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# Mental Illness and Ethnic Identity and Their Relationship with Internalized Stigma Among Individuals Identifying as Latinx and Diagnosed with a Mental Illness

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# Mental Illness and Ethnic Identity and Their Relationship with Internalized Stigma Among Individuals Identifying as Latinx and Diagnosed with a Mental Illness

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This thesis has been presented to and accepted by the office of Graduate Studies, John Jay College of Criminal Justice in partial fulfillment of the requirements for the degree of Master of Arts in Forensic Psychology

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## Table of Contents

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## Abstract

Identity plays a key role in all matters regarding mental health, especially in experiences of stigma. Stigma, a term used to describe the processes of labeling and stereotyping of particular groups, has been shown to be a major contributor to mental health outcomes. Internalization of stigma, is an emotional and behavioral response that further affects an individual's functioning beyond the effects of a mental disorder. The relationship between stigma and certain identities, such as gender, have been clearly demonstrated in prior research. However, identity is a complex concept that varies in meaning between individuals. The significance of a particular identity relative to other identities within an individual, termed identity centrality (IC), is a concept that has been scarcely studied. This notion is generally defined as the extent that an identity is considered central and important to one's sense of self. Identity centrality has been shown to alter perception and has been studied as a moderating variable when measuring distress and behavior, in certain populations. This study aimed to identify the differences in levels of internalized stigma (IS) and identity centrality (IC) in a sample (N=191) of Latinx individuals diagnosed with a mental illness (MI). Participants were surveyed to determine centrality between two identities: ethnicity and experience of a MI. Participants who scored higher centrality in their ethnicity were placed in the "ethnicity" group and those with higher centrality in their experience with a MI were placed in the "MI" group. A t-test was performed to compare means between both groups in IS, identity regard, and self-esteem. The results show that the MI group scored higher levels of IS and lower levels of self-esteem when compared with the ethnicity group. Both groups show generally negative attitudes about their experience with an MI and positive attitudes about their ethnic identity.


*Keywords:* identity, centrality, mental illness, stigma, internalized stigma.

People with serious mental illness (SMI) are part of the most stigmatized communities globally (Pachankis et al., 2017). A serious mental illness is defined as disorders that have a substantial impact on functioning and most commonly include disorders with psychotic features (Ruggeri et al., 1998). Stigma is a term used to describe processes such as labeling, stereotyping, social rejection, and discrimination, that are aimed at particular individuals or groups of people (Yanos, 2018). There are many factors that contribute to why individuals are stigmatized. The labeling of those with an SMI as "mentally ill" remains a strong predictor of stigma. Furthermore, stigma has been found to be a multi-level phenomenon, operating on an intrapersonal, interpersonal, organizational, and structural level (Rao et al., 2019). The effects of stigma on the intrapersonal level specifically, are far reaching and profound. Individuals with an SMI who are stigmatized often times internalize the stigma, leading to more detrimental outcomes (Yanos, 2018). Hence, internalization of stigma is an emotional and behavioral response that further affects an individual's wellbeing and functioning (Yanos, p.91). This phenomenon occurs when an individual endorses the stigma that is placed upon the group to which the individual belongs (Corrigan, 2005).

The role of internalized stigma and its relationship to different marginalized identities has been researched intensely. A marginalized identity is an identity that is a part of a group that has been historically and systemically disenfranchised (Williams, 1998). Additionally, intersectionality- the combined effects of two or more identities- has become an important topic over the last decade and more studies are showing the importance of social identities and their impact on mental well-being. Amongst the most researched areas of identity and stigma are those relating to serious mental illness (SMI), race/ethnicity, sexual orientation, and certain medical diagnoses such as HIV/AIDS (Camacho, Kalichman, & Katner, 2020). It has been found that

unique patterns arise when analyzing attitudes toward mental illness in the context of race, ethnicity, and gender (DuPont-Reyes et al, 2020). This highlights the complex relationship between stigma and identity.

The relationship becomes increasingly complicated when investigating the structure and makeup of identity, and how this relates to internalized stigma. The notion that individuals, often times, have an identity that is central and more substantial to their sense of self than other relevant identities has been termed identity centrality (IC) (Cross, 1992). Identity centrality in the context of marginalized identities has been shown to correlate with overall wellbeing (Tuthill, 2021). Moreover, having a sense of the magnitude of an identity in an individual can provide extra utility in conceptualizing a client in treatment and other areas. The study of IC and its relationship to stigma can shed light on the differences between those who are highly sensitive to stigma and those who are less responsive to it effects. The current literature provides interesting findings on the relationship between internalized stigma, identity, and intersectionality.

**Stigma**

Before researchers began deeply exploring the notion of stigma, the general notion was that the effects of stigma were minor. Link et al. (1989) concisely summarized the way in which stigma can begin with labeling and end with life-changing effects. They proposed a modified labeling perspective which built upon an already existing labeling theory. The model proposed persons already develop an awareness of negative stereotypes about mental illness through the socialization process prior to being officially labeled. Once labeled, the individual internalizes societies' conceptions about mental illness. This leads to negative responses such as isolation or social withdrawal, which in turn leads to further consequences to self-esteem and other aspects of the individual's life. The result of this is that the individual becomes vulnerable to new

disorders or to recurring episodes of the existing disorder (Link et al., 1989). The significant results of this study reveal the myriad of variables that play some role in this complex relationship.

Jahn et al. (2020) aimed to study this complex relationship by analyzing the mediating factors between stigma and harm recovery outcomes. Their study aimed to evaluate the directionality of paths between experiences of stigma, internalized stigma, self-esteem, and self-efficacy on recovery. The sample (N=516) was recruited from mental health clinics or programs with male veterans making up over half of the sample. The study had multiple hypotheses that when illustrated, showed the pathways that lead from stigma to recovery. Their hypothesis predicted that internalized stigma, self-esteem, and self-efficacy would mediate the relationship between experiences of stigma and recovery, the relationship between stigma and perceived quality of life, and the relationship between stigma and social withdrawal. Using multiple survey measures to gauge these variables, the researchers conducted a regression-based model for assessing direct and indirect effects. They found a significant pathway in which internalized stigma was the first mediator, followed by self-efficacy and self-esteem. The outcomes of this study highlight the influence of internalized stigma on other elements of experience and recovery. However, a limitation of this study is that the sample consisted mostly of male veterans, which can have an impact on the generalizability of the results.

Similarly, a meta-analysis conducted by Del Rosal et al. (2021) aimed to look at the broad effects of internalized stigma. After analyzing 52 studies, they found that self-esteem, quality of life, hopeful feelings, and stigmatizing experiences, as well as clinical variables such as depressive symptoms, were strongly associated with internalized stigma. High levels of internalized stigma were associated with low personal recovery, low levels of quality of life, self-

esteem, personal functioning, and empowerment (Del Rosal et al., 2021). It is important to note that the effects of internalized stigma on these variables adds to the effects that these variables already produce on their own. These findings emphasize the adverse consequences of internalized stigma on subjective experience and well-being. Internalized stigma is a persistent variable that multiplies the effects of stigma and makes recovery all the more difficult. It has been shown that internalized stigma also influences the decision to seek help. Individuals who had attempted suicide or experienced depression reported strong internalized stigma and feelings of shame and guilt. These individuals were more likely to want to hide their behavior and report feelings of embarrassment (Carpiniello & Pinna, 2017).

**Internalized stigma and Identity Among Latinx Individuals**

Stigma and identity are two closely related constructs. Yanos et al. (2015) precisely defined internalized stigma in relation to identity as follows:

> The state in which a person with severe mental illness loses previously held or hoped for identities (self as student, self as worker, self as parent, and so on) and adopts stigmatizing views (self as dangerous, self as incompetent, and so on) (Abstract).

As previously stated, the roles of different identities and their relationship to internalized stigma have been given significant attention.

One example of a common central identity is race/ethnicity. What makes race/ethnicity an important identity is that it is often times tied to important experiences. Both racial and ethnic identities produce feelings of belonging and are strongly tied to behaviors and values (Phinney & Ong, 2007). The study, conducted with 5-year-old Mexican-origin children (N=182) examined the relationship between identity attitudes and functioning. Emphasizing that during this developmental period children start paying attention to visible racial differences, the researchers

hypothesized that children with greater positive attitudes about their racial identity would be associated with greater interactive play and greater observed cooperation with adults in the school setting. Fittingly, it found that positive ethnic-racial attitudes were associated with greater social functioning, whereas negative ethnic-racial attitudes predicted maladaptive social functioning (Williams et al., 2021). The findings of this study introduce the importance of positive attitudes towards one's identity and the profound effects toward overall well-being, even beginning in childhood. This study would benefit from expanding the measures of the social functioning variable to include behavior outside of the classroom. As discussed, although many independent identities have been shown to have a relationship with internalized stigma, less studies have focused on the intersectionality of identities and their effects on stigma experience.

As previously stated, intersectionality refers to the intersecting effects between several characteristics or identities. These can be race, gender, sexual orientation, and others (Seng et al, 2014). The study of intersectionality and its role in mental health becomes important when assessing whether different identities further alleviate or worsen the effects of stigma and recovery. Intersectionality research also sheds light on some of the less studied marginalized groups such as the Latin American or Asian population.

DuPont-Reyes et al. (2020) aimed to examine how mental illness stigma varies across race, ethnicity, and gender in young adolescents. Using a sample of adolescent Hispanic/Latino, non-Latino White, and non-Latino Black sixth graders (N=667), the researchers examined the independent effects of race/ethnicity and gender on stigma outcomes and also bivariate associations between intersectional groups. They found interesting and unique patterns when assessing attitudes toward mental illness. They found that adolescents belonging to ethnic minority groups were more likely to desire social distance from individuals with a mental illness

when compared to White adolescents. There were even differences within race and within gender, where Black males reported greater social distance when compared to Black females, Latina females and White adolescents. Although the effects of gender on mental health attitudes have been studied independent of race/ethnicity, and vice versa, this study provides a unique opportunity to discover the effects of multiple factors on one another and how this affects mental health attitudes (DuPont et al., 2020). The findings of this research also point to a different approach to treatment in which intersectionality enables more tailored techniques based on individual characteristics.

**Identity Centrality and Stigma**

Research conducted specifically on identity centrality and its relationship to stigma has been limited. The existing research shows mixed results on the effects of centrality on well-being (Tuthill, 2021) and ethnic centrality has been shown to be associated with perceived discrimination in ethnic minorities. Camacho, Allen, and Quinn (2019) explored the mediating effects of ethnic centrality and neighborhood ethnic composition on perceived discrimination in a sample (N=237) of Latinx students. The participants were measured for ethnic centrality using a three-item scale (Leach et al., 2008) containing statements such as “Being a member of my racial/ethnic group is an important part of how I see myself.” Five-digit zip codes of their U.S residence prior to attending college were provided by participants to assess neighborhood ethnic composition. To assess perceived discrimination, participants indicated the frequency of perceived ethnic discrimination and negative stereotypes they have experienced. The authors found that, not only was ethnic centrality positively correlated with perceived discrimination and neighborhood ethnic composition, they also found that neighborhood ethnic composition influenced perceived discrimination via its effect on ethnic centrality, even when accounting for

other demographic factors. The results of this study contribute to findings that support the concept of centrality being a strong mediator for different perceptions and experiences.

Similarly, a study conducted by Quinn et al. (2014) examined the effects of anticipated stigma and centrality on psychological distress for people with concealable stigmatized identities (CSI). The researchers defined centrality as the extent to which an identity is considered central and important to one's sense of self, and defined a CSI is defined as socially devalued identities that can be hidden from others. The CSI's this study explored were mental illness, substance abuse, experience of childhood abuse, experience of domestic violence, and experience of sexual assault. Noting that previous work on centrality of concealed identities was related to more distress, the study hypothesized that greater centrality of the CSIs predict greater reported distress (Quinn, 2014). The results revealed that the mental illness group had significantly higher centrality than the rest of the groups. They also found that although the mental illness and substance abuse groups had higher levels of anticipated stigma and internalization, the substance abuse group had the lowest level of identity centrality. The contradicting findings of this study echoes a need for more research on the effects of centrality. This study raises questions on whether centrality only affects certain groups or whether certain factors affect centrality.

Tuthill (2021) aimed to bridge the gap that exists between centrality and intersectionality. Noting the underrepresentation of sexual minorities in research, Tuthill examined the intersection of racial/ethnic and sexual identity centrality among sexual minorities of color. Tuthill also noted that previous work pointed to a complicated relationship between sexual identity centrality and psychological distress. Some studies show that higher levels of sexual identity centrality are associated with higher levels of psychological distress (Quinn & Chaudoir, 2009), whereas other studies show that higher centrality is associated with positive indicators of psychological well-

being (Shramko, Toomey, & Anhalt 2018). In his study, Tuthill found a unique association where the main effects of each type of centrality (sexual identity centrality and racial ethnic centrality) suggested a negative association with mental-wellbeing. However, the interaction effects from both centralities indicated a slight positive association for particular levels of racial/ethnic centrality. Tuthill concluded that perceiving both identities to be central is associated with better mental health. This finding highlights the complexity that can arise from intersectionality within marginalized identities. There is also a complexity that is seen in the levels of centrality and their effects on overall well-being.

**Summary and Current Study**

As mentioned in the studies discussed, the centrality of an identity can be associated with positive outcomes if the identity is held in a positive regard. However, high centrality of an identity that is perceived as negative, can have detrimental outcomes and can worsen mental wellbeing. Taking note of the scarcity of research on groups with multiple marginalized identities, the current study aims to analyze how variations in identity centrality in a sample of Latinx individuals diagnosed with a mental illness plays a role on internalized stigma. It was hypothesized that Latinx individuals that have higher centrality on their MI, as opposed to their race/ethnicity, would endorse greater internalized stigma of mental illness and lower self-esteem. Accordingly, it was hypothesized that individuals who have higher centrality on their race/ethnicity would endorse lower internalized mental illness stigma and higher self-esteem. We also hypothesized that individuals who hold negative attitudes about their central identity would endorse more internalized stigma than those who hold positive attitudes. It is anticipated that the current study will provide a clearer understanding in the field of stigma and identity centrality.

# Methods

## Participants

Participants (N=191) were recruited from the Prolific platform. Prolific is an online recruitment platform and allows for the administering of questionnaires through the website. The consent form and questionnaires were assembled using Qualtrics XM, a platform that allows for the designing and creating of questionnaires and surveys. Results from the completed questionnaires were also exported from Qualtrics for analyses. Screening of participants to fit the studies' requirements was carried out via Prolific, in which participants have their own account. Participants on this platform are free to participate in any study they qualify for in exchange for an incentive. Recruitment was based on whether the participant is an adult (18 years and older) and has been diagnosed with a mental illness (MI), or has experienced symptoms of an MI. Recruitment was targeted only to participants that identified as Latinx. In addition to the screening done through Prolific, participants were asked two additional questions, whether they identified as being Latinx and whether they had been diagnosed or had experienced symptoms of an MI, for more accurate screening. Those who answered "no" to either question were directed to the end of the survey and were excluded from the study. The study recruited 200 participants via prolific and nine participants were excluded due to not meetings the study's criteria. To participate in the study participants had to be literate (be able to read at 8$^{th}$ grade reading level) and English-speaking. An incentive of $2 was provided for participants that completed the study. The incentive was provided via the Prolific platform which identified individuals by their unique identification codes. The participants also read through a consent form and agreed to participate in the study. After agreeing to participate, a series of questionnaires were presented to the

participants. Demographic information, including self-reported diagnosis, was collected at the end of the survey for an accurate description of the sample.

## Measures

### *Centrality and Identity Attitude Variables*

The construct of centrality served as the independent variable. As stated previously, the centrality variable indicates which identity, ethnicity or MI, is more central to the participant and was measured by asking questions related to identity strength. Attitudes regarding one's identity (whether positive or negative) was used as a covariate that may help explain the effects of centrality on internalized stigma. The centrality and identity attitude variables were measured using items from one questionnaire, the Multidimensional Model of Black Identity (MMBI) (Sellers, 2013). This questionnaire was created to measure different aspects of Black identity using multiple subscales. For the purposes of this study, only two subscales from this questionnaire were used: the centrality items subscale and private regard items subscale. Wording on the items were slightly changed to reflect the variable of either "MI" or "ethnicity" instead of the original variable of Black racial identity that the questionnaire used. Due to the simplicity of the statements on the MMBI, changing of the wording to reflect other identities is not expected to greatly affect validity. The centrality scale consists of 8 items and the private regard scale consists of 6 items. On a 7-point scale of strongly disagree (1) to strongly agree (7), participants were asked to rank how strongly they agree with each item (e.g., "Overall, having a mental illness has very little to do with how I feel about myself", "I feel good about Latino(a) people"). As stated, the statements on the MMBI are not specific to any culture or race and are geared toward assessing centrality in an identity. The centrality and identity regard subscales showed good internal consistency, with Cronbach's alpha of .835 and .830, respectively.

### *Internalized Stigma*

Internalized stigma (IS) was the main dependent variable. The IS variable indicates the degree that a participant has internalized the stigma placed on individuals with an MI. The IS variable was measured by asking questions regarding different aspects of stigma. The questionnaire used was the 29-item version of Internalized Stigma of Mental Illness Inventory (ISMI). This questionnaire measures experiences of stigma using subscales that examine different aspects of stigma such as Alienation, Stereotype Endorsement, and others (Ritsher et al., 2003). The items included phrases that were ranked by the participant on a 4-point scale that indicated whether they strongly disagree (1) or strongly agree (4) (e.g., "I feel out of place in the world because I have a mental illness"). The ISMI showed excellent internal consistency (Cronbach's alpha of .918).

### *Self-esteem*

Self-esteem was measured using two separate questionnaires to assess further differences between both groups. The Collective Self-esteem (CSE) questionnaire consists of 16 statements (e.g., I am a worthy member of the social groups I belong to") and participants are asked to rate on a 7-point scale how strongly they agree with each statement. For this questionnaire, higher scores indicate higher self-esteem. The second questionnaire administered was the Rosenberg Self-esteem Scale (RSS). This questionnaire consists of 10 statements (e.g., "All in all, I am inclined to feel that I am a failure") and participants rated how strongly they agreed or disagreed on a 4-point scale (e.g., (1) strongly agree – (4) strongly disagree). For the RSS, higher scores indicate lower self-esteem. Both measures showed good to excellent internal consistency (Cronbach's alpha of .852 for the CSE, and .913 for the RSS)

### *Exploratory Questions*

To add further detail to our understanding of participants' identities, participants were also asked additional open-ended questions at the end of the survey. Participants were asked "Which of these two identities do you feel contributes most to your sense of self?" This question was specifically asked to assess differences between participants' scored identity and their self-reported identities. This question also served as a tie-breaker for participants that received identical scores for both identities in the centrality measure. Participants were also asked about their mental health diagnoses, and about additional identities that they feel contributes to their sense of self.

## Procedure

Participants were directed to the survey on Qualtrics through a link on Prolific. Participants completed the survey on their own time and in the setting of their choice. After electronically signing consent forms, participants were taken to the next screen which provided a document for them to read summarizing the purpose of the study and any possible risks. Sequentially, the participants then began to complete the questionnaires. The first questionnaire that was administered is the MMBI that measures centrality. The MMBI was administered two times for each participant. The first time, the questionnaire was worded to reflect and measure centrality for the MI identity. The second time, the questionnaire was worded to reflect the ethnicity identity. Essentially, each participant was measured for centrality in both identities. Participants then filled out the subscale of the MMBI that measures for attitude toward the identities. Lastly, participants filled out the ISMI, CSE, and RSS questionnaires. Measures from all questionnaires were numerically scored for each individual. Higher scores indicate higher centrality for that particular identity, and higher scores for the ISMI and CSE reflect higher

levels of IS and higher levels of self-esteem, respectively. For the RSS, higher scores indicate lower self-esteem.

## Statistical Analysis

For statistical analysis, IBM SPSS 28.0.1software was used. The questionnaires used in this study were numerically scored and all variables operate on an interval scale of measurement. Participants were placed in one of two independent groups: MI group or ethnicity group. Group placement was dependent on the scores that they received on the first questionnaire that measures the independent variable (identity centrality). Participants who scored higher in the MI identity variable than in the ethnicity identity variable were part of the MI identity group. Those who scored higher in the ethnicity identity measure were part of the ethnic identity group. The hypothesis being tested assumes that the group with higher identity centrality on their mental illness (MI group) will also have higher levels of internalized stigma. If the MI group scores higher on internalized stigma than the ethnicity group, the null hypothesis that there is no difference between the groups is rejected.

The main statistical procedure used was a t-test. The scores of the second questionnaire that measures the dependent variable (internalized stigma) were compared between the two independent identity groups. Scores from the identity attitude subscale and the self-esteem measurement were used as possible moderator/mediator variables. T-tests were also done with these variables comparing the scores from both groups. Drawing from the conclusions of the study conducted by Williams et al (2021) discussed earlier, it was predicted that lower scores in these measures can contribute to an explanation for why the null hypothesis was rejected.

## Results

The sample (*n*=183) was made up of 55% female participants (*n*=102), 36.6% male participants (*n*=67), and 7.7% non-binary/third gender participants (*n*=14) (Table 1). Some notable characteristics of this sample include education, with approximately 80% of participants (*n*=148) having completed some level of college, trade school, or higher. The majority of participants in the sample were also between the ages of 18-34 (*n*=150) and reported having income of $60,000 or lower (*n*=122). As can be seen in Table 1, the distribution of demographic characteristics (including gender and education) was similar across participants regardless of whether they identified with their MI or ethnicity. The primary identity factor was a result of each participant's scores on the MMBI scale that measured centrality between their MI and ethnicity identity. For each participant, scores for both identities were compared to determine the identity with higher centrality. Worth noting is that a majority of the sample (*n*=136) scored higher centrality in their ethnicity identity and only 25.7% (*n*=47) scored higher centrality in their MI identity in the MMBI scale. Self-reported identity refers to the identity that participants chose when asked which of the two identities contributed most to their sense of self. Although significantly different than the scored primary identity factor, the self-reported identity factor reflected a more proportionate distribution with 44% (*n*=81) stating that their MI is their primary identity and 56% (*n*=102) stating that their ethnicity is their primary identity. Demographic characteristics were not significantly different when comparing both groups.

Participants in the study were also asked about their diagnoses. Over 20% of participants reported 3 diagnoses or more, but only the first three diagnoses were coded. 37.2% of participants reported a depressive disorder as their first diagnosis and anxiety disorders followed second with approximately 20% reporting an anxiety disorder. 9.4% reported bipolar disorders as

their first diagnosis and 8.4% reported a neurodevelopmental disorder such as autism and/or ADHD (Attention-Deficit/Hyperactivity Disorder). Approximately 5% of participants reported a trauma and stressor-related disorder as their first diagnoses.

For second diagnoses, 8% of participants reported a neurodevelopmental disorder or a trauma and stressor-related disorder. Anxiety and depressive disorders were still the most common for second diagnoses with approximately 45% of participants combined. Other less common disorders included psychotic disorders, OCD and related disorders, eating disorders, and personality disorders. Findings on self-reported diagnoses suggest that the majority of the sample would not meet criteria for “serious mental illness”, which usually includes persons diagnosed with schizophrenia-spectrum and bipolar disorders.

**Table 1** *Characteristics of total sample and across primary identity*

| | | MI | Ethnicity | Full Sample |
|---|---|---|---|---|
| Gender | | | | |
| | Male | 15 (31.9%) | 52 (38.2%) | 67 (36.6%) |
| | Female | 28 (59.6%) | 74 (54.4%) | 102 (55.7%) |
| | Non-binary/Third gender | 4 (8.5%) | 10 (7.4%) | 14 (7.7%) |
| Race | | | | |
| | White | 27 (57.4%) | 86 (63.2%) | 113 (61.7%) |
| | Black or African American | 2 (4.3%) | 2 (1.5%) | 4 (2.2%) |
| | American Indian or Alaskan | 2 (4.3%) | 10 (7.4%) | 12 (6.6%) |
| | Other | 16 (34%) | 38 (27.9%) | 54 (29.5%) |
| Education | | | | |
| | Some high school, high school diploma, or GED | 10 (21.3%) | 25 (18.3%) | 35 (19.1%) |
| | Some college, no degree | 15 (31.9%) | 38 (27.9%) | 53 (29%) |
| | Trade/ technical/ vocational training | 3 (6.4%) | 6 (4.4%) | 9 (4.9%) |
| | Associate degree | 8 (17%) | 12 (8.8%) | 20 (10.9%) |
| | Bachelor's degree | 8 (17%) | 45 (33.1%) | 53 (29%) |
| | Master's degree/ Professional degree | 3 (6.4%) | 8 (5.9%) | 11 (6.0%) |
| | Doctorate degree | 0 (0.0%) | 2 (1.5%) | 2 (1.1%) |
| Age | | | | |
| | 18-24 years old | 21 (44.7%) | 50 (36.8%) | 71 (38.8%) |
| | 25-34 years old | 20 (42.6%) | 59 (43.4%) | 79 (43.2%) |
| | 35-44 years old | 5 (10.6%) | 18 (13.2%) | 23 (12.6%) |
| | 45-54 years old | 0 | 6 (4.4%) | 6 (3.3%) |
| | 55-64 years old | 1 (2.1%) | 3 (2.2%) | 4 (2.2%) |
| Income? | | | | |
| | Under $20,000 | 8 (17%) | 31 (22.8%) | 39 (21.3%) |
| | $20,001-$40,000 | 13 (27.7%) | 37 (27.2%) | 50 (27.3%) |
| | $40,001-$60,000 | 12 (25.5%) | 21 (15.4%) | 33 (18%) |
| | $60,001-$80,000 | 4 (8.5%) | 25 (18.4%) | 29 (15.8%) |
| | $80,001-$100,000 | 2 (4.3%) | 8 (5.9%) | 10 (5.5%) |
| | $100,001 or over | 8 (17%) | 14 (10.3%) | 22 (12%) |
| Primary identity | | | | |
| | MI | 47 (25.7%) | | 47 (25.7%) |
| | Ethnicity | | 136 (74.3%) | 136 (74.3%) |
| Self-reported identity | | | | |
| | MI | 42 (89.4%) | 39 (28.7%) | 81 (44.3%) |
| | Ethnicity | 5(10.6%) | 97 (71.3%) | 102 (55.7%) |

To test the stated hypothesis that participants with higher centrality in their MI would score higher levels of internalized stigma as well as lower self-esteem, a comparison of means was conducted to compare levels of internalized stigma, self-esteem, and ethnicity and MI attitude between the ethnicity and MI groups (Table 2). Consistent with what was hypothesized, the MI group produced means that are higher in overall internalized stigma (ISMI) when compared to the ethnicity group ($p<0.05$), indicating higher levels of internalized stigma (Table 3). For further clarification, the subscales of the ISMI (alienation, stereotype endorsement, discrimination, social withdrawal, and stigma resistance) were also compared for the two groups and the results indicated statistically significant differences for the subscales of alienation, discrimination, and social withdrawal. The results demonstrate the MI group having lower levels of self-esteem in both the Rosenberg self-esteem scale ($p<0.05$) and the collective self-esteem scale as compared to the ethnicity group (note that, for the Rosenberg Self-esteem Scale higher scores indicate lower self-esteem). The mean levels in ethnicity attitude for both groups are similar, indicating that both groups have a more positive attitude about their ethnicity ($p<0.05$). This direction is reversed when observing the mean levels in MI attitude between both groups. Both groups scored low mean levels suggesting more negative attitudes for MI identity in both groups (see Table 2).

Not shown in Table 2 are the results obtained for the comparison of means using the self-reported identities. The results show a similar outcome, with those self-reporting their mental illness as their primary identity scoring lower levels of internalized stigma and lower levels of self-esteem as compared to the self-reported ethnicity group. These results were also statistically significant ($p<0.05$).

As mentioned, participants were also given an open-ended question that asked about other identities, aside from MI and ethnicity, that contributed most to their sense of self. 30% of participants reported two or more identities but only the first two identities were coded for this study. Overall, approximately 20% of participants reported their gender as being the identity that contributes most to their sense of self. Approximately 14% reported ethnicity/race and approximately 13% reported their mental illness/physical disability as their main identities. Other mentioned identities included religion (≈10%), sexual orientation (≈10%), parenthood (≈9%), career/profession (≈5%), family (≈4%), age/generation (≈2%), and other (≈8%).

**Table 2** *Mean levels of ethnicity attitude, MI attitude, internalized stigma, and self-esteem across primary identity*

| Primary Identity | MI | | | Ethnicity | | | Total | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | N | Std. Deviation | Mean | N | Std. Deviation | Mean | N | Std. Deviation | F | Sig. |
| Ethnicity Attitude | 34.587 | 46 | 5.31487 | 36.6074 | 135 | 3.97398 | 36.0939 | 181 | 4.42681 | 7.401 | .007** |
| MI attitude | 19.8298 | 47 | 5.18073 | 19.0662 | 136 | 5.12684 | 19.2623 | 183 | 5.13735 | .771 | .381 |
| Levels of internalized stigma (ISMI) | 66.1778 | 45 | 13.87163 | 60.4419 | 129 | 13.74028 | 61.9253 | 174 | 13.96321 | 5.785 | .017** |
| Alienation subscale of the ISMI | 16.766 | 47 | 3.53377 | 15.0000 | 135 | 4.11405 | 15.456 | 182 | 4.03791 | 6.885 | .009** |
| Stereotype endorsement subscale of the ISMI | 12.1957 | 46 | 3.34411 | 11.3308 | 133 | 2.94063 | 11.5531 | 179 | 3.06323 | 2.751 | .099 |
| Discrimination subscale of the ISMI | 11.4043 | 47 | 3.80309 | 10.0000 | 136 | 3.31327 | 10.3607 | 183 | 3.48954 | 5.806 | .017** |
| Social withdrawal subscale of the ISMI | 15.6522 | 46 | 4.26988 | 13.7481 | 135 | 4.35842 | 14.232 | 181 | 4.40344 | 6.615 | .011** |
| Stigma resistance subscale of the ISMI | 10.5957 | 47 | 2.4905 | 10.3759 | 133 | 2.4912 | 10.4333 | 180 | 2.48594 | .270 | .604 |
| Rosenberg self-esteem scale | 27.5532 | 47 | 6.34449 | 24.8647 | 133 | 5.92731 | 25.5667 | 180 | 6.13635 | 6.886 | .009** |
| Collective self-esteem scale | 74.4318 | 44 | 14.67381 | 78.8168 | 131 | 12.41203 | 77.7143 | 175 | 13.11306 | 3.741 | .055** |

## Discussion

The current study aimed to provide a deeper understanding of identity, stigma, and the important intersection between the two. Every individual possesses multiple identities that contribute to a sense of self. The weight and significance of each of these identities may impact life outcomes and general well-being. As discussed, the difference in personal significance given to an identity when one has multiple identities is termed identity centrality. Exploring the impact of identity centrality can contribute to a better understanding of individuals' unique circumstances as well as provide a different lens with which to approach negative experiences. Stigma is a strong factor that contributes to or creates negative experiences for individuals diagnosed with a mental illness, and, as mentioned, this effect is worsened when the stigma is internalized.

It was hypothesized that Latinx individuals that have higher centrality on their MI would have experience greater internalized stigma of mental illness as well as lower self-esteem and those individuals who have higher centrality on their ethnicity will have experienced lower mental illness stigma and higher self-esteem. Because ethnicity and having a mental illness are generally influential factors in a person's life experience, the former usually being a source of pride and providing a sense of unity and the latter generally seen as undesirable and negative, the centrality of these identities were compared for their impact on levels of internalized stigma. All participants in the study were of Latinx ethnicity and all participants were diagnosed with a mental illness (MI). Findings clearly supported our hypotheses.

As shown, participants from both groups had an overall positive attitude about their Latinx ethnicity, but had an overall negative attitude about their mental illness experience. This difference can help explain the hypothesis that those with higher centrality in their mental illness

identity will experience higher levels of internalized stigma as compared to those with higher centrality in their ethnicity. The results also show lower levels of self-esteem for those in the MI group, further supporting the hypothesis. Although the CSE did not produce statistically significant results, this scale measured self-esteem in the collective sense rather than the personal sense. The difference in self-esteem between both groups can be explained by the scores produced in the identity regard scale.

In the United States, Latinx identity and mental illness are both subjected to negative and/or patronizing stereotypes. What is notable about the current study is that all participants possessed *both* identities, so what distinguished between them is how important they considered each identity to their self-definition. As stated, the sample overall viewed their mental illness experience negatively. When a stigmatized identity becomes central to a person's experience, they are more likely to experience its negative effects. This is further evidence of the detrimental consequences of stigma and society's labels on those that are diagnosed with a mental illness. The notable difference between mental illness and ethnicity as stigmatized identities is that ethnic identity has been shown to serve as a source of cultural pride and can provide a sense of community and belonging. As previously discussed, the opposite is true for those experiencing a mental illness, which can result in feelings of inferiority and rejection. This was further indicated by the generally negative attitudes participants had toward their MI experience and the generally positive attitudes about their ethnic identity. Further research can provide more clarity on how the severity and distinctiveness of stereotypes compare between stigmatized identities leading one to having more negative internalizing effects.

An important question which this study was not able to answer is why some participants with multiple identities primarily identify with one versus another. Participants in this study were

similar demographically, but they may have had different experiences with mental illness or its treatment that may have impacted their identity centrality.

**Limitations**

As demonstrated, identity centrality is a complex factor that can result in or exacerbate different life experiences. Attentiveness to this concept can assist in understanding the unique experiences of individuals experiencing a mental illness. In addition to the well-known difficulties of being diagnosed with a mental illness, stigma continues to be one of the strongest factors in overall negative outcomes. Understanding the factors that lead to or increase internalization of stigma is the first step toward helping reverse this negative affect.

An important limitation of this study is that it was cross-sectional, so definitive causal inferences cannot be drawn from the findings. Although all participants identified as having both mental illness and Latinx ethnicity, there may have been other, unmeasured, factors which explained the relationship between mental illness identity centrality and internalized stigma of mental illness.

Additional limitations of this study include the identities chosen and lack of a more rigorous centrality measure. The number of identities that could be studied is without limit. This study just focused on two. A more thorough analysis would require a closer look at a variety of identities and how the difference in centralities affect other experiences. Centrality is a scarcely studied concept which explains the lack of comprehensive measures for this variable.

Another limitation includes the recruitment and administration of the questionnaires via online platform. When administering questionnaires online, the accuracy and reliability of the responses can be compromised and difficult to control. Similarly, when recruiting participants, the goal was to recruit individuals who had experienced or been diagnosed with a serious mental

illness. Most of the participants reported disorders that would not be considered a serious mental illness by definition. Additionally, the sample sizes between the ethnicity group and the mental illness group using the scored primary identities were not identical.

Much research has been focused on the effects of internalized stigma on experience but future research should focus on the factors that enhance or lessen this internalization. Furthermore, research on the concept of identity centrality can provide other avenues for comprehension and knowledge.

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