverse, non-inpatient populations.

### Conclusion

The goal of this study was to test for a multiplicative psychological health burden resulting from experiencing racial discrimination and internalizing one's mental illness status. We conducted this study using a community sample of Blacks and Latinos with a range of mental illnesses. Our study did not find support for a multiplicative impact on psychological distress. Results do reveal a significant association between experiencing day-to-day racial discrimination and psychological distress, and a near significant correlation between experiencing internalized mental illness stigma and psychological distress. Additional research is needed to examine the potential additive and multiplicative effects of multiple marginalized identities and experiences among diverse samples.

Tables

Table 1: Black and Latino Group Differences

<b>Variables</b>		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Day-to-Day Discrimination	Between Groups	0.06	1	0.06	0.093	0.761
	Within Groups	41.8	65	0.64		
	Total	41.8	66			
Lifetime Discrimination	Between Groups	0.12	1	0.12	0.04	0.85
	Within Groups	210.57	65	3.24		
	Total	210.69	66			
Stigma Internalization	Between Groups	2.86	1	2.86	1.13	0.29
	Within Groups	163.75	65	2.52		
	Total	166.6	66			
Psychological Distress	Between Groups	0.85	1	0.85	3.42	0.07
	Within Groups	15.63	65	0.24		
	Total	16.47	66			
Age	Between Groups	703.66	1	703.66	6.24	0.02
	Within Groups	7104.8	63	112.78		
	Total	7808.46	64			
Yearly Household Income	Between Groups	2.15	1	2.15	0.76	0.39
	Within Groups	183.64	65	2.83		
	Total	185.79	66			
Language	Between Groups	2.65	1	2.65	23.93	0
	Within Groups	7.2	65	0.11		
	Total	9.85	66			
Sex	Between Groups	0.04	1	0.04	0.19	0.66
	Within Groups	14.73	65	0.23		
	Total	14.78	66			
Education	Between Groups	6.53	1	6.53	1.41	0.24
	Within Groups	301.89	65	4.64		
	Total	308.42	66			

Table 2: Descriptive Statistics for Endorsed Mental Illness

<b>Mental Illness</b>	<b>Number</b>	<b>Percentage of Sample</b>
Major Depressive Disorder	27	40.3%
Anxiety Disorder	20	29.9%
Obsessive Compulsive Disorder	9	13.4%
Current or Previous Drug or Alcohol Addiction	19	28.4%
Eating Disorder	10	14.9%
Cutting or Self-Mutilation	5	7.5%
Personality Disorder	7	10.4%
Trauma Disorder	7	10.4%
Bipolar Disorder	18	26.9%
Schizophrenia	18	26.9%

Table 3: Descriptive Statistics for Continuous Variables

Variable	Mean	Range		Std. Dev.
		Min.	Max	
Psychological Distress	.32	-0.96	1.43	.50
Stigma Internalization	3.43	1.00	7.00	1.59
Day-to-Day Racial Discrimination	2.47	1.00	4.00	.80
Lifetime Racial Discrimination	1.75	0.00	11.00	1.79

*Higher numbers indicate greater endorsement*

Table 4: Correlations between Study Variables

<b>Variable</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
1. Language	--								
2. Age	.12	--							
3. Sex	-.24*	-.16	--						
4. Yearly Household Income	-.13	-.18	.17	--					
5. Education	.00	-.01	.19	.22	--				
6. Stigma Internalization	.07	-.08	-.29*	-.01	.06	--			
7. Day-to-Day Racial Discrimination	-.01	.06	-.17	-.04	-.10	.41**	--		
8. Lifetime Racial Discrimination	-.04	.07	-.29*	-.06	-.32**	.25*	.42**	--	
9. Psychological Distress	.32**	-.10	-.04	-.20	-.14	.22	.27*	.15	--

\*\*  $p \leq .01$

\*  $p \leq .05$

Table 5: Hierarchical Regression with Interaction Term: Predicting Psychological Distress

<b>Predictor</b>	<b>Step 1</b>	<b>Step 2</b>	<b>Step 3</b>	<b>Step 4</b>
	<b><math>\beta</math></b>	<b><math>\beta</math></b>	<b><math>\beta</math></b>	<b><math>\beta</math></b>
Language	.34**	.36**	.36**	.35**
Age	-.16	-.18	-.16	-.17
Sex	.09	.18	.19	.19
Yearly Household Income	-.18	-.19	-.19	-.19
Education	-.12	-.09	-.10	-.10
Day-to-Day Racial Discrimination (DDRD)		.32*	.29*	.29*
Lifetime Racial Discrimination		.05	.04	.04
Internalized Mental Illness Stigma			.08	.07
Internalization X DDRD				.02
<b>Change in R-square</b>	<b>.18</b>	<b>.11</b>	<b>.00</b>	<b>.00</b>
<b>Adjusted R-square</b>	<b>.11</b>	<b>.20</b>	<b>.19</b>	<b>.18</b>

\*\*  $p \leq .01$

\*  $p \leq .05$

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