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The Effect of Race and Gender in the Stigmatization of Mental Illness

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Race and Gender in the Stigmatization of Mental Illness

Abstract

Previous studies have shown that men and minorities are more likely to experience stigma for having mental illnesses (Dupont-Reyes et al., 2020). This study was conducted to determine whether there would be an impact of race and gender on internal and external mental illness stigma. The participants were 179 undergraduate students at a college that is majority white and female. It was hypothesized that men and minorities would experience more internal and external stigma than women and whites. The hypotheses were tested by having participants read a vignette of a mentally ill person whose race and gender were manipulated, and then complete measures on general external stigma, workplace stigma, and internalized stigma. A 2x3 Factorial ANOVA showed that men are more likely to experience external stigma in the workplace, whereas women are more likely to experience general external stigma, and report experiencing internal stigma. This external stigma imposed on mentally ill men and women can be damaging, and may contribute to internalized stigma.

Introduction

Race and gender impact the stigma associated with mental illness. External stigma includes the negative attitudes held towards the mentally ill, while internal stigma, or self-stigma, is the negative attitudes felt and internalized by the mentally ill (Corrigan & Watson, 2002). Previous studies show that men and people identifying as Black, Hispanic, or Latinx are more likely to experience internal and external stigma for having mental illnesses (Dupont-Reyes et al., 2020). Researchers postulate that the relationship between race and mental illness stigma is the result of visible immigrants not wanting to be labeled as both minorities and mentally ill (Berg et al., 2014). Despite their status as a dominant group in society, men are also stigmatized

specifically in the realm of mental illness (Seymour, 2018). This is because men are often stereotyped as being strong and unemotional, and receiving help for having a mental illness is inconsistent with these stereotypes (Moss-Racusin & Miller, 2016). The relationship between race and gender and the stigmatization of mental illness may also be the result of intergroup prejudices, as men, Blacks, and Latinx individuals are also more likely to stigmatize others within their racial and gender groups. The intersection of mental illness stigma, race, and gender has the potential to further stigmatize and restrict access to mental health resources, so it is important to know how these traits impact the stigmatization of mental illness (Conner et al. 2010). The existing literature is limited in that it does not focus on the intersection of race and gender on the stigmatization of mental illness, and largely explores *just* the relationship between race and mental illness, and *just* the relationship between gender and mental illness. The present research will explore the interaction between race, gender, and external and internal stigma.

Stigma

Goffman's *Stigma* (1963) is a seminal work that has been used to inform researchers about stigma for many decades. According to Goffman (1963), stigmatizing traits are those that deviate from the expectations of society, and repel those who abide by the rules of society. Stigma is a social construct, as it refers not to a physical thing, but the negative attitudes held towards certain groups of people (Brown et al., 2010). Stigmatizing traits can include physical deformities, mental disorders, imprisonment, addiction, alcoholism, unemployment, suicidal attempts, and the tribal stigma of race, nation, and religion (Goffman, 1963). Many of the traits Goffman considered stigmatizing, like addiction, alcoholism, and suicidal attempts, are also often the result of mental illness, making mental illness perhaps the most salient stigma. A discomfort exists between those with stigmatizing attributes and those without, impacting their

social interactions (Goffman, 1963). This discomfort stems from a miscommunication, and limits interactions between the stigmatized and others. Those without stigmatizing attributes either feel sympathy or discomfort around those with stigmas, while the stigmatized, who are more aware of these interactions, are cognizant of this sympathy, and feel equally uncomfortable (Goffman, 1963). The stigmatized grow used to the reactions of the rest of society, and learn to isolate themselves (Brown et al., 2010). They are met with either sympathy and compassion, or disgust and aversion, but either way, the stigmatized are treated as outsiders. Because interactions between the stigmatized and others are so limited, it is difficult to eradicate stigma and the negative attitudes associated with mental illness and other attributes like race and gender.

Stigma leads to isolation, prejudice, discrimination, and stereotyping. Stigmatization can take two forms: external and self-imposed, or internal. Misconceptions and miscommunication lead to external stigma (Waugh et al., 2017). External stigma is the negative attitudes, including prejudice, discrimination, and stereotying, held towards the mentally ill (Corrigan & Watson, 2002). Mentally ill people often internalize these negative attitudes, feeling bad about themselves as a result of negative public opinions about mental illness (Waugh et al., 2017). This results in self-imposed, or internal stigma, the negative attitudes felt and internalized by individuals with mental illness (Corrigan & Watson, 2002). Stereotypes and prejudices regarding the mentally ill are often gendered or racial. For example, men are characterized by gendered stereotypes as being strong, stoic, and unemotional, whereas women are characterized as being weak and dependent (Moss-Racusin & Miller, 2016). When women are mentally ill, they fulfill the typical female stereotypes of weakness, emotionality, and dependence, but when men are mentally ill, they violate the typical male stereotypes of stoicism and independence, and are met with more basklash. Additionally, due to racial stereotypes, minorities are labeled as

violent and unpredictable when they are mentally ill. This is supported by Wirth and Bodenhausen's (2009) findings that mentally ill men and minority groups are often characterized as violent, whereas mentally ill women are characterized as dependent or incompetent. These gendered and racial stereotypes further the stigma associated with mental illness. A major limitation in prior research on stigma is that it lacks a focus on intersectionality between race, gender, and the stigmatization of mental illness. The interaction of mental illness, gender, and race has the potential to perpetuate stereotypes, further stigma, and restrict access to mental health resources, so it is important to study how these traits impact the overall stigmatization of mental illness (Conner et al. 2010).

Race and Mental Illness Stigma

Race itself is stigmatizing (Goffman, 1963). In the United States, people are often stigmatized on the basis of race and culture (Brown et al., 2010). Black Americans experience unique stigma in the medical field, because in the 20th century and prior, they were portrayed as carrying diseases (Wailoo, 2006). This stigma, in addition to the racial stigma perpetuated by centuries of slavery and ongoing racism and racial struggle, adds to the mental illness stigma experienced by Black Americans. People who identify as Hispanic or Latinx also face stigma in the United States because they do not descend from European countries, despite often appearing white. They are often labeled as outsiders because they may speak Spanish or they may not look white. Oftentimes, people make implicit associations between being American and being white, leading people who identify as Hispanic to feel like outsiders in their own country (Sanchez et al., 2018). Additionally, miscommunication often leads to the external stigmatization of mental illness, so being bilingual or speaking Spanish may increase this stigma (Waugh et al., 2017). Previous studies show that racial minority populations are more likely to stigmatize mental

illness *and* experience stigma, and are less likely to seek out resources to treat mental illness (Garcia et al., 2011, Anglin, Link & Phelan, 2006, Budhwani & Dre, 2019). Racial minorities stigmatizing mental illness is important to study because this intergroup stigmatization may be the result of being stigmatized themselves by the majority population, not just within their cultural groups. Additionally, limited access to mental health resources is the result of stigma, so it is an indicator of mental illness stigma (Conner et al., 2010).

People who identify as Hispanic are more likely to experience stigma and discrimination than non-Hispanic whites in the United States. Many white Americans assume that Latinx or Hispanic individuals are not from America or do not speak English (Sanchez et al., 2018). This leads to microaggressions, prejudice, and discrimination, making people who identify as Hispanic feel like foreigners in their native country (Sanchez et al., 2018). Colorism, judging someone based on the color of their skin, is highly prevalent in the United States (Uzogara, 2018). Uzogara (2018) found that among Latinx American women, light-skinned women most resembling whites experienced less discrimination than darker skinned Latinx women. This is damaging to the mental health of Latinx and Hispanic individuals (Sanchez et al., 2018). Previous studies also show that people who identify as Hispanic are more likely than non-Hispanics to experience post-traumatic stress disorder because of discrimination (Sibrava et al., 2019). Previous literature is limited on the relationship between being Hispanic or Latinx and experiencing external stigma for mental illness, but research does suggest that being Hispanic or Latinx is linked with experiencing discrimination, so it is likely that having a mental illness may excaberbate this relationship between race and external mental illness stigma. Additionally, people who identify as Hispanic or Latinx are more likely to experience internal

stigma and have stigmatizing views towards mental illness which is linked with experiencing external stigma (Waugh et al., 2017).

Hispanic and Latinx populations are more likely to hold stigmatizing views towards mental illness, and are less likely to have access to mental health resources ("Findings on Mental Health Diseases," 2021). Lack of access to mental health resources is largely the result of mental illness stigma (Conner et al., 2010). Latinos have significantly less access to mental health resources when compared to non-Hispanic whites (Caplan, 2016). This is largely because of lack of health insurance, language barriers, and the lower socioeconomic status of some Latinx populations (Caplan, 2016). Additionally, cultural beliefs and religion act as barriers to seeking out resources for mental illness in Latinx and Hispanic populations. The belief that mental illness is a sign of weakness and a reluctance to disclose personal information outside of the family are common Latinx values that prevent them from receiving adequate care for mental illness (Caplan, 2016). In an 100 question survey administered to urban and rural Latinos, significantly fewer rural Latinos knew where to access mental health resources for depression compared to whites (Garcia et al., 2011). More urban Latinos agreed with the statement that "in my culture, seeing a mental health professional is crazy" than their white counterparts (Garcia et al., 2011). Fewer of these urban Latinos agreed that "in my culture, it is okay to seek help for depression" (Garcia et al., 2011). These results show that Latinx youth felt it was inappropriate to seek help for mental health issues in their culture. This indicates strong stigmatizing attitudes towards mental illness in Latinx cultures. The intergroup stigma in racial and ethnic minority groups may be the result of them being stigmatized by the entire population, not just within their cultural groups. Previous literature is limited on findings regarding the stigmatization of Latinx and Hispanic individuals with mental illness by other groups, but it is clear that prejudice

towards Latinx populations exists in the United States. It is important to know how and whether whites stigmatize Latinx and Hispanic individuals with mental illnesses because this stigma could further limit their access to mental health resources.

Black populations are also more likely to stigmatize mental illness. In a study where participants were randomly assigned to listen to a vignette in which a person had depression, schizophrenia, or a physical illness, significantly more Black respondents expressed that those with mental illness were more dangerous than white respondents (Anglin et al., 2006). The researchers collected results on participants' opinions and attitudes on the vignettes, as well as if they felt the individual in the vignette was violent and if they should be blamed or punished (Anglin et al., 2006). Black respondents also felt that those with mental illness were not to be blamed or punished for their actions, presenting conflicting findings (Anglin et al., 2006). Again, these intergroup prejudices toward mental illness may be the result of society as a whole stigmatizing racial minorities for having mental illnesses.

Black Americans are also more likely than whites to experience external stigma, and therefore less likely to have adequate health care as a result. Black patients in psychiatric facilities report experiencing microaggressions, dismissal of racial issues, and stereotyping from white supervisors (Constantine & Sue, 2007). The stereotyping included assumptions that Black patients were violent or unemotional (Constantine & Sue, 2007). In a qualitative study on the treatment of mentally ill patients of difference races, Black Americans reported being ignored by family and health care professionals, and experiencing discrimination and condescention (Holly et al., 2016). They also reported that their privacy and respect were often disregarded, and their intelligence was assumed to be low (Holly et al., 2016). Black adults are more likely to internalize this public stigma, and as a result, have less positive attitudes towards seeking help

for mental illness than white individuals (Conner et al., 2013). In a study that analyzed the physical and mental health of mentally ill patients of various races, perceived stigma was measured by asking participants if their health was better, the same, or worse than individuals of other races (Budhwani & Dre, 2019). The researchers found that the stigma associated with racial minorities causes patients to have not only poorer mental health, but also poorer physical health (Budhwani and Dre 2019). These results show that the stigmatization of mental illness is also a limitation to accessing mental health resources in Black communities. Minority populations experience greater stigmatizing attitudes towards mental illness and are also less likely to gain access to mental health resources.

These results are staggering, specifically because certain mental illnesses are more common in populations of color. Black Americans are three times more likely to have schizophrenia than their white counterparts (Bresnahan et al., 2007). In a study comparing racial groups experiencing symptoms of psychosis, Black Americans were more likely to have symptoms of schizophrenia than their white and Asian counterparts (Perlman et al,. 2016). Additionally, Hispanic individuals are also more likely to have symptoms of schizophrenia than whites (Chang et al., 2010). Despite the higher likelihood of people who identify as Black or Hispanic to have schizophrenia, they are still less likely to seek help for mental illnesses. In a comparison of visible immigrants (Black and Hispanic) to whites and white Norwegians, visible immigrants were more likely to experience psychosis (Berg et al. 2014). Berg et al. postulate that this is as a result of the stigmatizing attitudes visible immigrants face in comparison to whites. Black and Latinx individuals are also more likely than whites to experience post-traumatic stress disorder as a result of discrimination and prejudice (Sibrava et al., 2019). People who identify as Black or Hispanic, who are already labeled by their races, may not also

want to be labeled as mentally ill by seeking help. These stigmatizing attitudes that people who identify as Black or Hispanic face on the basis of their race alone may result in the stigmatization of mental illness. Black and Hispanic and Latinx populations likely need the *most* access to mental health resources, and as a result of stigma, are receiving the *least.*

Gender and Mental Illness

In addition to race, gender is also a stigmatizing trait in many institutions in our society. Generally, the stigma of gender impacts women more than men, in education, in the workplace, in the home, and in other areas of life. In the case of mental illness, men are stigmatized more than women (Schroeder et al., 2021) As of 2019, the rate of suicide was highest in middle aged white men, with men being 3.63 times more likely to commit suicide than women ("Suicide Statistics," 2019). Gender stereotypes present men as stoic, independent, strong, and unemotional, whereas women are displayed as kind, warm, and weak (Moss-Racusin & Miller, 2016). Research shows that men experience more backlash if they violate these gender stereotypes by admitting they have mental illnesses (Moss-Racusin & Miller, 2016). In a study analyzing the National Male and Female Health Policies in Australia, a researcher found that men are met with unique challenges regarding the intersection of race, sex, and gender (Seymour, 2018). It is a commonly held view that men lack interest in seeking out mental health resources because doing so may be considered weak, but this view is problematic because it blames men for their limitations in healthcare when it may in fact be the system itself failing men (Seymour, 2018). This is damaging to men, as it stigmatizes male mental healthcare and limits their access to mental health resources.

Men stigmatize mental illness at a higher rate than women. A study on adolescent views towards mental illness revealed that young men were more likely than young women to have

negative attitudes towards mental illness (Dupont-Reyes et al., 2020). Another study that assessed negative attitudes and social distance before and after a contact based educational program, found that men had higher stigmatizing attitudes in the pre and post-tests than women, and their opinions changed less in the post-test than women (Wong et al., 2018). Loch also found that in psychiatrist populations, men are more likely to hold negative attitudes towards mental illness (2012). A study about parents with mental illness found that men were also more likely to stigmatize others for mental illness (Lacey et al., 2014). Men not only stigmatize themselves for seeking out mental health resources, but they also stigmatize other men and women for it. It is possible that men stigmatize other men and women at higher rates because they experience more stigma for having mental illnesses.

Men experience stigma for mental illness at higher rates than women, and this limits their access to mental health resources. A study that compared perceived gendered mental illness in North Dakota found that men, specifically older men, experience more stigma for having mental illnesses than women (Schroeder et al., 2021). Additionally, in a study that compared college-aged men and women's willingness to disclose mental illness, researchers found that men experience greater stress due to public stigma and are therefore less likely to disclose having mental illnesses (Brown et al., 2018). Stigma, specifically internal stigma resulting from public stigma, is a barrier for men accessing mental health resources (Latalova et al., 2014). In a study on students' willingness to seek out psychological help, researchers discovered that female students have more positive attitudes toward seeking help than male students (Nam et al., 2010). The study that questioned an urban and rural Latinx community found that young Latina women were four times more likely to know where to find mental health resources than young Latino men (Garcia et al., 2011). These studies reveal that men are not only more likely than women to

stigmatize mental illness, but they are also less likely to seek out help for mental illness. There is little research on how the intersection of race and gender impacts mental illness stigma. This is important to research, as men and minorities already experience more stigma for mental illness than whites and women, and therefore men who are part of minority groups may experience *the most* stigma for having mental illnesses.

Present Research

The present research explored the impact of race and gender on internal and external stigma. The independent variables were race and gender, and the dependent variables were internal and external stigma. The study first asked participants to read a vignette regarding a mentally ill person, in which race and gender are manipulated. Participants then completed the Bogardus Social Distance Scale and the Workplace Social Distance Scale to measure desired social distance and external stigma (Gjedia & Barjami, 2017, Yoshii et al., 2014). Internal stigma was also measured using the Internalized Stigma for Mental Illness Scale (Tanabe et al., 2016).

Hypotheses

Based upon findings from previous studies, I hypothesized that participants would express more external stigma towards individuals described as African American or Hispanic than individuals described as whites. I also hypothesized that participants would have more external mental illness stigma towards males than the females. I hypothesized that participants would express *the most* external stigma towards individuals who are both male and Hispanic, or male and African American. I also hypothesized that minority populations and males would experience the most internal stigma.

Method

Participants

The participants in this study were undergraduate students the age of 18 or over who attend a small liberal arts University in Virginia. They were recruited using a schoolwide email. Psychology lab students also had a research assignment and were encouraged to complete student research studies. Some participants were from this psychology lab. There were 179 participants. The average age of participants was 19.5 years old (SD = 2.5). One hundred and sixteen participants were female, 56 participants were male, and 7 were gender non-conforming. Seventy-seven percent of participants were white, 11.7% were African American, 8.4% identified as other / mixed race, .6% were Asian American, 1.1% were Hawaiian / Pacific Islander, and 1.1% identified as Native American / Alaskan Native. 10.1% of participants were Hispanic or Latinx.

Experimental Conditions

The participants read one of six vignettes about Jordan, an individual who previously worked a full time job and had a good relationship with their family and community, but then began experiencing symptoms of psychosis (see Appendix A for full vignette). Jordan's gender and race were manipulated in the vignettes. The genders were male or female, and the races were white, African American, or Hispanic/Latinx, producing six vignettes total. This was a 2x3 factorial design. The vignettes were identical except for Jordan's race and gender. About an equal number of participants read each vignette.

Measures

Demographic Questions

Participants were first asked demographic questions about their age, gender, race, and ethnicity (refer to Appendix B for demographic questions and response options).

External Stigma

Bogardus Social Distance Scale.

The Bogardus Social Distance Scale is a 17 item scale that measures desired social distance and the stigma associated with mental illness (Gjedia & Barjami, 2017). It was measured on a 4-point Likert scale including very likely, likely, unlikely, and very unlikely. Very likely was coded as a 4, likely was coded as a 3, unlikely was coded as a 2, and very unlikely was coded as a 1, except for reverse-coded items. Three items were reverse-coded. A lower score indicated more desired social distance and more external stigma. I altered the original Bogardus Social Distance scale so that the questions specifically referenced Jordan. This included questions like: How likely would you be to marry Jordan? How likely would you be to decline to be seen in public with Jordan? (reverse coded). How likely would you be to take Jordan to be a guest at your church? (see Appendix C for full scale) (Gjedia & Barjami, 2017). The Cronbach's alpha was .91.

Workplace Social Distance Scale.

The Workplace Social Distance Scale is an 8 item scale that measures desired social distance and perceived workplace competence of the mentally ill (Yoshii et al., 2014). The scale includes the subscales of work relations, shallow relationships, and employment, but the total score was used to assess mental illness stigma in the workplace. All items are scored equally. It was measured on a 4-point Likert scale including strongly agree, agree, disagree, and strongly disagree. Strongly agree was coded as a 4, agree was coded as a 3, disagree was coded as a 2, and strongly disagree was coded as a 1, except for reverse-coded items. Two items were

reverse-coded.. A higher score indicated more desired social distance and more external stigma in the workplace. It included statements like: It would bother me to work next to a coworker with psychosis and I would not drive in a car with a coworker with psychosis (see Appendix D for full scale) (Yoshii et al. 2014). The Cronbach's alpha was .89.

Internalized Stigma

Lastly, the Internalized Stigma for Mental Illness Scale is a 29 item scale that measures internal or self-imposed stigma, and external stigma (Tanabe et al., 2016). There are five subscales: Alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. Alienation and social withdrawal measured internal stigma, whereas discrimination experience measured perceived external stigma. Stereotype endorsement measured the participants' external stigma. Stigma resistance items were reverse-coded. The items were scored on a 5-point Likert scale, including strongly agree, agree, disagree, strongly disagree, and not applicable. Strongly agree was coded as a 5, agree was coded as a 4, disagree was coded as a 3, strongly disagree was coded as a 2, and not applicable was coded as a 1. A higher score on the alienation (Cronbach's alpha = .963) and social withdrawal subscales (Cronbach's alpha = .929) indicated more internal stigma. A higher score on the discrimination experience subscale (Cronbach's alpha = .951) indicated more perceived external stigma. A higher score on the stereotype endorsement subscale (Cronbach's alpha = .811) indicated more participant external stigma. Once reverse-coded, a higher score on the stigma resistance subscale (Cronbach's alpha = .766) indicated less resistance to stigma. The scale included statements like: I feel out of place in the world because I have a mental illness, People ignore me or take me less seriously just because I have a mental illness, and People with mental illness cannot live a good,

rewarding life (see Appendix E for full scale) (Tanabe et al., 2016). The Cronbach's alpha was .91.

Procedure

All participants received a recruitment email and clicked on a link that brought them to the SurveyMonkey survey. On the survey, they first read a consent form and confirmed that they were the age of 18 or over. Next, they answered demographic questions about their age, preferred gender, and identified race. After this, they read one of the six vignettes about Jordan, in which the race and gender were manipulated. The vignette was followed by questions from the Bogardus Social Distance Scale, the Workplace Social Distance Scale, and the Internalized Stigma for Mental Illness Scale (Gjedia & Barjami, 2017, Yoshii et al., 2014, Tanabe et al., 2016). The participants from the psych lab clicked on a separate link not linked to their survey responses to provide their contact information in order to receive class credit. The duration of the survey was about 15 minutes.

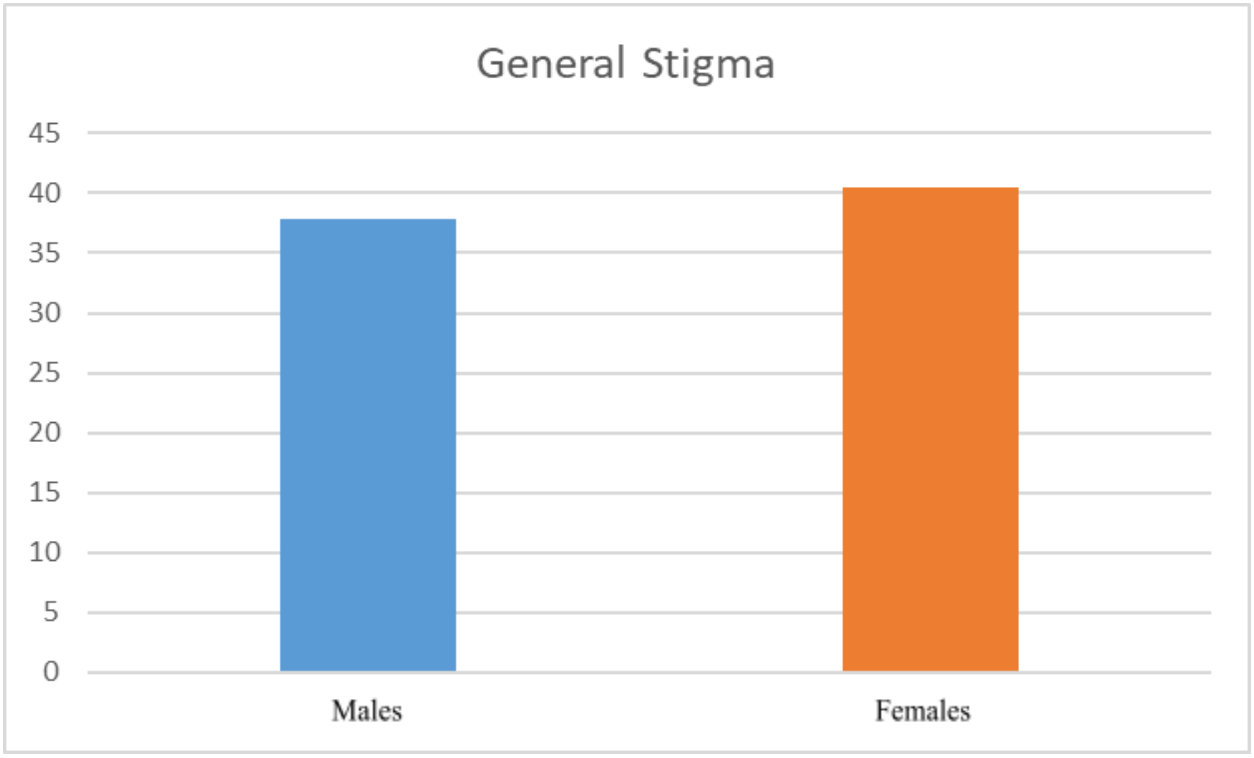
Results

General External Mental Illness Stigma

I hypothesized that participants would express more general external stigma towards mentally ill males than females, and more general external stigma towards mentally ill individuals described as African American or Hispanic than individuals described as white. A 2 (Gender) x 3 (Race) Factorial ANOVA was conducted to analyze the relationship between vignette gender, vignette race, and the stigmatization of mental illness for all hypotheses. There was not a significant main effect for race, F (2,168) = 1.491, p = .228. The participants with the African American vignette scored a mean of 40.1 (SD = 8.98), the participants with the Latino vignette scored a mean of 37.5 (SD = 8.75), and the participants with the white vignette scored a

mean of 39.8 (*SD* = 7.15) (see Table 1 for all means). Because general external mental illness stigma did not significantly differ for the vignette races, the hypothesis that participants would express more general stigma towards minority individuals was not supported. There was a significant main effect for gender, F (1,168) = 3.809, p = .053. The participants with a male vignette scored a mean of 37.8 (*SD* = 8.46), whereas the participants with a female vignette scored a mean of 40.5 (*SD* = 7.92). Because the genders significantly differed for general external mental illness stigma, but females scored higher than males, the hypothesis that participants would express more general stigma towards males than females can also not be supported.

Figure 1



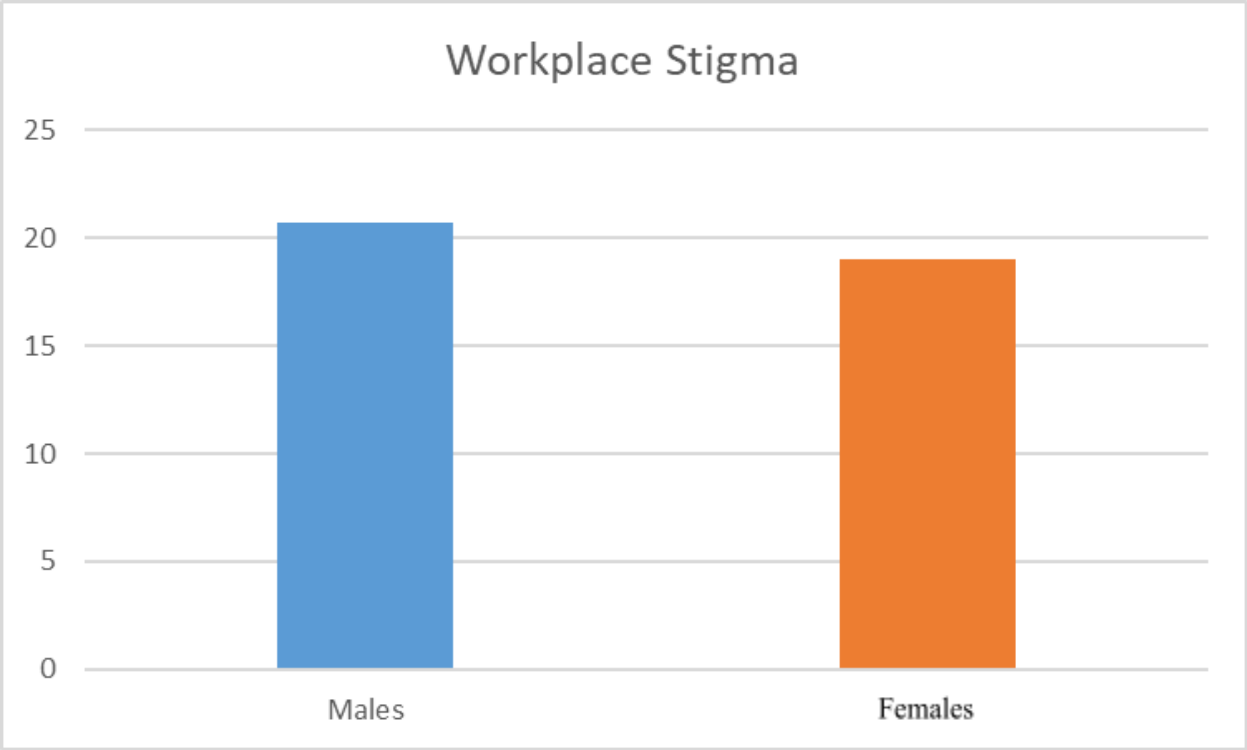
I also hypothesized that participants would express *the most* general external stigma towards individuals who are both male and Hispanic / Latino, or male and African American. There was

not a significant interaction between race and gender, F (1,168) = .191, p = .827. The participants with both male and Latino vignettes scored a mean of 36.53 (SD = 9.17) and the participants with both male and African American vignettes scored a mean of 39.08 (SD = 9.46), whereas the participants with white, male vignettes scored a mean of 37.79 (SD = 6.85). Because there was not a significant interaction between race and gender for general external mental illness stigma, the hypothesis that participants would express the most general stigma towards minority men cannot be supported.

Workplace Mental Illness Stigma

I also hypothesized that participants would have more workplace mental illness stigma towards African American and Hispanic vignettes than white vignettes, and more workplace mental illness stigma towards males than the females. There was not a main effect for race, F (2,172) = .619, p = .540. The participants with the African American vignette scored a mean of 19.5 (SD = 4.74), the participants with the Latino vignette scored a mean of 20.5 (SD = 5.29), and the participants with the white vignette scored a mean of 19.6 (SD = 4.25) (see Table 2 for all means). Because there was no significant difference between races for workplace mental illness stigma, the hypothesis that participants would express more external stigma towards minority individuals than whites cannot be supported. There was a significant main effect for gender, F (1,172) = 5.200, p = .024. The participants with the male vignette scored a mean of 20.7 (SD = 4.44), whereas the participants with the female vignette scored a mean of 19.0 (SD = 4.85) (see Figure 1). Because the genders significantly differed on workplace mental illness stigma, the hypothesis that participants would express more workplace stigma towards men than women is supported.

Figure 2

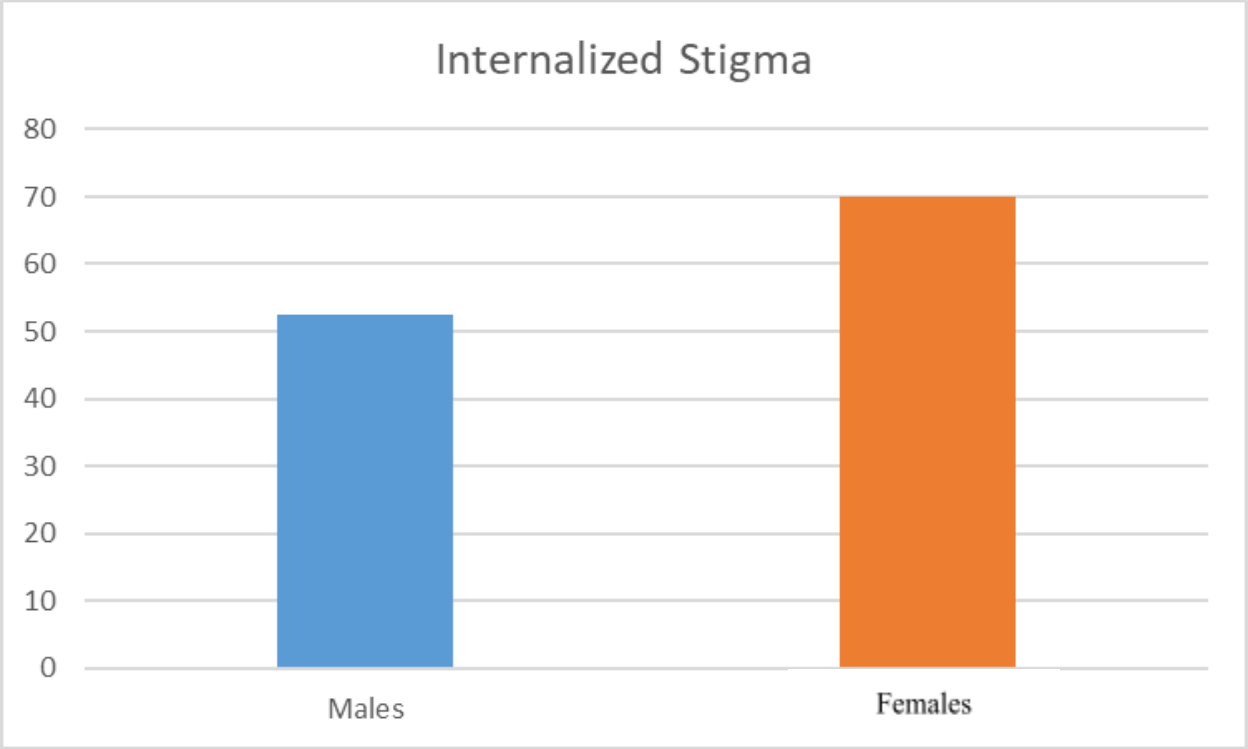


I also hypothesized that participants would express *the most* external stigma towards individuals who are both male and Hispanic / Latino, or male and African American. There was not a significant interaction between race and gender for workplace mental illness stigma, F (1,172) = .203, p = .816. The participants with the male, Latino vignette scored a mean of 21.19 (SD = 4.96), the participants with the male, African American vignette scored a mean of 20.11 (SD = 4.25), and the participants with male, white vignettes scored a mean of 20.90 (SD = 4.18). Because there was not a significant interaction between race and gender on workplace mental illness stigma, the hypothesis that participants would express the most workplace stigma towards mentally ill minority men cannot be supported.

Internalized Stigma

I also hypothesized that minority populations and males would experience the most internal stigma. A 2 (Gender) x 2 (Race) Factorial ANOVA was conducted to analyze the relationship between participant gender, participant race, and the internal stigmatization of mental illness. Races other than African American and white were not included due to the low number of participants for other races. There was a significant main effect for participant gender for internalized stigma, F (1,145) = 13.258, p = .001. The female participants scored a mean of 69.88 (SD = 23.90), whereas the males scored a mean of 52.50 (SD = 19.74) (see Table 3 for all means). Although there was a significant main effect, the hypothesis was not supported because female participants scored higher than male participants (see Figure 2). There was not a significant main effect for participant race on the Internalized Stigma for Mental Illness Scale F (1,145) = .058, p = .881. The African American participants scored a mean of 61.90 (SD = 26.85), whereas the white participants scored a mean of 64.67 (SD = 23.59). There was not a significant interaction between participant race and gender, F (1,145) = .485, p = .487. For internalized stigma, the mean for white males was 53.46 (SD = 20.73), and the mean for African American males was 48.33 (SD = 14.97). The white females scored a mean of 69.58 (SD = 23.19) on the ISMIS, whereas the African American females scored a mean of 72.08 (SD = 29.74). Because there was not a significant main effect for race, and there was no significant interaction between race and gender, the hypothesis minorities would experience the most internalized stigma was not supported.

Figure 3



Internalized Stigma Subscales

There was no official hypothesis regarding the relationship between the internalized stigma subscales and gender, however it was hypothesized that men would experience more internalized stigma than women. There was a significant main effect for gender on alienation, F (1,147) = 12.251, $p < .001$. For alienation, the mean for women was 16.14 (SD = 7.32), and the mean for men was 11.17 (SD = 6.21). There was also a significant main effect for gender on stereotyping, F (1,148) = 8.552, $p = .004$. For stereotyping, the mean for women was 15.16 (SD = 4.19), and the mean for men was 12.90 (SD = 3.89). There was also a significant main effect for gender on discrimination experience, F (1,148) = 13.052, $p < .001$. For discrimination experience, the mean for women was 11.5, (SD = 5.49), and the mean for men was 7.54 (SD =

3.67). Additionally, there was a significant main effect for gender on social withdrawal, F (1,148) = 12.413, $p < .001$. For social withdrawal, the mean for women was 14.93, (SD = 6.39), and the mean for men was 10.27 (SD = 4.73). Lastly, there was a significant main effect for gender on stigma resistance, F (1,146), $p = .027$. For stigma resistance, the mean for women was 12.49, (SD = 3.68), and the mean for men was 10.63 (SD = 3.39). There were significant main effects between gender and alienation, stereotyping, discrimination experience, social withdrawal, and stigma resistance, but they showed that women scored higher than men on all items, completely refuting the hypothesis that men would experience more internalized stigma.

Discussion

It was hypothesized that participants would express more stigma towards African American and Hispanic vignettes than white vignettes. Previous studies showing the presence of discrimination and colorism towards Latinx and Hispanic populations in the United States are consistent with this hypothesis (Sanchez et al., 2018, Uzogara, 2018). Additionally, studies showed that Blacks often experience microaggressions and stereotyping, leading to more stigma (Constantine & Sue, 2007). It was postulated that the presence of discrimination based on race would only increase the stigma felt towards mentally ill people of color. Despite previous data supporting this hypothesis, greater stigma towards mentally ill people of color than whites was not replicated in the present research. Bias and prejudice against mentally ill people was present in the participants' responses to the vignettes, but it did not differ based on race. It is possible that in the population sampled, there was simply less stigma held towards mentally ill people of color than in the general population. A different explanation could be that the Bogardus Social Distance Scale and the Workplace Social Distance scale simply did not measure external stigma

as well as how it was measured in previous studies. External stigma is a broad concept and using only a social distance scale may have limited the ability to measure it.

It was also hypothesized that participants would have more external stigma towards men than women. This is consistent with previous research showing that men experience more backlash if they violate the gender stereotypes of being strong and unemotional (Moss-Racusin & Miller, 2016). Women, conversely, are expected to be weak and emotional, and therefore would experience less stigma for being mentally ill (Moss-Racusin & Miller, 2016). In the present study, women experienced significantly more general external stigma than men. Although women experienced more general external stigma on this campus, there is no previous research to support this finding. Again, the Bogardus Social Distance scale may not be as effective in measuring general external stigma as well as how it was measured in previous studies. Men experienced more workplace stigma than women for being mentally ill. Gender-based stereotypes presenting men as unemotional may be amplified in a formal work setting, making this mental illness stigma more prominent for men. In general, mentally ill people are 3-7 times more likely to be unemployed, showing a strong stigma against mental illness in the workplace (Janssens et al., 2021). This stigma specifically impacts men. A study found that managers were less likely to hire individuals with alcohol addiction or violent tendencies, which are both identified as gender typical illnesses for men (Janssens et al., 2021, Wirth & Bodenhausen, 2009) Although more general external stigma was not found for males, more workplace stigma was, so the hypothesis is partially supported. A future study with more participants, and perhaps a different scale to measure general external stigma, may have yielded a different relationship between general mental illness stigma and gender.

Because of previous studies reflecting greater amounts of stigma towards mentally ill men and minorities, it was hypothesized that a mentally ill man who was also a minority would experience the most stigma. This hypothesis was based on the concept of intersectionality, but it was not supported by data in the present research. There was not a significant difference between external stigma expressed towards mentally ill African American or Hispanic men, compared to mentally ill white men. Perhaps participants in the sample simply did not hold more external stigma towards mentally ill men just because they were part of a minority, but this is doubtful, considering the stigma and prejudice minorities face. Another possible reason why people did not report more stigma towards minority men may have been because of social desirability. In the case of self-report measures, people often respond in a way that is socially desirable, not necessarily honest (Dahlgren et al., 2015). When it comes to race, individuals may misreport their actual opinions or preferences in order to avoid being seen as prejudiced (Krupnikov, 2016). This phenomena may be mitigated by anonymous surveying but not completely. Additionally, it may have helped if the vignettes showed a picture of Jordan. Future studies could include this in the vignette in order to make Jordan's race more salient in their minds.

Lastly, it was hypothesized that men and minorities would experience the most internal stigma for mental illness among participants. This hypothesis was based on a combination of previous literature, showing that men and minorities experience more external stigma, but also that internalized stigma is a direct result of external stigma (Waugh et al., 2017). The present research showed no significant differences between races on internalized stigma, meaning that the participants surveyed did not significantly differ on the amount of internal stigma they felt for having mental illnesses based on their races. This is likely a result of the limited diversity in the

present study. There was a significant difference between the genders on internalized stigma, but it actually refuted the hypothesis that men would experience more internal stigma for being mentally ill. Conversely, there was a significant relationship between being female and having higher levels of internal stigma. Those who expressed the most internal stigma were Black women though, showing that perhaps there is some influence of race on internalized stigma. The higher levels of internalized stigma in female populations is actually supported by previous literature. Men are more likely to stigmatize mental illness, whereas women are more likely to internalize this stigma (Lacey et al., 2014).

There were no specific hypotheses on how participants would score on the subscales of the ISMIS, but it was hypothesized that men would experience more internal stigma than women. This hypothesis was completely refuted by the results. Not only did women score higher on the ISMIS as a whole, but they also scored higher than men on every single subscale. Female participants reported feeling more alienation and discrimination than male participants, and felt the need to socially withdraw because of this. Women were also less likely to resist the stigma associated with mental illness. Women also endorsed more stereotypes about the mentally ill, showing that these stereotypes are ingrained in their consciousness. This shows that women on this campus are highly stigmatized for having mental illnesses, whether it be external or internalized. Despite previous research, men scored lower on the ISMIS. This could be because men are highly stigmatized for mental illness, and they may not want to report their mental illnesses as a result of this, but there are other explanations. It is possible that women, because they are stereotyped as weak and emotional, experience more stereotyping, prejudice, and discrimination for being mentally ill when their experiences align with these gendered stereotypes (Moss-Racusin & Miller, 2016). Additionally, despite the findings that men

experience more workplace stigma for having mental illnesses, they may not internalize the stigma they experience as much as women. Previous studies show that women internalize stigma more than men (Lacey et al., 2014).

There were several limitations to this study regarding research design and population sampled that could be improved in future studies. Because this study was unable to find a significant relationship between race and general external stigma, future studies could be improved by using different scales to measure general external stigma. The Bogardus Social Distance Scale is a time-honored scale, but it is also quite antiquated. This scale was first used in 1925, and was used nationally for the last time in 2005. For my study, it may be useful to use a more recent scale to measure general external stigma. It is also meant to measure desired social distance, not external stigma for mental illness. There are few scales that measure external mental illness stigma, but it would be useful to use one. Additionally, it may be helpful to include a picture of the vignette so that race is more salient in participants' minds when they read it. This could help in finding significant differences between races for external stigma. Another major limitation of this study was the sample size. A larger sample could be found at a larger University, and may yield more significant results. This study was conducted to determine whether specifically men and minority populations would experience more stigma, so having a more diverse, more heavily male population to sample from would also be very important for future research. Possible recruitment tactics could be recruiting male sports teams, IFC fraternities, multicultural societies, and historically Black sororities and fraternities to participate. This would create a far more diverse sample, and could yield more significant results regarding the impact of race on internalized mental illness stigma.

This study showed that there was more perceived stigma in the workplace for mentally ill men than women. Because men are already significantly less likely to talk about mental illness or reach out for or receive help for being mentally ill, this stigma can be very damaging (Brown et al., 2018, Garcia et al., 2011, Nam et al., 2010). Additionally, this stigma creates workplace discrimination for mentally ill men. Education programs about mental illness in the workplace could be used to mitigate some of this stigma, but it may continue to be a prevalent issue on this campus. This study also found that women are more likely to experience general external stigma, and far more likely than men to experience internal stigma for being mentally ill. This finding confirms prior research showing that external stigma and internal stigma are linked (Corrigan & Watson, 2002). Internalized stigma is damaging for self-esteem and often worsens mental illness, so this has negative implications for mentally ill female populations on this campus. Stigma also decreases access to mental health resources, like counseling and medication. Counseling center outreach programs for female students experiencing significant internal stigma could be helpful in the future. Overall, both men and women, regardless of race, seemed to be impacted by the stigma associated with mental illness, whether it be in the workplace or the general campus community. Future studies could replicate this study on other college campuses and learn more about the impact of race on mental illness stigma.

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Tables and Figures

Table 1

Bogardus Social Distance Scale Means

Gender Condition	Race Condition	Mean	Standard Deviation	N
Male	White	37.80	6.85	29
	African American	39.08	9.46	26
	Latino	36.54	9.17	26
	Total	37.80	8.47	81
Female	White	41.30	7.08	40
	African American	41.07	8.57	28
	Latino	38.40	8.37	25
	Total	40.45	7.92	93
Total	White	39.83	7.15	69
	African American	40.11	8.98	54
	Latino	37.45	8.75	51
	Total	39.22	8.26	174

Table 2

Workplace Social Distance Scale Means

Gender Condition	Race Condition	Mean	Standard Deviation	N
Male	White	20.90	4.18	30
	African American	20.11	4.25	27
	Latino	21.19	4.96	27
	Total	20.74	4.44	84
Female	White	18.68	4.09	40
	African American	18.89	5.18	28
	Latino	19.77	5.61	26
	Total	19.04	4.85	94
Total	White	19.63	4.25	70
	African American	19.49	4.74	55
	Latino	20.49	5.29	53
	Total	19.84	4.72	178

Table 3

Internalized Stigma for Mental Illness Scale Means

Gender 2	Race 2	Mean	Standard Deviation	N
Male	White	53.46	20.73	39
	African American	48.33	14.97	9
	Total	52.50	19.74	48
Female	White	69.58	23.19	89
	African American	72.08	29.74	12
	Total	69.88	23.90	101
Total	White	64.67	23.60	128
	African American	61.90	26.85	21
	Total	64.28	24.00	149

Appendix A - Vignette

Jordan is a divorced 28 year-old (black/white/Latino) man (woman) with two sons. (S)he goes to Catholic mass once a week and is moderately religious. (S)he graduated from a University and received his (her) Bachelor's of Science with highest honors. (S)he is considering applying for a Doctorate program at a reputable University. Up until recently, (s)he was working full time as a database engineer. (S)he was a great coworker and friend, as well as a member of his (her) homeowner's association and local bowling club. Previously, (s)he had never experienced any disturbances in his (her) mental health. (S)he was fired two weeks ago for disruptive and irregular behavior in the workplace, including yelling at coworkers, mumbling to himself (herself), and expressing paranoid thoughts about his (her) boss. His (her) relationship with his girlfriend (her boyfriend) has also taken a turn for the worst, as (s)he is fearful that (s)he is cheating on him (her) for no reason. (S)he has begun yelling at his (her) sons unpredictably for their grades, and how they are performing in soccer games. Lately, (s)he has been staying up late at night applying for jobs that (s)he has no qualifications for. Jordan also believes that their new neighbors across the street have been plotting to break into their home. His girlfriend (her boyfriend) is deeply concerned about him (her) and fears (s)he has had a psychotic episode and should go to a mental hospital.

Appendix B - Demographic Questions

“How old are you?”

“To which gender do you most identify?”

Options were male, female, transgender male, transgender male, or gender nonconforming.

“Are you of Hispanic, Latinx, or Spanish origin?”

“How would you describe yourself?”

The options were white or Caucasian, Black or African American, Asian or Asian American, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and Other for mixed race individuals.

Appendix C - Bogardus Social Distance Scale

1. How likely would you be to marry Jordan?
2. How willing would you be to have your brother or sister marry Jordan?
3. How willing would you be to have your son or daughter marry Jordan?
4. How likely would you be to have Jordan as a friend?
5. How likely would you be to have Jordan as a part of your social circle?
6. How likely would you be to have Jordan as merely an acquaintance?
7. How likely would you be to decline to speak to Jordan? (reverse coded)
8. How likely would you be to have Jordan as a guest at public dinners?
9. How likely would you be to decline to be seen in public with Jordan? (reverse coded)
10. How likely would you be to have Jordan as your guest at private dinners?
11. How likely would you be to entertain Jordan in your home?
12. How likely would you be to want to have Jordan's family live in your city block?
13. How likely would you be to want Jordan removed from your neighborhood? (reverse coded)
14. How likely would you be to take Jordan to be a guest at your church?
15. How likely would you be to have Jordan as your pastor, or religious guide?
16. How likely would you be to have Jordan as your teacher?
17. How likely would you be to want Jordan's children to attend school with your children?

Appendix D - Workplace Social Distance Scale

Work Relations

1. It would bother me to work next to a coworker with psychosis.
2. It is best not to associate with a coworker with psychosis.
3. Individuals with psychosis should not be allowed to train in the workplace.

Shallow Relationships

4. I would be against my secretary marrying a man / woman with psychosis.
5. I would not drive in a car with a coworker with psychosis.
6. It is wrong to shy away from a coworker with psychosis. (reverse coded)

Employment

7. I would rather not hire a person with psychosis.
8. If I needed a babysitter, I would be willing to hire a person with psychosis. (reverse coded)

Appendix E - Internalized Stigma for Social Distance Scale

Alienation

1. I feel out of place in the world because I have a mental illness.
2. I am embarrassed or ashamed because I have a mental illness.
3. I feel inferior to others who don't have a mental illness.
4. I am disappointed in myself for having a mental illness.
5. Having a mental illness has spoiled my life.
6. People without mental illness could not possibly understand me.

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Stereotype Endorsement:

1. Mentally ill people tend to be violent.
2. Mentally ill people shouldn't get married.
3. People with mental illness cannot live a good, rewarding life.
4. People can tell that I have mental illness from the way that I look.
5. Because I have a mental illness, I need others to make most decisions for me.
6. I can't contribute anything to society because I have a mental illness.
7. Stereotypes about the mentally ill apply to me.

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Discrimination Experience:

1. People discriminate against me because I have a mental illness.
2. People often patronize me, or treat me like a child, just because I have a mental illness.
3. People ignore me or take me less seriously just because I have a mental illness.
4. Nobody would be interested in getting close to me because I have a mental illness
5. Others think that I can't achieve much in life because I have a mental illness

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Social Withdrawal:

1. I avoid getting close to people who don't have a mental illness to avoid rejection.
2. I don't socialize as much as I used to because my mental illness might make me look or behave "weird."
3. I don't talk about myself much because I don't want to burden other with my mental illness.
4. Negative stereotypes about mental illness keep me isolated from the "normal" world.
5. Being around people who don't have a mental illness makes me feel out of place or inadequate.
6. I stay away from social situations in order to protect my family or friends from embarrassment.

Stigma Resistance (reverse-coded items)

1. People with mental illness make important contributions to society.
2. I feel comfortable being seen in public with an obviously mentally ill person.
3. Living with mental illness has made me a tough survivor.

4. In general, I am able to live my life the way I want to.
5. I can have a good, fulfilling life, despite my mental illness.