CULTURE AND ETHNICITY IN MENTAL ILLNESS STIGMA: A LITERATURE REVIEW

A Foundation for the Promising Practices Program for Culturally-Effective Stigma Reduction

EDUARDO VEGA, M.A.
Executive Director, Mental Health Association of San Francisco Director; and Principal Investigator, The Center for Dignity, Recovery and Empowerment

LAWRENCE YANG, PH.D.
Co-Principal Investigator, The Center for Dignity, Recovery and Empowerment

VALERIE WAI-YEE JACKSON, M.P.H.
Research Consultant, The Center for Dignity, Recovery and Empowerment

October 2013
Sponsored by the California Mental Health Services Authority
The Center for Dignity, Recovery & Empowerment (the Dignity Recovery Center) is a project of the Mental Health Association of San Francisco (MHASF), in partnership with the National Consortium on Stigma, and the Columbia University Mailman School of Public Health. This project is funded by the California Mental Health Services Authority (CalMHSA), an organization of county governments working together to improve mental health outcomes for individuals, families, and communities. CalMHSA initiatives, including the Center for Dignity, Recovery & Empowerment, are funded by the voter-approved Mental Health Services Act (authorized by passage of Proposition 63 in November 2004).

The Dignity Recovery Center and its statewide partners are led and staffed by individuals of diverse cultural backgrounds with personal lived experience of mental illnesses or mental health conditions. This brilliantly prismatic diversity of expertise and experiences enables the center to simultaneously develop, evaluate, and improve its research, training, and communications programs.

Our mission is to advance and sustain human dignity and wellness by reducing biases and other undesirable attitudes about mental health conditions. We attain progress through development, evaluation, and dissemination of stigma reduction best practices that have proven to be effective in diverse communities. We firmly believe that advancement of the field of stigma change research and practice is to the benefit of all people.

For More Information
Visit The Center for Dignity, Recovery, & Empowerment at:
www.dignityandrecoverycenter.org
Primary objectives of the CalMHSA Promising Practices and Programs project (“Promising Practices” or PPP) include enhanced understanding of culture-specific barriers that stigma associated with mental illness poses to treatment and recovery. This will inform stigma-change interventions for underserved ethnic populations. In this report, we provide an overview regarding how the existing literature might help us understand mental illness stigma in four main ethnic groups in California (African American, Asian American/ Pacific Islander, Latino and Native American). This is the first known systematic attempt to review literature across multiple populations and to organize results by ethnic/cultural group with a focus on culturally-specific stigma-change interventions.

A review of stigma literature from 1990-present was conducted in PsycINFO, Medline, and Google Scholar, yielding 5,292 abstracts. Abstracts were reviewed for relevance to race, ethnicity, and culture, and full text sources were reviewed when relevant. Most stigma articles examined attitudes and conceptions towards mental illness among the public, as well as the internalized stigma experienced by people with mental illness in different cultural settings. Articles most frequently examined African Americans, followed by Latinos, and Asian/Pacific Islanders. A smaller subset of articles also examined stigma among Native Americans. From the international studies, the studies from “East and Southeast Asia”, “South Asia” and “Latin America” have relevance for such first-generation immigrant groups within California. The California Reducing Disparities Project’s (CRDP) population-specific reports were also reviewed to identify culturally-specific stigma interventions as recommended by California community agencies. Together, these sources inform how stigma occurs among these groups within California. Overall, mental illness stigma was found to be highly prevalent across these cultural communities as a whole and in comparison with Whites.

A main conclusion of the present study is that stigma researchers have primarily sought to empirically measure the levels of stigma that exist within different cultural groups, rather than to identify and describe practices among ethnic groups that might by themselves reduce stigma. This confirms that the focus of Promising Practices is highly innovative, has not been comprehensively examined within the existing stigma literature, and that any advances through this program have significant potential impact for the culture and stigma field. While the current trends within the stigma literature might inform our understanding of stigma in differing cultural groups, the PPP project itself presents tremendous opportunities to highlight the best in community practices and simultaneously strengthens and informs academic research in this important and emerging area.

ACKNOWLEDGEMENTS

The authors would like to thank the members of the Center for Dignity, Recovery and Empowerment for their input and feedback; in particular, Luba Botcheva, Ph.D., Daniel Esparza, and Monica Martinez. We are grateful to have received research support from research assistants at Columbia University; in particular, Shayla Cashwell, M.A., Jeanette Chong, Jenny Kim, Chak Wong, M.A., and Melinda Wong, M.A.
Mental illness stigma has been identified as one of the most important barriers to the recovery and social reintegration of persons with severe and chronic psychiatric disorders. The supplement to the Surgeon General’s Report on Mental Health highlights the need for research on stigma in ethnically diverse populations (1). Understanding culture-specific barriers that stigma poses to treatment and recovery will inform intervention guidelines for underserved populations. However, to date there has not been a comprehensive review or synthesis of how stigma manifests across diverse cultural groups. The present Review document addresses this gap through a comprehensive literature review on existing research of stigma in ethnic/cultural groups in North America and international populations. We also address findings from The California Reducing Disparities Project’s (CRDP) population-specific reports to identify new approaches to reducing mental health disparities as reported by California community agencies. This is the first known systematic attempt to review literature across multiple populations and to organize results by ethnic/cultural group with a focus on culturally-specific stigma-change interventions.

We intend this Review to be especially relevant and applicable to the people of California and its counties, in particular its major ethnic groups (African American, Asian American/Pacific Islander, Latino, and Native American). This review is presented as a core report with appendices to supplement the core report with further details. In the Introduction of this core report, we provide an overview of basic concepts and terminologies used in mental illness stigma, followed by an overview of the PPP project. We then describe our research methodology in the Methods section and present the findings from our literature review. In the Results section, we first describe cultural features of stigma for African Americans, Asian Pacific Islanders, Latinos, and Native Americans. Subsequently, we describe wellness and culturally-specific anti-stigma strategies. Finally, we provide a set of Conclusions, highlighting implications for PPP. Note that each of these sections compromise a core report summarizing findings, with additional details in Appendices A (Glossary of Terms), B (Extended Methods), and C (Extended Results). Appendices contain more comprehensive results and analyses than covered in the core literature review, and are provided as a supplement to the core report for those particularly interested in research findings.

MENTAL ILLNESS STIGMA

We present a brief overview of stigma here; see Appendix A for a glossary of terms with further explanation of stigma vocabulary. Stigma processes are often conceptualized in three ways: public stigma, self-stigma, and structural stigma. Public stigma is the process in which the general public stigmatizes individuals with mental illness. Public stigma consists of three components: Stereotypes, Prejudice, and Discrimination (2). Self-stigma (or internalized stigma) occurs when an individual takes the publically acknowledged or assumed beliefs of stereotypes and applies it him or herself. In addition to public and self-stigma, a third type of stigma is described as structural (institutional) stigma. Structural stigma is the stigma evidenced in societal structures such as laws, health care policy, treatment practices, and mental health funding (3). Structural stigma may occur through subtle forms of institutional practice, as well as systematic discrimination in employment due to preferential hiring practices (4).
PROMISING PRACTICES PROGRAM

OVERVIEW

The Promising Practices Program (PPP) is implemented by the Center for Dignity, Recovery and Empowerment at Mental Health Association of San Francisco, through contract partnership with the California Mental Health Services Authority (CalMHSA). The purpose of PPP is to increase knowledge of age appropriate and culturally-relevant effective and promising programs and practices that reduce stigma and discrimination. Due to California’s demographic diversity, one area where there is a need for research is in stigma and discrimination strategies for ethnic and cultural communities. To capture the wealth of innovation, expertise and experience in California, PPP aims to help build the evidence for promising practices and disseminate those that have been found to be effective.

RATIONALE AND GOALS OF THE LITERATURE REVIEW

To the best of our knowledge, a comprehensive review of mental illness stigma in ethnically diverse groups has not been done before. We aim to summarize these diverse experiences of stigma, as well as to find useful models in the literature for how PPPs work to reduce stigma in California among ethnically diverse groups. It is important to know where PPP falls within the scope of the literature, as this project attempts to advance stigma reduction in cultural groups in novel ways. This report summarizes the literature review and findings. It should be noted that while there are many more ethnic groups in California that those covered in this report, for the purposes of this literature review only the four major groups defined by the PPP project proposal will be reviewed in depth.

METHODS

A search and review of literature was conducted to identify culturally-focused research on mental illness stigma. A review of the literature from 1990-present was conducted in PsycINFO, Medline, and Google Scholar. Search terms were purposefully broad in order to capture papers including culture beyond being listed as a search term. Of the 5,292 abstracts reviewed, 541 were retained per our study criteria for full-text review. See Appendix B for greater detail on methodology. We also address findings from The California Reducing Disparities Project’s (CRDP) population-specific reports to identify new approaches to reducing mental health disparities as reported by California community agencies. For the purposes of The Center’s PPP literature review, the same ethnic/cultural groups as CRDP were used for broad reporting purposes (African American, Asian/Pacific Islander, Latino, and Native American). While CRDP produced an LGBTQ report, we did not review LGBTQ literature.

RESULTS

See Appendix C for greater detail on results as only salient points are presented below.

OVERVIEW

Results from the literature review are broken down into the four major ethnic/cultural group categories determined by the scope of the PPP project, and additional findings are presented on other cultural groups pertinent to California’s population (i.e., rural groups). In each section, we provide a summary of stigma findings in each ethnic/cultural group.

One of the drawbacks across the sources found for this literature review is that many do not address the heterogeneity of ethnic/cultural groups. For instance, many studies group Asian Americans into one large group, without noting their generational and immigrant status or whether participants are from China, India, or another country with distinct cultural beliefs.
Immigrant groups were often broadly grouped together in order to make generalizations that may not actually be useful for individual ethnic/cultural subgroups. Early attempts to make generalizations across groups may actually be detrimental to the understanding of stigma in culturally diverse groups, as they could easily lead to misrepresentation. We present findings as ethnically-specific as possible.

**AFRICAN AMERICANS**

The literature indicates a general pattern that African Americans endorse more mental illness stigma than do Whites. However, some studies suggest that African immigrants have less stigma, where some African immigrant subgroups (i.e., Afro-Caribbeans) are more likely to believe that recovery is possible. Few studies were conducted in African international contexts, which limits comparisons of public stigma between individuals living in Africa and African immigrants to the U.S. One notable finding concerning public stigma in African Americans was that mental health literacy and beliefs about effectiveness of treatment was associated with lower levels of stigma, suggesting the potential use of mental health literacy to reduce public stigma in this group. Another study indicated that some Christian churches may hold negative attitudes toward mental health treatment, which may require targeted outreach to most effectively reduce stigma. For African Americans with mental illness and their family members, research revealed that they generally experience high levels of self-stigma. Self-stigma in this group has been found to be associated with social isolation, loss of self-esteem, demoralization, and to constitute a significant barrier to mental health treatment. Because of the historical experience of racism and discrimination in African Americans, both structural discrimination and racial discrimination compound the negative effects of mental illness stigma in African Americans.

*Understanding culture-specific barriers that stigma poses to treatment and recovery will inform intervention guidelines for underserved populations*

**NATIVE AMERICAN**

No studies comparing mental illness stigma among Native Americans vs. Whites were found in our review. Given the lack of studies examining stigma in Native American groups, we recommend this as an area for future study. In terms of structural discrimination, the historic discrimination and oppression experienced by Native Americans is further manifested in lack of culturally appropriate care and generally limited resources for mental health services, especially in rural areas. Stigma experienced by Native American groups is related to how much traditional belief systems are lost and conversely related to how much Western health beliefs are adopted. That is, the loss of cultural beliefs is associated with more stigma in Native Americans. In terms of public stigma, levels of stigma may be lower in this group because interpretations of symptoms differ greatly in Native American populations. For example, those who hear voices, see visions, or speak to spirits are traditionally revered, even though they are behaviors associated with schizophrenia. In terms of self-stigma, a primary reason for avoiding formal mental health care among Native American adolescents was embarrassment and stigma, particularly because confidentiality was a concern in small isolated communities. In sum, while stigma appears to be a factor that constitutes a barrier to mental health services among Native Americans, much more empirical work is recommended to clarify how stigma operates in this group.
**ASIAN PACIFIC ISLANDER**

Asians and Asian Americans show consistently more mental illness stigma than do Whites across general community, college student, and multiple stakeholder group samples. Many studies take place internationally, which may be used to help understand stigma in recent immigrants. Recent Asian American immigrants may face structural discrimination in relation to language services, citizenship status, and access to health insurance. Public stigma among Asian and Asian American groups is elevated; however, they are more in favor of allocating resources to help consumers’ relatives. Notably, less acculturated Asian Americans endorse higher levels of social distance towards people with mental illness. One potential way to explain the higher levels of stigma among Chinese immigrants is that mental illness represents an increased threat to the lineage among Chinese vs. other groups. Measuring ‘what matters most’ may provide a conceptual framework to assess the culture-specific aspects of stigma both among Asian American and other cultural groups. Among many Asian international groups, stigma associated with the individual also spreads to family due to concerns of ‘face’ and the emphasis on family. Among Asian American groups, caregivers of individuals with mental illness who have face concerns tend to internalize mental illness stigma, which in turn is related to more psychological distress, subjective burden, and poorer quality of life. Chinese immigrant caregivers in particular have been found to be more secretive and withdrawn than caregivers in other ethnic groups. The use of indigenous labels such as “excessive thinking” is less stigmatizing. Helping consumers to find face-saving communication strategies—such as avoiding Western labels and framing experiences in terms familiar to consumers—is an approach that may reduce self-stigma in Asian Pacific Islanders.

**LATINO**

Few studies directly examine stigma comparing the level of stigma that Latinos endorse vs. Whites. This may be because there are fewer quantitative studies and a greater number of qualitative studies with in-depth examination of the processes concerning stigma in Latinos. Recent Latino immigrants may face structural discrimination in relation to language barriers, lack of culturally-appropriate care, citizenship status, and access to health insurance. Latinos often experience double stigma of racial discrimination in addition to the stigma of mental illness. Acculturation affects the stigma associated with mental illness in Latinos, with U.S.-born Latino immigrants endorsing less stigma than their internationally-born counterparts. Interestingly, beliefs in biomedical causes of depression are associated with decreased stigma in Latinos. Psychotherapy is less stigmatized since the cultural value of “unburdening oneself” is thought to be important to maintaining emotional health. However, among Latino immigrants, stigma appears to be strongest with respect to medications, both in fear of addiction and being called crazy (loco). Stigma emerges in derogatory perceptions of people with mental illness in some Latino immigrant communities, such as illegal drug user or weak (floja), useless (inútil), or small (chiquitita). Self-stigma is an important cause of medication non-compliance and is associated with treatment non-adherence in Latino immigrants. Having a trusting relationship with their provider has a positive effect on treatment participation among some Latinos, likely due to Latino relationship characteristics of trust (confianza) and sympathy/friendliness (simpatia). Family plays an important role in the recovery of many Latinos, and understanding stigma in family caregivers is important for removing barriers to care. Keeping the illness within the family and turning to church for support constitutes major ways of coping and reducing stigma for Latino immigrants. As there is a significant Latino population in California, consider reading detailed results in Appendix C for a more comprehensive review of stigma in Latinos. Further research in this area would particularly benefit California residents given the larger number of diverse Spanish-speaking populations.
RURAL GROUPS

Summaries for rural groups are presented below. Studies examining mental illness stigma in Middle Eastern and Arab Americans, former Soviet Union Americans, and Orthodox Jews are described in Appendix C. Only five articles were found specifically targeting mental illness stigma among rural groups, all demonstrating high levels of stigma. Two studies were conducted with ethnic groups in the U.S.; one examined stigma among rural African American adolescents (5) and another examined mental health views of Latino LGBT migrants in the U.S. (6), both showing significant mental illness stigma and problems with access to care. These studies might contribute to our understanding of stigma among African American and Latinos within rural communities in California. International comparisons were made, where stigma of depression in rural areas of India was lower than in rural areas in the U.S., with alternate explanations for symptoms and culturally-congruent treatments such as yoga (7). Rural consumers (8) and parents of rural children were also found to have significant mental illness stigma, which prevented them from bringing their children to mental health professionals (9). As a whole, rural groups have high levels of stigma, including structural barriers like trouble accessing culturally appropriate care and limited resources for mental health services.

WELLNESS AND CULTURE-SPECIFIC STIGMA INTERVENTIONS

Now that we have concluded reviewing features of stigma within each ethnic/cultural group, we describe emerging anti-stigma interventions that exist for each group. We first summarize suggestions from the CRDP reports. We then describe findings from our literature review with community programs focusing on holistic approaches to health, which might act as the basis for future PPP interventions.

AFRICAN AMERICAN

Findings from the CRDP report for African Americans note that African Americans have higher rates of mental illnesses than the general population in various statistics (e.g., diagnosis with psychiatric disorder, suicide attempt) (10). Although they make up the third highest number of mental health service consumers, less than 1% of California’s 2.2 million African Americans use California Department of Mental Health (CDMH) services. According to the CRDP report, cultural, financial, and social barriers prevent this group from seeking mental health services, with stigma acting as a significant contributing factor.

Acceptance by peers and at the community level appears key in reducing mental illness stigma in African American groups. One study within our literature review indicated that mental health condition-specific support groups may be helpful for low-income African American women in reducing stigma, such as a panic disorder peer-support group (11). At the family and community level, parents within the African American community fear that others might blame them for their child’s mental health challenges (5). This suggests parents and their informal supports should be incorporated into treatment efforts as collaborators, which might ease community stigma. Further, a report indicates that stigma of help-seeking is reduced among African Americans when friends or family members personally identified mental health sources as effective (12). These findings highlight the importance of building community resources to facilitate participation and acceptance.

Given the scarcity of spiritually-based interventions in psychiatry and the importance of religion among many African American groups, faith, prayer, and informal support from friends and family constitute preferred coping mechanisms that are central to reducing stigma (13). Religious
Acceptance by peers and at the community level appears key in reducing mental illness stigma in African American groups

based interventions may be especially helpful because religion permeates all aspects of life, and may in particular benefit those who lack other material resources (14). Further, the use of non-medicinal treatments (e.g. prayer and spiritual healing) may normalize mental health treatment and reduce stigma (15). African American clergy of underserved populations may serve as informal gatekeepers and ‘culture brokers’ to health services (16). However, not all African American churches necessarily endorse positive views towards mental illness. Explicit approval by clergy to disclose mental health conditions within the church may decrease feelings of self-stigma among those with mental health conditions. Such change might be facilitated when encouraged and supported within the context of the faith group. Of note, one important study found that a video-based contact intervention approach was successful in decreasing stigma levels in a African American community when conducted in the context of the church community (14). This demonstrates the importance of community acceptance, particularly acceptance by the church community, in reducing stigma among African American groups.

NATIVE AMERICAN

Findings from the CRDP report for Native Americans identify the central role of unintentional structural discrimination in allocating insufficient funding for mental health (36). Stigma is further associated with disconnection from culture and traditional values, misdiagnoses or labels associated with a severe mental illness, and lack of access to mental health services (which often also does not align with cultural needs and expectations). Also recommended by the report was a two-fold stigma reduction plan: a media component in the form of a poster contest promoting wellness, culture, and suicide prevention, and also addresses stigma; and a speaker component consisting of a series of community gatherings where guest speakers present on wellness and the strength of family and community.

Affiliation with cultural heritage among Native American groups appears key to promoting wellness and reducing stigma associated with mental health issues. Incorporating positive messages regarding cultural heritage to increase sense of self-worth among Native American adolescents and encouraging coping through traditional ways of seeking social support may be a culturally-appropriate way to decrease stigma (37). Stigma reduction interventions derived from within the community that taps traditional knowledge might be effective to the extent that they integrate cultural values of the Native American group, respect traditional practices, and reinforce cultural identity (38). Wellness is dependent on balance and harmony in inner and outer environments, and might be addressed by: 1) entering individuals’ worlds by listening to their stories; 2) creating a metaphor for the illness and 3) constructing a ceremony that becomes therapeutic for any mental health challenges (38). These healing processes may include prayer, water-clearing techniques, massages, and herbology (39).

Ritual Healing Meeting has great cultural salience in the Native American community and has been recognized as useful for reducing stigma among Native Americans with mental health challenges

We identify a specific PPP—a Ritual Healing Meeting—that has great cultural salience in the Native American community and has been recognized as useful for reducing stigma among Native Americans with mental health challenges. A Ritual Healing Meeting is an example of when a community-based intervention is merged with a meaning-centered intervention for a specific cultural group (40). Members of the community attend the ceremony, where prayers for healing
and strength are directed towards an individual, or to the group for continued health. Symbolic healing occurs through sharing of food, prayer, singing, and meditation. Fundamental to this approach as a PPP, a Ritual Healing Meeting is not just seen as remedial, but is also seen as preventative and growth-oriented. Any stigma associated with the ritual treatment is not apparent; in contrast, the person who actively seeks psychological harmony through ritual is valorized rather than stigmatized (40). Via this symbolic healing ritual, psychological distress is expressed, discharged, and transformed in a destigmatizing manner. See Appendix C for further details of the use of a Ritual Healing Meeting as an example of a promising practice for stigma reduction.

**ASIAN PACIFIC ISLANDER**

Findings from the CRDP report for Asian Americans show that factors such as cultural beliefs, acculturation, immigration history, language barrier, and unfamiliarity with the mental health service system all influence how mental illness stigma manifests among Asian Pacific Islander populations (17). Culturally competent services and clinicians should be provided to reduce mental illness stigma, as well as more outreach to counteract stigma.

Regarding public stigma and contact, some features of effective stigma reduction in Asia might be relevant to first generation immigrants. First, interpersonal contact for Chinese medical students worked to improve attitudes towards mental illness (18). Significantly, contact via video has effectively reduced stigma in Hong Kong student groups, although only when an education component preceded video-based contact (19). These studies provide culture-specific guidelines for anti-stigma intervention in these groups.

Innovative efforts to de-stigmatize contact with psychiatric services also have been undertaken in Asian Pacific Islander groups. Recent efforts in Hong Kong have been made to rename schizophrenia from its original, highly stigmatizing name (20). Further, promotion of treatment in traditional healing terms appears to de-stigmatize psychiatric treatment for Chinese consumers, such as using qi-gong (21) and framing treatment as righting imbalance of yin/yang (22). Among South Asian immigrants, prayer, traditional medicine and cultural healers are proposed to reduce stigma (23).

*Interventions that promote positive contact and dialogue among family members have shown positive and stigma-reducing effects*

Interventions that promote positive contact and dialogue among family members also have shown positive and stigma-reducing effects (24). In particular, addressing social functioning and family roles is proposed to help consumers and family members rebuild their social networks (25). Psychoeducation and mutual aid groups have enabled caregivers to share their concerns, and to reduce impacts of affiliate stigma and face concern (26). These discussions can potentially normalize caregivers’ experience and empower them to mobilize efforts against stigma. These discussions have been found effective in Chinese and Tamil immigrant clients and caregivers (27). This mutual support group format provided opportunities for family members to share real life narratives to relate experiences of burden and stigma.

Finally, wellness programs within Asian American communities that emphasize community development, cultural events, positive contact and dialogue with families, faith leaders, and youth groups provide models for future promising practices (24). For example, an art exhibition by people with mental illness in Japan resulted in 87% of community respondents endorsing positive impressions of the art, and “normalized” these individuals as “understandable” and decreased stigma by sharing in creativity (28). We also highlight one program for positive
youth development for Cambodian immigrant youth which draws upon the strengths, resiliency, and creativity of youth that might be useful for anti-stigma approaches (29). While not explicitly an anti-stigma program, this program identifies strategies of youth development for Cambodian American young women and emphasizes that story listening fosters youth development and community development. These young women join together to conduct workshops for each other and share stories of their struggles. This approach is adaptable to reduce stigma within other Asian American youth groups who might suffer from mental health challenges. These models of art and storytelling may constitute future PPP research and practice.

LATINO

Findings from the CRDP report for Latino Americans show that Latino culture and tradition greatly influences various forms of stigma associated with mental illness, such as cultural barriers to treatment and help-seeking, conceptions of masculinity, and acknowledgement of mental health condition (30). Existing anti-stigma strategies also aim to reduce individual and community stigma via traditional strategies such as psychoeducation, better mental health services and outreach, peer-support and mentoring programs, and anti-stigma campaigns. While support exists for Latino communities to reduce mental illness stigma, there has yet to be a comprehensive plan to do so.

CONCLUSION

We now draw conclusions about how mental illness stigma present among the four identified ethnic groups (African American, Asian American, Latino American, and Native Americans). When possible, we note when similar dynamics occur across these four ethnic groups, and then point out salient specific cultural features that may be of particular interest to clinicians, researchers, and policy-makers. In all areas, further research should be conducted to better understand the role of culture in stigma and stigma change. Throughout, we also note implications for the PPP approach.

1) To begin, our literature review indicates that there is currently an emphasis by stigma researchers on traditionally measuring stigma similar to the CRDP report, involving bilingual and culturally informed providers (promotoras/es, consejeras/es) to educate the community is a powerful way to reduce stigma associated with seeking mental health services (31). The involvement by community and family is reinforced by the finding that Hispanic families of individuals with mental health difficulties had much broader social networks and did not experience the ruptures with relatives and friends (32). Many of these Hispanic families’ social networks provide ongoing and significant support, thus decreasing stigma and social isolation. Community acceptance by close social networks appears to be key (33), indicating anti-stigma interventions within Latino American groups might be optimized by building on the strengths of pre-existing family and social networks.

In terms of deriving anti-stigma recommendations from wellness practices, traditional healing practices have widespread support among particular Latino groups (34). The most commonly found is in Mexican culture, and is termed curanderismo (35). Curanderismo is identified as a form of Hispanic folk medicine associated with spiritual healing and the maintenance of harmony and balance with nature. Incorporation of such a wellness practice with an anti-stigma intervention might further reduce mental illness stigma in culturally-syntonic ways by decreasing effects of mental illness labeling. Given the significant Latino population in California, consider reading detailed results in Appendix C.

Latino Americans show that Latino culture and tradition greatly influences various forms of stigma associated with mental illness
in the four identified cultural groups, and that
description of innovative outreach programs for
cultural groups were also quite few in number.
Our first conclusion thus is that the PPP project is
highly innovative, has not been examined in any
depth within the existing stigma literature, and
that the advances that we make in this project
promise to be very impactful for the culture and
stigma field.

2) Due to the varying amount of literature that
directly compares the level of stigma between
the four identified ethnic groups vs. Whites, it is
difficult to make general conclusions such as that
stigma among ‘non-White’ groups is higher than
‘White’ groups. Rather, these patterns appear to
vary, and are nuanced, by ethnic group.

- Attention should also be paid to specific ethnic
  subgroups within the larger ethnic category
  when characterizing stigma, because there
  are significant differences between these
groups.

- Potential mechanisms for explaining cultural
differences in stigma are scarce in the
empirical literature.

- Acculturation to U.S. culture appears to be a
  significant factor predicting decreased public
  stigma among Asian American and Latino
groups specifically.

3) While the amount of evidence varies in
each ethnic group, evidence exists within each
of the four identified ethnic groups that self-
stigma in consumers and their families appears
to have adverse psychological effects and to
negatively impact mental health treatment use
and adherence.

4) Our literature review identifies key features
of cultural groups that might promote stigma
reduction among the four identified ethnic
groups. One common feature is to activate and
promote close social networks in order to reduce
stigma towards help-seeking among people with
mental illness.

5) Initial evidence suggests that specific
cultural conditions among particular ethnic
groups might support the effects of contact-
based interventions. Stigma reduction occurs
through interactions between the public and
consumers (“contact”), particularly when the
consumer contradicts some of the public’s
stigmatizing beliefs.

6) When considering potential promising
practices among the four identified ethnic
groups, it should be noted that these groups
share alternative “relabeling” processes of
mental illness as a culturally-explained form
of distress. These cultural reinterpretations
of psychiatric distress typically take place
through an indigenous form of healing, which
through this re-interpretive lens, serves to
reduce stigma for both community members
and the person experiencing mental health
distress. The cultural reinterpretations differ
within each ethnic group. Examples include
religious-based interventions (e.g., prayer,
religious conversation, and spiritual healing)
for African Americans, traditional Chinese
medicine for Asian Americans, Curanderismo
(e.g., folk medicine associated with spiritual
healing and maintenance of harmony with
nature) for Latinos, and a Ritual Healing
Meeting among Native Americans. Avoidance
of psychiatric labeling, in conjunction with
providing culturally-congruent means
of healing that promote social support,
contribute to anti-stigmatizing effects.

- Wellness programs also offer key
  mechanisms by which PPPs might decrease
mental illness stigma within specific
cultural groups. Key features of these
wellness programs include: gathering of
individuals sharing a stigmatized status or
set of experiences, sharing stories of survival,
contact with empowered members of this
stigmatized group who share experiences
of personal growth, and use of cultural
stories or traditions to promote individual
development and community integration.
One common feature that may be shared by some types of PPPs and may account for their anti-stigmatizing effects are that these practices are not just seen as remedial in nature for treating an existing “problem” within an individual, but that these practices are also seen as preventative and growth-oriented in nature and further require community participation to enact. Because these practices promote individual growth and community involvement, the person who seeks this psychological harmony through such culturally-sanctioned rituals is honored or valorized, thus neutralizing stigma.

In sum, the literature demonstrates that, across multiple ethnic and cultural groups, mental illness stigma is significantly detrimental to the lives of people with mental health challenges. It should be noted that this review focuses primarily on four specific ethnic groups, and other cultural groups such as LGBTQ and rural groups may be reviewed in further details in future research. Additional research is necessary to better understand the role of culture in stigma and stigma change. The Promising Practices and Programs project will form a valuable means by which to highlight the best of community practice to strengthen and inform academic research in this important and novel area.

APPENDIX A: GLOSSARY

The following is a reference for terms as they are used throughout this report.

**Consumer:** those who receive or have received mental health services or have a mental health diagnosis.

**Dangerousness:** a stereotyped behavior that is often attributed to individuals with mental health challenges.

**Disclose:** to publicly or privately share having been diagnosed or received treatment for a psychiatric disorder; also known as “coming out” about a psychiatric history.

**Discrimination:** the negative behavioral reaction towards a person who has a mental illness. A discriminatory behavioral measure is social distance, which functions as a proxy measure for behavioral intent to discriminate against people with mental illness.

**Incompetence:** to the stereotyped perception that people with mental illness are unable to live independently or able hold anything except for the most menial job.

**Labeling:** an alternative to the word “diagnosed” when referring to psychiatric disorders. Labeling is more often used in research addressing stigma because of theories related to labeling that explore how people are perceived differently because of a certain “label”.

**Label avoidance:** when an individual decides to not seek services (such as psychiatric treatment or accommodations for a psychiatric disability) because of fear of the negative consequences of others tagging him or her as “mentally ill”.

**Prejudice:** the endorsement of a stereotype targeted at stigmatized groups.

**Public stigma:** the beliefs, attitudes, and discrimination by members of the general public towards individuals with mental illness.

**Self- (internalized) stigma:** when individuals who have been labeled with a psychiatric diagnosis internalize negative public attitudes and apply those negative attitudes to other mental health service users or to themselves.

**Stereotypes:** common negative beliefs or attitudes about people or groups of people, and these conceptions are generally based on myths or grossly exaggerated statements of facts.

**Social distance:** a desire to distance oneself from individuals with mental illness (e.g., not wanting to rent a room in your home to a person with mental illness).

**Structural (institutional) stigma:** larger institutional and sociocultural rules, laws, health care policies, treatment practices and mental health funding that intentionally or unintentionally discriminate against members of marginalized or oppressed groups.

**Unpredictability:** a stereotyped behavior, often used to describe the expected erratic behaviors of people with mental illnesses.