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The Impact of Higher Education, Ethnicity, & the Intersection of Both on Perceptions of People with Mental Illness

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The Impact of Higher Education, Ethnicity, & the Intersection of Both on
Perceptions of People with Mental Illness

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by

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Abstract

The purpose of this study was to explore how higher education and ethnicity may individually impact perceptions of people with mental illness, as well as to explore the intersection of higher education and ethnicity on such perceptions. Descriptive phenomenological in design, this study explores the experiences of ten students at a university in Portland, Oregon. In semi-structured, open-ended interviews participants recalled experiences in which higher education, ethnicity, and the intersection of both impacted how they thought about mental illness. Interview transcripts were coded and analyzed using Colaizzi's (1978) seven-step process. The analysis resulted in several themes supporting the current literature on higher education and ethnicity, including: *perspective shift towards acceptance*, *increased self-awareness*, and *cultural value of emotional restriction*. New themes were also discovered regarding the intersection of higher education and ethnicity, including: *difficulty accepting stigmatizing cultural beliefs*, *increased awareness of the role of family*, *no intersection*, and *clearer understanding of one's own culture*. Future research may expand on each theme uncovered in this study in greater depth to provide more insight into what specific mechanisms within each theme are influencing perception of mental illness.

 Keywords: mental illness, stigma, higher education, ethnicity, race, perception, attitudes

Table of Contents

Acknowledgements

The Impact of Higher Education and Ethnicity on Perceptions of Mental Illness

Approximately one in five adults in the United States experiences a mental illness in a given year, which equates to 43.8 million people or 18.5% of the population (National Alliance on Mental Illness, 2017). This statistic demonstrates that mental illness remains a prevalent issue in American society that affects a significant portion of the population. Thus, understanding factors that may influence the quality of life for people with mental illness is an important challenge.

Observer perception is one factor that may impact the quality of life for people with mental illness (Yuan et al., 2016). Perception is a mental impression that impacts how individuals see, understand, and interpret the outside world. Perception may influence acceptance and tolerance for people with mental illness (Yuan et al., 2016). Alternatively, perception may also influence stigma, which is defined as negative attitudes towards a group perceived as different from the observer (Stromwall, Holley, & Kondrat, 2012). Stigma has the potential to reduce the quality of life for individuals with mental illness due to both perceived and real discrimination. Researchers found mental illness related stigma may lead to a reduction in help-seeking behaviors or treatment and also may present additional barriers for seeking employment, obtaining housing, and receiving proper medical treatment (Corrigan, Druss, & Perlick, 2014; Corrigan, Watson, & Ottati, 2003; Stromwall et al. 2012). Based on these findings, societal perceptions may have an impact on the quality of life for people with mental illness. Thus, understanding what factors influence observer's perception of people with mental illness is important to help address implications of stigma and increase public acceptance of mental health issues and treatment.

Two factors that researchers have suggested may impact observers' perceptions of people with mental illness are the observers' experiences with higher education and their ethnicity (Abdullah & Brown, 2011; Arvaniti et al., 2009). Experience obtaining a higher education through a university or college has been shown to influence people's perceptions about mental illness in others (Arvaniti et al., 2009). Additionally, experience with the cultural values or norms associated with someone's ethnic group have also been shown to influence people's perception about mental illness in others (Abdullah & Brown, 2011). To date, no studies have assessed both of these factors simultaneously using qualitative methods. Thus, there is an opportunity to explore both of these variables, experience with higher education and ethnicity, in greater depth. This study, therefore, explores both the individual impact and the intersection of higher education and ethnicity to determine how they impact perceptions of people with mental illness.

Statement of the Problem

Current research on the impact of higher education on perceptions of people with mental illness is inconclusive. Numerous studies suggest that higher education is a factor that may influence perceptions of people with mental illness for the positive (Arvaniti et al., 2009; Barke, Nyarko, & Klecha, 2011; Yuan et al., 2016). Research on this topic, however, also suggests people with higher levels of education may be better at hiding negative attitudes or displaying more socially acceptable views (Mann & Himelein, 2008; Phelan, Bromet, & Link, 1998). Based on the discrepancy in research findings, an in-depth analysis on how formal higher education impacts perceptions of people with mental illness is necessary to add to the current literature and to uncover if higher education is

reducing stigmatizing attitudes or better equipping matriculates in masking unchanged attitudes.

A second variable shown to impact perceptions of people with mental illness is ethnicity. A trend in research findings suggests cultural beliefs within different ethnic groups may impact perception formation and often influences stigmatizing beliefs (Abdullah & Brown, 2011; Chen & Mak, 2008; Ward, Clark, & Heidrich, 2009). While research demonstrates ethnicity may influence perception, there is a lack of research on this topic in the ethnically diverse region of North America (Abdullah & Brown, 2011). The limited number of studies that have examined this topic in North America have found ethnic minority groups to articulate more stigmatizing attitudes than Americans of European heritage (Abdullah & Brown, 2011). Thus, while current research suggests ethnicity may impact perception formation about people with mental illness, there is currently a lack of research examining the impact of ethnicity on perception in populations within the United States.

Additionally, there is a lack of research on the intersection of formal higher education and ethnicity, and how these factors work together to impact perceptions of people with mental illness. Further research on this topic may illuminate the role of higher education in ethnicity-specific stigma.

Purpose and Significance of the Study

The purpose of this qualitative study was to explore how students' experience with higher education and ethnicity may have individually impacted their perceptions of people with mental illness, as well as to explore how the intersection of higher education and ethnicity may have impacted students' perceptions. By examining the influence of

ethnicity and higher education on perceptions, this study uncovered how higher education may influence ethnicity-specific perceptions of people with mental illness, as well as filled some of the gaps in the existing literature about the impact of both of these variables on perception.

As such, the present study contributes valuable insight to mental illness stigma research. Results from the study may help clarify factors that increase or reduce stigma in adults through an in-depth exploration of how participants' lived-experiences with both higher education and ethnicity impacted their perceptions of people with mental illness. Additionally, the majority of previous studies on these topics have utilized quantitative methods through surveying participants. Thus, studying both the intersection and individual impact of these variables utilizing a qualitative, phenomenological method allowed me to draw out participant-driven meaning from responses and clarify poorly understood aspects of the topics under study.

Further, a study of this nature has several practical implications: the findings from this study may be utilized to inform policy decisions to make higher education more accessible, influence how educators teach students about stigma and mental health; and increase people's self-awareness about ethnicity-specific bias that may be influencing attitudes towards people with mental illness.

Definitions of the Terms

Ethnicity: Differentiation of social groups on the basis of cultural criteria such as shared language, traditions, or religion. Represents a social identity based on one's ancestry, as modified by the culture where one currently resides (Kloos et al., 2012).

Ethnicity-specific biases: Negative attitudes or assumptions about people with mental illness attributed to cultural values or norms learned within an ethnic group.

Higher education: Indicated by any additional schooling beyond completion of high school/secondary school or the equivalent at the college or university level. This may include community and/or junior colleges in the literature, but only university level graduates were sampled in this study.

People with mental illness: People who have a real or perceived diagnosis of a mental health condition. This may range from a mild case of Anxiety with less obvious outward symptoms, to Schizophrenia with more apparent outward symptoms.

Perception: A way of regarding, understanding, or interpreting people with mental illnesses. This study looks at how perceptions may change or stay the same over time due to the impact of higher education and ethnicity.

Stigma: Negative attitudes towards a group perceived as different from the observer based on past experience (Stromwall, Holley, & Kondrat, 2012).

Research Questions

This study was designed to explore the individual impact of both higher educational experiences and ethnicity on perceptions of individuals with mental illness, as well as to explore how higher education and ethnicity interact to influence perceptions. This study will answer the following questions:

1.) How does higher education impact perceptions of people with mental illness?

2.) How does ethnicity impact perceptions of people with mental illness?

3.) How does the intersection of higher education and ethnicity influence

perceptions of people with mental illness?

Literature Review

This chapter presents the contextual information about mental illness and stigma that informed this study. An in-depth exploration of mental illness stigma from ancient history through today illuminates the etiological beliefs that may influence perceptions of people with mental illness and any resulting stigma. Exploring these topics may inform research on the individual impact of both higher educational experiences and ethnicity on perceptions of individuals with mental illness, as well as an examination of how higher education and ethnicity interact to influence perceptions. Past researchers have studied the impact of ethnicity and higher education as variables that may influence how individuals perceive others with a mental illness. While past studies have shown both ethnicity and higher education to have an impact on perceptions, there is little information about the intersection of higher education and ethnicity. In this study, I sought to provide descriptive clarity to both the individual impact and the intersection of ethnicity and higher education on perception. My goal was to illuminate how these variables may increase, reduce or have no effect on stigmatizing attitudes toward people with mental illness.

To provide relevant background context on the issue, the literature review will cover the current prevalence of mental illness in the United States to enlighten readers about the growing impact of this issue in the 21st century. As prevalence rates of mental illness increase, some societal attitudes towards those with mental illness have become more stigmatizing. To explore how mental illness stigma developed, the historical context of perceptions about mental illness is examined to depict how attitudes have shifted over the years and certain stigmas may have first formed. To offer contrast,

modern century attitudes and stigmas toward people with mental illness are also

examined.

Further, the literature review continues with a breakdown of relevant research on

the individual impact of higher education and ethnicity on perceptions of people with

mental illness, as well as offers a discussion about current gaps in research findings on

each topic. Additionally, the lack of research on the intersection of ethnicity and higher

education on perceptions is also examined to further validate the need for a unique

examination of these topics through my study.

The first four sections of this chapter explore both the historical background and

significance of perceptions about mental illness and stigma, as well as describe its current

prevalence in American society. The first four sections include: (a.) current prevalence &

impact of mental illness (b.) early historical perceptions of mental illness (c.) historical

development of stigma (d.) modern perceptions of mental illness. The last three sections

of this chapter draw awareness to the variables examined in the study, and acknowledge

current trends and gaps in the current literature. The last three sections include: (e.)

higher education (f.) ethnicity (g.) the intersection of higher education and ethnicity.

Current Prevalence & Impact of Mental Illness

Mental illness is a public health issue impacting both adults and children in the

United States. In 2016, 44.7 million adults (18.3% of all U.S adults) were estimated to be

living with a mental illness (National Institute of Mental Health (NIMH), 2017). In the

United States, 18.1% of adults experienced an anxiety disorder, 6.9% of adults

experienced at least one major depressive episode in the past year, 2.6% of adults lived

with bipolar disorder, and 1.1% of adults lived with schizophrenia (National Alliance on

Mental Illness (NAMI), 2017). Additionally, 20.2 million adults were reported to have

experienced addiction issues or a substance use disorder-- with 10.2 million of those

individuals experiencing a co-occurring mental illness (NAMI, 2017). While mental

illness continues to impact the lives of a significant percentage of adults in the U.S

population, mental illness may also impact children and young adults.

Mental illness issues among children and young adults are a significant public

health concern because of their potentially negative implications for child development,

early onset, and impact on family and community (Centers for Disease Control and

Prevention, 2013). Overall, young adults ages 18-25 demonstrated higher prevalence

rates for any mental illness (22.1%) than adults ages 26-49 (21.1%) and older adults ages

50 and over (14.5%). Additionally, young adults also showed higher prevalence rates for

serious mental illness that substantially interfered with one or more of their major life

activities (5.9%) compared to adults (5.3%) (NIMH, 2017). For children in the U.S, a

total of 13%–20% of the population under age 18 are reported to have experienced a

mental illness in a given year (Centers for Disease Control and Prevention, 2013).

Further, the median age of onset for symptoms of mental illness in children ranges

depending on the disorder-- from an onset of age six for anxiety disorders to an onset of

age fifteen for substance use disorders (Merikangas et al., 2010). While the majority of

children may not experience mental illness issues, the prevalence rates for certain mental

illnesses in children are increasing (Mental Health America, 2018).

Rates of children with severe depression were reported to have increased from

5.9% in 2012 to 8.2% in 2015 (Mental Health America, 2018). Increased rates of mental

illness in children may be associated with negative life outcomes (NAMI, 2017). For

example, 37% of students ages 14 and over with a mental health condition will drop out of school (NAMI, 2017). Further, 70% of youth involved in the juvenile justice systems are reported to have a mental illness (NAMI, 2017). Based on these findings, mental illness is a prevalent issue in American society that may impact the quality of life for both adults and children across a wide range of populations.

Further, adults and children with mental illness are at risk for additional physical and emotional setbacks. The Center for Disease Control and Prevention (2011) reported that mental illness caused more disability than any other category of illnesses in developed countries. These findings suggested that milder forms of mental illness such as anxiety and depression caused more of a population-level detriment to daily life than physical health conditions like cancer and heart disease due to the higher rates of mental illness (CDC, 2011).

Additionally, mental illness has contributed to higher monetary expenses for both individuals and society in the United States. The CDC (2011) estimated that mental illness cost America roughly $300 billion annually in 2002, which accounted for lost earnings and disability benefits. Additionally, Merikangas et al. (2010) found childhood mental illness to often be associated with unforeseen costs including: increased use of social services, increased use of special education, and increased entry into the criminal justice system. Further, medical costs for treating children with ADHD were estimated to cost $4306 annually per child as compared to approximately $1944 for a child without ADHD (Merikangas et al., 2010). Thus, individuals with mental illnesses may face more physical and emotional impairment and increased expenses than those who do not live with a mental illness.

As mental illness continues to be a public health issue for both adult and children in the United States, there is a growing need to understand any social factors that may impact quality of life for people with mental illness. Public perception has the potential to influence quality of life for people with mental illness by potentially persuading individual's behavior, viewpoints and actions towards people with mental illness. To illuminate how perception may influence attitudes towards people with mental illness, early historical perceptions about mental illness are explored.

Early Historical Perceptions of Mental Illness

Perception is a way of regarding, understanding, or interpreting something or someone in the outside world that may influence tolerance and acceptance or stigma and discrimination (Stromwall et al. 2012). Perceptions about people with mental illness are often influenced by fear of the unknown or behavior straying from societal norms (Farreras, 2018). To illustrate how public perceptions of mental illness have both shifted and remained similar over time, early historical perceptions are explored.

Mental illness is a concept that dates back to ancient history. Whether a behavior was considered abnormal or normal primarily depended on the context of the time period and the culture. Historically, there have been three main theories of the etiology of mental illness: supernatural, somotogenic, and psychogenic (Farreras, 2018). The earliest conceptions of mental illness were often attributed to a supernatural etiology. Thus, early causes of mental illness were thought to include: displeasing the gods, demonic possession by spirits, sinning, or a celestial event such as an eclipse. Upon examination of prehistoric skulls from as early as 6500 BC, examiners found surgical drilling into the skulls, known now as trephination (Faria, 2013). Restak (2000) states trephination of the

human skull was an ancient treatment method used to address head injuries, epilepsy, and as a method of releasing evil spirits inside the skull (as cited in Farreras, 2018). For most of ancient history, a supernatural etiology appears to have been the dominant perspective regarding mental illness. While some Greek and Egyptian cultures began to separate supernatural beliefs from mental illness and implement somotegenic treatment methods around 1900 BC, other early civilizations continued to be influenced by the supernatural etiology of mental illness throughout classical antiquity. Uncontrollable and abnormal behavior was attributed to demonic possession and treatment methods generally involved religious healing ceremonies and incantations (Farreras, 2018). Additionally, Hebrew cultures believed madness to be a punishment from God, thus treatment involved confessing sins and repenting (Farreras, 2018).

Further, natural disasters and economic turmoil during the late Middle Ages between the 11th and 15th centuries, further fueled supernatural theories of mental disorders in Europe. People interpreted the unusual events occurring around them as signs of the devil and superstitions influenced treatment of those deemed to be possessed (Farreras, 2018). During this time, people with mental illness were thought to be living illustrations of the frailty of humankind (Overton & Medina, 2008). Influenced by the Puritanical movement of the 16th century Protestant Reformation, individuals who were unable to control their desires or actions were assumed to be exhibiting a manifestation of evil within their human bodies referred to as madness (Robey-Hooper, 2015). Madness was also thought to cause melancholia and depression (Robey-Hooper, 2015). To resolve the symptoms of madness, treatment methods involved public whipping, touching religious relics, confessions, prayer rites and atonement (Farreras, 2018; Robey-Hooper,

2015). Additionally, people exhibiting symptoms of mental illness were often thought to be possessed and either jailed as criminals or persecuted as witches up until the 18th century (Farreras, 2018). During this period in history, fear often influenced public attitude towards mental illness. Public perceptions challenged the character of mentally ill people and often considered them weak or unable to control their impulses. Thus, there is evidence of early stigma; that is, supernatural etiological assumptions appear related to early societal responses to the mentally ill.

During the Renaissance era, physicians began to move toward a somotogenic etiology of mental illness. Doctors began to treat individuals who exhibited signs of mania or depressive symptoms with physical procedures (Robey-Hooper, 2015 as cited in Duff, 1993). During this time, attitudes about mental illness were no longer as influenced by superstition; however, physicians associated mental illness symptoms with deficiencies in the physical body. Many people adopted the perspective of Hippocrates and believed illness- both physical and mental- was a result of an excess of an imbalance of the four essential bodily fluids (Farreras, 2018). Treatment methods of this time often involved bloodletting (Robey-Hooper, 2015).

During the 16th and 17th century, a social stigma around mental illness is evident due to the increased separation of people with mental illness from the rest of society. At the time, all communities were required to have working citizens and those who were unable to work, could not live in the community (Robey-Hooper, 2015). A growing desire to separate the working from the non-working resulted, and the separation began to have a stigmatizing effect on people with mental illness. During this time, the government began to create confinement laws that were focused on protecting the

public from people with mental illness (Farreras, 2018). As such, people with mental illness were regarded in the same category of undesirables as the poor, the unemployed, the homeless, and criminals (Farreras, 2018). To keep undesirable members of the population separate, community hospitals and asylums were first created to house and confine people with mental illness.

The practice of confinement grew throughout the United States in the 18th and eventually became known as institutionalization. Most individuals were institutionalized against their will, lived in inadequate conditions, and were thought to have the mental ability of an animal (Farreras, 2018). People institutionalized for insanity were thought to be nonhuman: unable to control themselves, lacking sensitivity to pain or temperature, and capable of unprovoked violence (Farreras, 2018).

The 18th and 19th centuries saw the growth of a more humanistic view of people with mental illness. Practices within institutions improved and mental illness began to be known as a treatable condition. However, this separation of people with mental illness from the rest of the community had a distancing effect on society (Ernst, 2011, as cited in Robey-Hooper, 2015). Institutions provided a means for community members to avoid individuals with mental illness that they may have found unfavorable. Some researchers suggest the separation of people with mental illness from larger society directly contributed to the formation of a social stigma towards those in institutions (Ernst, 2011).

Today, while mental institutions may no longer be in existence, early institutionalization practices may continue to influence the way mental illness is perceived in the United States. During early institutionalization, some individuals developed negative attitudes towards the mentally ill by the visible distancing of the

public from the mentally ill. By creating distance, the human qualities of people with

mental illness became less apparent to the public and contributed to the stigmatization of

perceptions about mental illness. While institutionalization may have contributed to the

mainstreaming of stigma, stigma towards people with mental illness may have existed

prior to institutionalization.

Historical Development of Stigma

Researchers suggest mental illness stigma first developed as a result of

institutionalization practices adopted in the 16th and 17th century (Robey-Hooper, 2015;

Stuart, 2008). Stigma may have existed, however, prior to the medical model of mental

illness. To more clearly examine the role of stigma in current perceptions about people

with mental illness, a look into the historical development of stigmatizing attitudes is

necessary.

While the term, -stigma-, is thought to have first appeared during the 16th and 17th

century to reflect a mark of shame, mental illness was not clearly understood in early

history (Stuart, 2008). Fear and a lack of understanding contributed to society's desire to

"treat" mental illness and restore socially normative behavior. While stigma was not a

conscious concept during this time, ancient cultures first began to single out individuals

with mental illness-like symptoms as different from the rest of society. While there is no

evidence that mentally ill individuals were segregated into separate communities during

prehistoric times, -(-which occurred in later history as institutionalization)- common

treatment methods suggest abnormal behavior was not welcome in most ancient societies.

From trephination to remove the evil spirits in prehistory to jailing people exhibiting

symptoms of mental illness in the Middle Ages, treatment of mental illness involved

silencing the abnormal behavior in some manner. Thus, while not explicitly "mental illness" stigmatizing in nature, impressions of people with what we now know to be mental illness were often unfavorable in most early societies.

In contrast, some early societies in France and Belgium adopted more optimistic perspectives towards those with mental illness. The Gheel Colony of the Insane dates back to the 6th Century in Belgium (Van Walsum, 2004). Many mentally ill people travelled to Gheel believing they could experience a miracle and be healed from their symptoms. As a result, the residents of Gheel became accustomed to mentally ill people and developed skills in caring for them (Van Walsum, 2004). As such, mentally ill people who came to Gheel were housed and cared for by church officials. Ancient paintings from Gheel depict patients being cared for by nuns with no restraints. Additionally, there were no depictions of supernatural demons exiting the patients' bodies, which was a common depiction of the mentally ill in the 17th century (Van Walsum, 2004). Eventually, as Gheel moved away from church-based care, each mentally ill person was place with a family and encouraged to interact in all parts of their daily life. They were given freedom and not sent to the asylums like the majority of mentally ill people in other parts of the world during this time period.

Additionally, Goldin (1971) stated that the mentally ill people in Gheel were never referred to as "crazy," but rather, they were often called "our sick" (as cited in Van Walsum, 2004, p. 223). Thus historians agree that the people of Gheel approached mental illness in a fundamentally different manner than most other historic societies (Van Walsum, 2004). The uniquely tolerant attitudes of the people of Gheel are often attributed to the influence of Catholic hospitality and hospice care. Additionally, caring for the

mentally ill became a community tradition that was passed down over several

generations, which may have created a cultural norm of inclusivity for people with

mental illness (Van Walsum, 2004). Overall, the mentally ill people of Gheel appear to

have faired better than those confined to asylums in early history. The people of Gheel

treated the mentally ill with respect and dignity, as they would any member of their

society (Van Walsum, 2004). As such, the practices of caring for the mentally ill in Gheel

were long lasting and proved to be sustainable into the future, unlike the practice of

confinement in asylums, which no longer exist today.

Thus, we see examples of acceptance of mental illness evident in early history in

the society of Gheel (Van Walsum, 2004). We also see stigmatization of the mentally ill

in 16th century America through confinement practices in asylums (Farreras, 2018).

While many early societies cast out the mentally ill, other communities offered them the

freedom to heal without constraints. As modern perspectives shifted to a psychogenic

etiology of mental illness, both of these perspectives would influence modern perceptions

and treatment of people with mental illness.

Modern Perceptions of Mental Illness

Attitudes towards people with mental illness have shifted throughout history.

With modern psychiatry recognizing mental illness as both a medical and psychological

condition, there is arguably enough evidence to prove that mental illness is not caused by

demonic possession or witchcraft, as some believed in early history. Despite the modern

idea of mental illness as a treatable condition, perceptions towards people with mental

illness may continue to be influenced by stigma. To further explore how perceptions have

both changed and stayed the same regarding mental illness, modern perceptions of mental illness are explored below.

In the 20th century, a psychogenic etiology of mental illness emerged as the dominant medical perspective (Farreras, 2018). Health care professionals began to attribute the cause of mental illness to dysfunctions of the mind and brain, thus psychotherapy became a prominent treatment method. Today, in the 21st century, mental illness is rarely attributed to supernatural causes or a build up of bile in the body, and treatment plans do not involve physical harm or religious relics. In contrast to earlier centuries, the 20th century marked a time of deinstitutionalization of the mentally ill from asylums in favor of protecting human rights. With developments in modern psychiatric research, physicians, psychologists, and other mental health professionals are now better able to identify the cause of many mental illness symptoms and offer a diagnosis. As a result, mental illness diagnoses continue to rise in the United States and many individuals are able to find relief from symptoms through proper treatment.

While the ability to treat and diagnose mental illness has improved, stigmatizing public attitudes continue to persist. Researchers identified a "backbone" of public perception towards mental illness, which illuminates the primary factors that influence mental illness stigma for the majority of people (Pescosolido, Medina, Martin, & Long, 2013, p. 853). The backbone is threefold and influenced by the following attitudes: intimate settings such as the family, vulnerable groups, or self-harm cause a greater negative response from the public; the majority of individuals struggle to accept someone in a position of authority who has a mental illness; and the public often feels unsure about how to interact with an individual with a mental illness without inciting aggression

(Pescosolido et al., 2013). Thus, public attitudes appear to be most influenced by fear of unpredictable behavior, especially from individuals in positions of power or vulnerable populations.

Further, as seen in ancient societies, fear of unpredictable behavior may result in stigmatizing attitudes when perceptions are shaped by supernatural and moral etiology of mental illness (Farreras, 2018). Today, supernatural and moral etiological assumptions may continue to mediate the presence of stigma in some individuals. For instance, some Asian cultures believe the etiology of mental illness is personal failure, and thus moral etiological assumptions continue to influence their attitudes toward people with mental illness today (Chen & Mak, 2008). Further, stigma may also be underpinned by the current psychogenic etiological assumptions that associate behavior as dysfunctions of the mind and brain. Parcesepe & Cabassa (2013) found drug and alcohol dependence disorders to be most associated with fear of dangerous behavior in the U.S. This finding suggests that stigma towards dependence disorders may be influenced by current etiological assumptions about mental illness as a dysfunction of the mind, and thus the public may perceive drug and alcohol dependency issues as a weakness of the mind.

As such, stigma remains a prominent component of attitudes towards people with mental illness in American society. Stigmatizing attitudes become problematic if they create barriers for people with mental illness and/or reduce treatment-seeking behaviors. While there is difficulty in pinpointing exactly what causes stigmatizing attitudes in each person, examining factors that reinforce or challenge current etiological assumptions in certain groups may offer insight into why stigma continues to exist today. Next, one factor that may influence etiological beliefs about mental illness, higher education, is

explored.

Higher Education

One variable that researchers suggest may impact societal perception of people with mental illness is higher education (Arvaniti et al., 2009; Barke et al., 2011; Yuan et al., 2016). A trend among research findings suggests experience with higher education is associated with more positive perceptions of people with mental illness, and lower levels of education (high school/secondary school and below or the equivalent) are associated with more negative perceptions of people with mental illness. (Arvaniti et al., 2009; Barke et al., 2011; Yuan et al., 2016). A study in Singapore using the Attitudes towards Mental Illness scale (AMI) found people with an education level of secondary school or below to be consistently associated with more negative attitudes towards people with mental illness on all four factors of the AMI. The AMI scale measures four factors of public attitude including fear and exclusion of people with mental illness, tolerance of mental illness, integration with people with mental illness in the community, and causes of mental illness (Yuan et al., 2016). Thus, these findings suggest people with lower levels of education are more likely to fear people with mental illness and their integration into society based on a lack of knowledge about the cause of their disorder. Additionally, Yuan et al., (2016) found those who had experience with higher education to be more positively associated with accepting attitudes towards people with mental illness including tolerance for community care of people with mental illnesses. Other researchers have reported similar findings.

Barke et al. (2011) reported a higher level of education to be associated with more positive attitude characteristics including lower levels of social discrimination, restriction

and less authoritarian views than individuals with education levels below secondary

school. Additionally, Arvaniti et al. (2009) found that people with a university-level

education presented less discriminatory and restrictive opinions regarding people with

mental illness. The researchers found people with a university-level education and higher

were significantly less likely to attribute the cause of a mental illness to internal factors

such as fault of the family (Arvaniti et al., 2009). While several studies suggested that

formal higher education has a place in influencing perceptions of mental illness for the

positive, some research on the topic is contradictory.

Researchers also suggest that people with higher educations may be better at

hiding negative attitudes or displaying more socially acceptable views (Mann &

Himelein, 2008; Phelan et al., 1998). Research on doctoral students in medical or

psychiatric residencies found some students to endorse stigmatizing attitudes about

people with mental illness, including perpetuating the belief that people with mental

illnesses are dangerous or unpredictable (Mann & Himelein, 2008). As a result of their

findings, Mann & Himelein (2008) suggested there is further need for research to

examine the presence of stigma in highly educated populations to determine if education

is truly effective in reducing stigmatizing attitudes toward people with mental illness.

Similarly, Phelan et al. (1998) studied mental illness stigma within families. They

found family members who had completed at least some university-level education were

significantly more likely to conceal a family member with a mental illness from outsiders

than a family member with less education (Phelan et al., 1998). Phelan et al. (1998)

recognized the contradiction of their findings compared to other studies that link higher

socioeconomic status with more tolerant attitudes toward people with mental illness, thus

leading the researchers to question if highly educated people truly have more tolerant

attitudes towards people with mental illness, or if they are more likely to express socially

acceptable views.

       Based on the discrepancy in research findings, an in-depth analysis on how formal

higher education impacts perceptions of people with mental illness is necessary to add to

the current literature and to uncover if formal higher education truly is reducing

stigmatizing attitudes. In addition to higher education, ethnicity may also impact

perceptions of people with mental illness.

Ethnicity

       Another variable suggested to impact perceptions of people with mental illness is

ethnicity. A trend in research findings suggests cultural beliefs within different ethnic

groups may impact perception formation and influence stigmatizing beliefs about people

with mental illness (Abdullah & Brown, 2011; Chen & Mak, 2008; Ward et al., 2009).

Chen & Mak (2008) found, in some Asian cultures, perceptions about mental illness may

be shaped by negative beliefs about the cause of a mental illness. Some Asian cultures

may attribute the cause of a mental illness to individual factors such as a personal failure,

thus their attitudes toward people with mental illness are shaped accordingly (Chen &

Mak, 2008). Similar research in African American communities found there to be high

levels of cultural mistrust surrounding mental illness diagnosis, thus attitudes about

friends seeking mental health treatment are often reported as shameful or influenced by

stigma (Ward et al., 2009).

       Additionally, Abdullah & Brown (2011) found people of some Middle Eastern

ethnicities may also experience stigma as a result of their cultural values. Many Middle

Eastern ethnicities place value on family honor and the concealment of emotions, thus

mental health treatment may feel incongruent with cultural values because patients are

required to openly discuss emotions and feelings. As such, some Middle Eastern cultures

may experience greater stigma towards mental illness treatment because of the value their

culture places on concealing emotions (Abdullah & Brown, 2011). Based on these

findings, there is merit in studying ethnicity as a way to draw attention to differences in

the experience of stigma. As Abdullah & Brown (2011) suggested, the majority of stigma

research is based on the assumption that everyone experiences stigma in the same way.

Thus, by studying how several ethnic groups and races differ in their assumptions and

attitudes toward people with mental illness, one is able to better able to see variations in

the experience of stigma.

Further, while research demonstrates ethnicity may influence perception, there is

a lack of research on this topic in the ethnically diverse region of North America.

Abdullah & Brown (2011) noted few studies have examined the differences in attitudes

towards people with mental illness and resulting stigma across different ethnic groups in

North America. The limited numbers of studies that have examined this topic in North

America have found ethnic minority groups to articulate more stigmatizing attitudes than

those of European heritage (Abdullah & Brown, 2011). Thus, while current research

suggests ethnicity may impact perception formation about mental illness, there is

currently a lack of research examining the impact of ethnicity on perception in

populations within the United States. By more clearly understanding how cultural beliefs

associated with one's ethnicity impact perceptions of people with mental illness, future

researchers may be able to bring more attention to the impact of ethnicity-related

unconscious bias.

Finally, in addition to examining the individual impact of ethnicity and higher

education, exploring the intersection between higher education and ethnicity on

perceptions of people with mental illness is also valuable due to a lack of current research

on the intersection of these major demographic characteristics.

The Intersection of Higher Education and Ethnicity

Currently, no studies have directly examined the impact of the intersection of

higher education and ethnicity on stigmatization of mental illness; that is, how these two

factors work together to impact perceptions of people with mental illness. The only

known studies that have examined the relationship between higher education and

ethnicity examined students seeking a higher education degree in a medical field.

Researchers examined the impact of medical school education on mental illness stigma

(Korszun, Dinos, Ahmed, & Bhui, 2012). One of their pivotal findings indicated that

medical students of European heritage exhibited a higher level of regard for patients with

symptoms of delusional behavior or hallucinations than Chinese and South Asian medical

students (Korszun et al., 2012). When surveyed, the Chinese students were found to have

the lowest level of regard for these patients, which researchers attributed to the

longstanding Chinese cultural values of a reserved emotional affect and desires to

preserve external appearances (Korszun et al., 2012). Researchers also acknowledged that

cultural models of illness tended to be applied in conjunction with medical models of

illness in some East and South Asian cultures, which may have further influenced the

Chinese participants' perception of people with mental illness in the study (Korszun et

al., 2012). Thus, findings from this study suggest higher education may not circumvent some ethnically influenced biases in the highly educated medical student population.

Further, Chambers et al. (2010) studied European nurses' attitudes towards patients with mental illness. This is a relevant population to examine because nurses are required to complete a higher education degree regardless of where they practice. Results of this study found nurses' attitudes to be primarily positive towards patients with symptoms of mental illness, and they found the most significant predictor of differences in attitude to be the county in which the nurse practiced (Chambers et al. 2010). Nurses in Lithuania were observed to have the most negative attitudes, while nurses in Portugal were noted to have the most positive attitudes about their patients with mental illnesses. Based on the result of their study, Chambers et al. (2010) noted that cultural differences seemed to significantly contribute to attitude differences between nurses in the study. These attitude differences may be attributed to differences in training programs between countries or they may be influenced by each country's general regard for people with mental illness (Chambers et al., 2010). In their discussion, Chambers et al. (2010) further asserted that there is no consensus on the factors that maintain either a positive or negative attitude toward people with mental illness, thus there is necessity in continuing the study of this topic. Further, attitudes are multifaceted and influenced by several forms of knowledge gained through education, training and experience. Thus, Chambers et al. (2010) agreed that there is necessity in further studying the relationship between an individual's knowledge and his or her socio-demographic characteristics to better understand if knowledge truly has a place in influencing attitudes.

Both of these studies offer indications that a relationship may exist between higher education and ethnicity, which may impact attitudes towards people with mental illness. However, examining the intersection of these two variables was not the primary goal of either of these research studies, but rather, an additional finding observed from results of the study. Thus, examining the intersection between higher education and ethnicity as one of the primary research questions ensures the relationship between these two variables is examined more fully and with more nuanced detail.

Additionally, both studies were conducted on medical students or individuals who had completed a medical degree and currently work in the medical field as nurses. Thus, while these studies provide insight on the impact of higher education on perceptions of mental illness, medical students do not make up the majority of students who seek higher education and there may also be an increase in stigmatizing attitudes associated with an advanced degree in a medical field. Based on these points, there is a clear lack of generalizable research on the impact of the intersection of higher education and ethnicity; and how these two factors work together to impact perceptions of people with mental illness. By studying the intersection of these two variables, the present study is better able to illuminate the role of formal higher education in ethnicity-specific stigma to determine if higher education is able to circumvent ethnicity-specific biases.

Conclusion

As the prevalence of mental illness increases for both adults and children, there is a growing need to understand the social factors that may impact quality of life for people with mental illness. Public perception may influence the quality of life for people with mental illness by persuading behavior, viewpoints and actions towards people with

mental illness. As the etiology of mental illness has changed throughout history, differing

public attitudes may be influenced by acceptance and tolerance for people with mental

illness or perception may still be influenced by historically stigmatizing beliefs. Higher

education and ethnicity are shown to impact public perceptions of people with mental

illness, but to date no studies have assessed both factors simultaneously using qualitative

methods (Arvaniti et al., 2009; Yuan et al., 2016). Additionally, the intersection of higher

education and ethnicity has never been studied within the context of perceptions about

people with mental illness. Thus the present study provides valuable insight into the

individual impact of higher education, ethnicity, and the intersection of both variables on

perceptions of people with mental illness.

Method

The primary goal of this study was to explore the individual impact of both higher educational experiences and ethnicity on perceptions of individuals with mental illness, as well as to explore how higher education and ethnicity interact to influence perceptions. As no other known research studies have examined the intersection of higher education and ethnicity, descriptive phenomenological interviewing was seen to be the best method for uncovering new insights. This chapter contains a detailed explanation of how descriptive phenomenological interviewing was utilized to answer the research questions presented in Chapter I. The chapter is organized into six sections: a.) design b.) selection of participants and sampling method c.) data collection & instrumentation d.) data analysis.

Design

The study was a non-experimental, qualitative and descriptive phenomenology that clarified poorly understood aspects of the participants' experience with the topic under study. Englander (2012) stated descriptive phenomenology allows a researcher to understand a phenomenon from the point of view of a person with the "lived experience" to be able to discover the meaning from it (p. 16). Ultimately, the purpose of the study was to discover how individuals experience higher education and ethnicity as impacting their perception of people with mental illness. A second purpose was to discover how the interaction of both of these variables influences participants' perception of people with mental illness.

Further, the study adhered to criteria of a descriptive phenomenological design as closely as possible to ensure data collection and analyses were rooted accurately in the

theoretical framework of phenomenology. In line with other phenomenological research

studies, I utilized semi-structured interviews with open-ended questions (Chan, Fung, &

Chien, 2013; Englander, 2012).

Selection of Participants and Sampling Method

The population of interest in this study included all graduate and undergraduate

students currently enrolled at a four-year university in Portland, Oregon. All of the

students in this population have some degree of experience with higher education, thus

they may be able to speak to both the impact of higher education and ethnicity on their

perceptions of people with mental illness. Within this population of students, the sample

was comprised of 10 students. For students who reported their majors, seven students

majored in Psychology, one student majored in Social Work, and two students did not

disclose their majors. Further, the demographic characteristics of the sample are found in

Table 1. Among non-white students, the following ethnicities and races were reported:

Southeast Asian/Chinese, Black, Mexican, Iranian, Chinese, and two bi-racial:

Black/Mexican.

Table 1: Demographic Characteristics of Study Participants

Gender	1 male	9 females
Education level	5 graduate students	5 undergraduate students
Ethnicity	7 non-white students	3 white students

Further, students were sampled using a non-probability, quota sampling method.

A quota sampling method is an effective tool to ensure the inclusion of a particular

segment of the population. The study required a sample of ethnically diverse individuals

that could speak about their experiences with ethnicity and perception of people with

mental illness. As white students represent the largest majority at this particular

university, a random sample might over represent white students and miss other ethnic

groups.

Initially, the sample was expected to consist of eight students to fulfill the quota.

To ensure a diversity of ethnicities were represented in the study, the quota needed to

consist of at least one individual who identified as Asian, one individual who identified

as Black, one individual who identified as White, one individual who identified as

Hispanic or Mexican, one individual who identified as belonging to an ethnic group from

the Middle East, and one individual who identified as bi-racial. The remaining two

participants would be able to identify with any ethnicity to allow for the inclusion of

other ethnic groups or races. After enrollment began, I invited all participants who met

age criteria to participate up until the ethnicity quota was met, rather than end enrollment

at eight participants. A total of 10 participants filled the final quota.

The final sample of participants included a wide range of education levels and

ethnicities, which increased the generalizability of the study. Additionally, Englander

(2012) recommended utilizing at least three participants in a phenomenological method

but stated that utilizing more participants can lead to better awareness of the variety of

the phenomenon. Further, in a phenomenological study, Englander (2012) states that

researchers are not concerned with "how many" people have had a particular experience,

but rather, they want to understand what the content of the experience is in-depth (as

cited in Giorgi, 2009). Thus, this study's inclusion of 10 participants allowed for a deeper

exploration on the variety of experiences between different ethnic groups and education levels without reducing the feasibility of the study within the timeline of the research project.

Finally, the only sampling inclusion criteria beyond the specifications set by the quota sampling method included: all participants must be at least 18 years of age and currently enrolled at a four-year university. There were no exclusionary criteria.

Data Collection & Instrumentation

Participants were recruited in two ways. First, fliers were posted on the campus of one university in Portland, Oregon. Second, fliers were given to several professors on the university's campus for distribution to their classes. The fliers contained information about the purpose of the study, a brief description of interview procedures and a method for contacting the researcher via email or phone (see Appendix A). In total, fliers were distributed to nine different classes containing both graduate and undergraduate students in psychology and writing courses.

Additionally, enrollment began on 3/21/2018 and ended on 4/30/2018. After participants were recruited and before the interviews took place, they were provided with a paper copy of an informed consent form (see Appendix B). The informed consent document explained the following: purpose of the study, foreseeable risks and benefits, confidentiality, right to withdraw, and researcher's contact information. All participants read and signed the form prior to their participation in the study. After participants completed their interviews, all participants received a debriefing form explaining local counseling references, should any emotions have arose from our conversation (see Appendix C).

In addition, the measurement instrumentation adhered to descriptive phenomenological design as closely as possible to ensure accurate data collection and analysis (see Appendix D). In adherence with the semi-structured interview style, each interview protocol contained four specific questions asking participant's to describe their experience with ethnicity, higher education, and the intersection of both. The interview protocol was self-designed as there is no known instrumentation that currently measures the intersection of ethnicity and higher education on perceptions of people with mental illness. Thus a self-designed interview was the most reliable way to ensure all of my research questions were addressed in a phenomenological style. While the interview questions were unique to this study, Shenton (2004) highlighted the importance of utilizing well-established research methods to inform an interview protocol and increase the credibility of qualitative research. Thus, interview questions were influenced by the published phenomenological work of Englander (2012) to increase credibility and to ensure adherence to a phenomenological theoretical framework.

Before data collection officially began, I created a reflexive diary and bracketed any preconceived notions or assumptions I may have had about ethnicity and higher education based on my prior knowledge and literature review. The process of bracketing adds validity to data collection and analysis by ensuring that I am re-examining my own values, beliefs, and potential biases to minimize their influence on the research process (Chan et al., 2013).

During qualitative data collection, participants took part in face-to-face interviews individually. Interviews took place in a private room in the university library, a familiar environment for all participants. Interviews ranged in length from 15 to 35 minutes.

During the interviews, participants were asked to respond to four pre-formulated open-ended questions pertaining to the research questions (again, see Appendix D). Each question asked the participant to describe an experience they may have had in as much detail as possible. After the participant appeared to have described their experiences to exhaustion, I asked them to reflect on how this experience may have impacted their life. Asking participants to reflect on the impact of the experience explores the relationship between the participant and the phenomenon and uncovers the resulting "lived persistent meaning" (Englander, 2012, p. 31). In keeping with the semi-structured style, I followed the cues of the participant with my follow up questions and spontaneously probed participants for clarification. Thus, by offering open-ended questions, participants were given the flexibility to speak to their own experiences and define the personal relevancy of each topic to their life.

Additionally, during each interview, participant responses were audio recorded with a password-protected phone. I also took notes to highlight keywords participants mentioned during their interviews to aid in later coding.

Data Analysis

To adhere to a descriptive phenomenological framework, the qualitative data was analyzed using Colaizzi's (1978) distinctive seven-step process. All analysis was conducted by highlighting significant phrases on printed copies of interview protocols. Further subsequent codes and themes were recorded on Excel spreadsheets. I did not use any Qualitative Data Analysis (QDA) software for data analysis in an attempt to stay as close to the data as possible (Morrow, Rodriguez, & King, 2015). Colaizzi's process provided a rigorous method to extract the essential structures of higher education,

ethnicity, and the intersection of both variables on perception while also staying close to the data with each step (Morrow et al., 2015).

Step one.

I familiarized myself with the data by reading through each transcribed interview protocol a minimum of three times. While reading, I underlined specific phrases that stood out as potentially related to my research question.

Step two.

I returned to each transcribed protocol and highlighted all significant statements that pertained to the phenomena under investigation: higher education, ethnicity, and the intersection of both on perceptions of people with mental illness. During this stage, I added to my reflexive diary while reading through the interviews to account for any knowledge or thoughts that arose from my experience being a psychology student and my research from the literature review (Shosha, 2012). These statements were written on three separate sheets according to their respective category. 84 total significant statements were extracted from the ten transcripts.

Step three.

From each significant statement in each of the three categories, I identified a formulated meaning relevant to the phenomenon. Again, I returned to the reflexive diary to bracket any assumptions or biases that arose when formulating meaning from significant statements.

Step four.

All of the formulated meanings were grouped into theme clusters. Each theme cluster reflects a unique theme contained within subsequent formulated meanings. Each

formulated meaning was only assigned to one theme cluster to reflect the distinctiveness of each theme. From there, groups of theme clusters that revealed a central idea were joined together to form emergent themes. All emergent themes and cluster themes are then added to the thematic map.

The category of ethnicity resulted in nine theme clusters and four emergent themes. The category of higher education resulted in seven theme clusters and four emergent themes. The intersection of ethnicity and higher education resulted in eight theme clusters and four emergent themes.

Step five.

I developed an exhaustive description of the impact of ethnicity, higher education, and the intersection of both using all of the themes produced in step four. The exhaustive description is intended to capture the whole structure of each element of the phenomenon.

Step six.

I condensed each exhaustive description of higher education, ethnicity and the intersection of both down to a statement that encapsulates only essential aspects to the structure of the phenomenon.

Step seven.

To add trustworthiness to the final results, I returned the fundamental structure statements to all participants to inquire if each statement captured their experience accurately. I contacted eight out of ten participants again via email, and three emailed me back. All three participants responded that each of the structures captured their experience well, and they had no changes to suggest.

Conclusion

The purpose of the present study was to describe people's lived experiences with higher education and ethnicity on their perceptions of individuals with mental illness, as well as to explore how higher education and ethnicity interact to influence their perceptions. The interview protocol contained a combination of well-established phenomenological research methods and self-designed content to increase both the credibility and validity of the final results. To maintain adherence to a descriptive phenomenological framework, I analyzed the qualitative data using Colaizzi's (1978) seven-step process. Adherence to descriptive phenomenology in design provided an effective method for uncovering the essential structures of higher education, ethnicity, and the intersection of both variables.

Results

After participants completed their interviews, Colaizzi's (1978) seven-step descriptive phenomenological process guided coding and data analysis examining the lived experiences of participants. Specifically, this chapter presents the findings from the data analysis and how they pertain to the three research questions: 1.) How does higher education impact perceptions of people with mental illness? 2.) How does ethnicity impact perceptions of people with mental illness? 3.) How does the intersection of higher education and ethnicity impact perceptions of people with mental illness?

Preliminary Analytical Steps

To prepare for data collection and analysis, I tried to shift my mindset about the information I was about to collect. While I had engaged in thorough research on the interview topics beforehand, I made sure to keep my open mind to learning about familiar topics from a new and different vantage point. Ultimately, my goal was to learn from participants to generate new knowledge, thus I engaged in the process of bracketing (Chan et al., 2013). During this preliminary phase, I wrote down any initial preconceived notions, experiences and knowledge gained during my initial research on the topic that may have come to mind during each interview and after, while analyzing each transcribed interview protocol for themes. The process of bracketing allows a researcher to bring reflexivity into consciousness, and as such, a reflexive diary is often used to write down these thoughts throughout the research process (Chan et al., 2013). Below, in Table 1, are examples of pre-interview entries in my reflexive diary.

Table 1

Pre-Interview Entries
Based on knowledge gained from lit review, I anticipate there being residual cultural bias in Asian participants despite higher education and a great emphasis on concealing bias.

Based on knowledge gained from lit review, I assume non-white participants will report early family bias toward mental illness and uphold stronger cultural values that emphasize not talking about mental illness.
Based on prior knowledge gained as a student, I thought black participants might report not seeking therapy due to cultural biases/prejudices that they experience (real or inferred) from white practitioners.
I assumed graduate students would show more openness towards people with mental illness than undergraduates due to increased level of education.
I am making the assumptions that no one will directly tell me if they feel negatively about people with MI, but that I will have to make inferences based on participant responses.

After I had finished interviewing all participants and transcribing the recorded audio files to written transcripts, I read through each interview protocol several times to familiarize myself with the data. During this stage, I identified significant statements pertaining to each of the individual research questions. Examples of some significant statements as they pertain to each research question variable are listed in the table below in Table 2.

Table 2

Higher Education	Ethnicity	Intersection of Higher Education & Ethnicity
"And it's just really helped me look at mental illness so much differently and like accept it, and respect it and then want to learn more about it."	"Since my grandma raised me, she always taught me to be compassionate and understanding-- what a person might be going through before judging them right away. I guess I'm not quick to judge necessarily. Not understanding something doesn't mean it's horrible or the person is like completely insane."	"Yeah - there is an intersection. I would say, that if I didn't get this higher education, then I would be back where I was. Where like, I identify as white and I'm problematic and just basically the stereotypes of mental illness like they're violent there's something wrong with them and they can't be helped or something like that. Whereas higher education has allowed me to like find myself and be more informed about mental illness and of course of other things-- that I didn't get

		from my parents or high school or anything."
"It's not only made me more comfortable with who I am, if that makes sense, like I'm not as ashamed of my struggles and it's kind of pushed me to voice it more and be more open about it as well as help others with mental illnesses."	"Yeah they [my parents] do not believe in mental illness, like they just believe stuff happens-- it's part of life and you need to get over it. Like as far as depression-- my mom does not believe in depression she's like you just need to go exercise and run it off. So that's why my sister and I have struggled so much because we don't have that family support."	"Learning about mental health kind of moves you out of like-- the perceptions that, at least, my family has."
"The more educated that I have become and the more exposure that I've had to different things and different ideas and different viewpoints-- has made it easier for me to understand mental illness and also has taken away the stigma."	"When I was really young-- I thought going to therapy was for 'crazy people,' but that was largely reflective of my Iranian background. My parents didn't really understand therapy either. Like, when I went into therapy when I was older, I actually had to hide my bills and stuff cause I was living at home. Because I didn't want them to get the wrong perception that something was wrong with them or they did something wrong. They think that any problem on their child is a reflection of their upbringing."	"Having been able to pursue higher education has also educated me more about my culture. What it means to be a minority and like how, for example, what I just said. My dad grew up in a low economic household and has been low economic his whole life. And all of these things that could have influenced that. And not like as an entire culture… like Black Culture. But even then, the Mexican side too-- like learning about that in like sociology or whatever. Like higher education has educated me more about my culture and like I don't think it's ever been 'Ok these two factors are directly learning about mental illness'. But I think to me, in my head, they are related."
"Until I came to [this university] and made the friends that I have, and been in the classes that I've been in with the professors that I've had-- has really helped me open up and look at mental illness a lot differently and given me a broader understanding and just being able to suspend my judgment and then truly look at people for people."	"Like the family that I grew up in being super aware of mental illness and—that kind of shaped how I thought about it, and how I viewed it, but I think that my experience would be unique compared to other white families and other white people in general."	"Having my family background and taking care of elders in my families. This education-- I took a degree in gerontology, and now with this social work-- I want to help. Helping people with mental illness."

While analyzing each interview protocol for significant statements, I added to my reflexive diary to account for any knowledge or thoughts that arose during this experience. Below, in Table 3, is a table containing examples of bracketed thoughts that came to mind during my analysis of significant statements.

Table 3

Significant statement	Bracketing
"[My family] said [another family member] was crazy. Maybe I picked up that language from that. I think at times that sticks with me, especially if I'm with them, and I see somebody with mental illness or something. Maybe I can see myself revert back into the old habits of 'They're crazy'.	Assuming the use of stigmatizing language towards people with mental illness is shame based
"I'm very different from-- a lot of my family and the way I perceive mental illness maybe. I'm sure they had some kind of influence, but I think I've broken from the way that they see things maybe. In terms of understanding and compassion, and wanting to understand what people go through-- that's something then I grew up with. So that influence, I mean, I just carry, you know. About understanding issues or just people going through issues. And I was in a supportive of household, so that's another issue. Like, I think I'm supported in that capacity also and that had an influence on me and the way that I perceive diverse groups of people."	The majority of participants interpreted their "ethnicity" as a reflection of the cultural values of their family and their upbringing. For coding purposes, I will consider family values and cultural values to mean the same thing.
"I feel like everything I really love today is a reflection of my warring values between the two. Like in college, I had like a really big identity crisis and I still continue to have that cause I was still hiding pieces of myself from my family."	"Warring values" was a phrase used by one of the participants that I assume describes her experience feeling conflicted between adhering to family cultural norms and growing up in the Western culture of the U.S
"I would say that if I didn't get this higher education then I would be back where I was. Where like, I identify as white and I'm problematic and just basically the stereotypes of mental illness, like they're violent there's something wrong with them, and they can't be helped or something like that. Whereas higher education has allowed me to find myself and be more informed about mental illness and of	In the context of this study, family level factors are considered things that have an impact on an individual's experiences with their own mental illness and also how they perceive others who may have a MI.

course of other things-- that I didn't get from my parents or high school or anything."	
"No. I don't think so [that there is an intersection]. No because I think the way I perceive it is more positive then I think what my race perceives it."	I am making the assumption that the participant who reported seeing "no intersection" between her higher education and her ethnicity is not taking into account her rationale for seeking higher education. (She reported wanting to break out of the stigmatizing mindset that her family has). However, in an effort to actively put my own assumptions aside, I'm creating a theme of "no intersection" to reflect her reported experience.

Research Question One

Question 1: How does higher education impact perceptions of people with mental illness? To understand the lived experience of higher education, participants were asked to describe a situation in which their experience with higher education may have influenced their perception of people with mental illness. After participants provided details about the situation to exhaustion, they were asked what kind of impact the experience had on their life. As mentioned previously, asking participants to reflect on the impact of the experience helped me to investigate the relationship between the participant and the phenomenon and uncovered the resulting "lived persistent meaning" of the experience from the participant's perspective (Englander, 2012, p. 31). Further, asking all participants to explain a personal experience with higher education aided in the determination of significant statements later on. During my analysis, I highlighted all statements that directly pertained to the participants' experience with higher education and considered those to be significant statements (#1 on Table 4).

To explore the impact of higher education, ten participants were recruited who were all actively enrolled as undergraduate or graduate students. Thus, these participants were able to describe their personal experience with higher education and the resulting

implications on perception. After identifying all statements that mentioned the participants' experience with higher education, I recorded each significant statement in an Excel document for further review. Upon reviewing significant statements in the Excel document, I thought back to my conversation with each participant. After spending up to an hour talking with each participant, I felt as though I understood why participants responded to each question in the way that they did. If I did not feel that I understood, I asked clarifying questions during the interview and recorded responses accordingly. As such, the formulated meanings reflect my attempt at bringing fourth the simplified essence of a large quotation, given my knowledge of the full interview conversation with the participant.

Next, after all significant statements had been assigned a formulated meaning (#2 on Table 4), I looked for patterns in all of the formulated meanings. For example, several participants mentioned relationships with peers and professors in college that impacted their perceptions. Additionally, several participants also mentioned learning the scientific language or theories behind mental illness. In the end, the ideas or topics mentioned most often by participants became the cluster themes. Additionally, I kept the theme clusters in language as close to the participants' responses as possible. The cluster themes for higher education were as follows: *trusted relationships with peers and professors*; *perspective about people with (mental illness) MI was expanded to incorporate accepting attitudes*; *hands on work provides exposure*; *increased understanding of self in relation to MI*; *provided language to accurately describe MI*; *deeper understanding of systemic issues impacting MI*; *more likely to search for a reason behind problematic MI behaviors*.

After seven theme clusters were determined (#3 on Table 4), I analyzed all of the theme clusters for possible overlap. For example, three theme clusters- provided language to accurately describe MI, deeper understanding of systemic issues impacting MI, and more likely to seek reason behind problematic behaviors – all seemed to describe participants learning about new dimensions of mental illness. To some people not trained in or experienced with mental health, mental illness may seem one-dimensional; as in, an individual receives a diagnosis and then lives with the symptoms. However, as students become trained and experienced with the scientific language behind mental illness and learn about systemic issues that may impact the experience of mental illness, knowledge about mental illness becomes multi-dimensional and takes on a new depth. Thus one emergent theme is: *new dimensions* (#4 on Table 4).

Next, I considered what the cluster themes, relationships with peers and professors, and hands-on work provides exposure, may have had in common. Both of these themes seemed to be describing how participants gained experiential knowledge outside of their textbook knowledge. Relationships with peers, professors and the community provided a way for participants to learn about mental illness through direct exposure. As such, a second emergent theme is: *experiential knowledge*.

Further, I considered what final cluster themes: perspectives about people with MI was expanded to incorporate accepting attitudes, and increased understanding of self in relation to MI, may have had in common. Both of these cluster themes seemed to represent different ideas. One theme represented participants' experience of recognizing their attitude shifting towards acceptance of others, and the other theme represented

participants' clearer understanding of themselves through increased self-awareness. As such, I felt both cluster themes should stand on their own as emergent themes. The final two emergent themes related to higher education are: *increased self-awareness* and *perspective shift towards acceptance*.

Below, Table 4 expands upon each cluster theme and emergent theme for each significant statement and formulated meaning pertaining to higher education.

Table 4 (next page)

Higher Education			
1. Direct Quote	**2. Formulated Meaning**	**3. Theme Cluster**	**4. Emerging Theme**
"Until I came to [this university] and made the friends that I have, and been in the classes that I've been in with the professors that I've had…. has really helped me open up and look at mental illness a lot differently and given me a broader understanding and just being able to suspend my judgment and then truly look at people for people."	Feels the friendships & professors she's met during her college experience have broadened her perspective and lessened judgmental attitudes towards people with mental illness	**Trusted relationships with peers and professors**	*Experiential knowledge*
"And it's just really helped me look at mental illness so much differently and accept it, and respect it and then want to learn more about it."	Feels perspective had been broadened about people with (mental illness) MI and she has an increased desire to learn more.	**Perspective about people with (mental illness) MI was expanded to incorporate accepting attitudes**	*Perspective shift towards acceptance*
"So we don't technically get like the hands-on experience unless you work outside of that and get it on your own. So I think that that was just kind of like a big gap in that I always got what I learned about mental illness or whatever from the classes and from the textbook…. and not from actual experience where as like in this social work class. I've learned that so many people have already done Hands-On work. So in a way, although I might be more like knowledgeable within the books, I'm not with hands-on experience."	Participant feels, although she has textbook knowledge about people with MI, but that hands on experience would have also been beneficial to gain experiential knowledge.	**Hands on work provides exposure**	*Experiential knowledge*

"But then also just them teaching it--- in all my psychology courses has truly just 180 changed my opinion on mental illness and as I previously said, it's just given me a broader understanding and it and has allowed me to see people for people."	Feels psychology courses have changed her opinion about people with MI to a broader understanding and acceptance.	**Perspective about people with MI was expanded to incorporate accepting attitudes**	*Perspective shift towards acceptance*
[Working at her internship site] it allowed me to look at it as in-- I'm not here to help you, I'm here to work alongside you. You [learn that you] really are so similar".	Feels internship experience in college helped her to relate on a personal level to gain experience.	**Hands on work provides exposure**	*Experiential knowledge*
"Knowing other people have had so many different experiences-- you just really don't know what people are going through, and so learning how to do that for your own self and to your professors or to your friends. It's all helped me broaden my understanding."	Feels increased empathy for self and others	**Increased understanding of self in relation to MI**	*Increased self awareness*
"It's my professors and [this university]. I specifically think it's because of [this university] and how it is so small and so you really do learn so much about students and about professors and so just, like, create those relationships and truly just like seeing such a broad perspective of everybody else. And you're not in this one family—getting one idea or one value or whatever."	Feels relationships with fellow students and professors allowed her to broaden her worldview to empathize with diverse perspectives	**Trusted relationships with peers and professors**	*Experiential knowledge*

"Certainly abnormal psychology and being a psych student has taught me theories and vocabulary to actually apply to what I'm seeing. Like is this verbal Tourette's versus nonverbal Tourette's. Like he definitely had other things going on. I think that being knowledgeable is something that education has given me."	Feels deeper understanding about mental illness as a result of psychology classes. These classes helped her become knowledgeable and gave her theories and vocabulary to apply to the real world.	**Provided language to accurately describe MI**	*New dimensions*
"I'm just more knowledgeable, and I'm more accepting, I guess. Or understanding. Given the opportunity I'm less likely to jump to conclusions thinking that they're just a horrible person because they did something that their body wasn't capable of controlling."	Feels she has gained a reduction in judgment of people with MI and a greater acceptance of deviant behaviors.	**Perspective about people with MI was expanded to incorporate accepting attitudes**	*Perspective shift towards acceptance*
"Sometimes helping makes things worse. When there are certain components that the helper doesn't understand. Or socially or culturally—they won't fit in like an intervention or prevention program. And not put everyone in the cookie cutter type of situation to be better."	Feels she better understands systemic issues that make it socially and culturally more difficult for people with MI to assimilate into society.	**Deeper understanding of systemic issues impacting MI**	*New dimensions*
"I took abnormal psych, so that helped with understanding the biology of it and the chemistry of it."	Feels psychology classes helped her understand the science behind MI which deepened her understanding.	**Provided language to accurately describe MI**	*New dimensions*

"I spoke with a professor that he actually worked at the old Oregon State Hospital before they tore it down, so hearing his perceptions, and his stories-- it feels like that influenced me. And of course classmates who've spoken out and said that they suffer from mental illness and this is what happens to them and everything like that helps to kind of like normalize it, I guess. It's kind of like putting a face to mental illness in a way, like it's not just out of sight out of mind. Like it doesn't happen if it's not somebody close to you… it's around."	Relationships with classmates and professors provided a broadened perspective and normalized MI	**Trusted relationships with peers and professors**	*Experiential knowledge*
"Yeah. And like I said I don't know if that just has to do with-- because I have a higher education."	Acknowledges that she sees things differently than others of her race and considers that it may be because of her education level.	**Increased understanding of self in relation to MI**	*Increased self awareness*
"It's not only made me more comfortable with who I am, if that makes sense. Like I'm not as ashamed of my struggles and it's kind of pushed me to voice it more and be more open about it as well as help others with mental illnesses."	Feels education has helped her understand her own MI issues more and thus both accept them and advocate for others/self.	**Increased understanding of self in relation to MI**	*Increased self awareness*
"And it's also exposed me to an amazing support system, like the professors here are amazing and very	P feels influenced by the support system of professors.	**Trusted relationships with peers and professors**	*Experiential knowledge*

involved in my life struggles."			
"I've been able to kind of put a reason to things that have happened in the past or even current events. It's changed my way of like thinking about other people's actions. Like before Psychology was part of my life, I feel like, oh this person did that thing that's terrible, but now with psychology, it's like, "okay they did that bad thing, why did they do that bad thing?" So it's like made me think of the reasons more than just acknowledging what happens. "	Feels education has helped provide rationale for human behavior, which led to an increased acceptance of MI not as a personal fault.	**More likely to search for a reason behind problematic MI behaviors**	*New dimensions*
"It gave me more understanding of like "oh this is why my dad is the way he is"... and like this is why I am the way I am type of thing. I think it provided like a lot more context and I can see things more objectively, like 'oh, I'm reading a book and the teacher is telling me this is what this is and like applying that to my own life versus subjectively just from my own experiences being just super like crazy and confused."	Feels education has helped provide rationale for human behavior, especially in her immediate family. Allows her to utilize additional dimensions/frame of reality to understand MI instead of just her own experiences.	**More likely to search for a reason behind problematic MI behaviors**	*New dimensions*
"It truly gave me a wider perspective. I'll use this example. I grew up and my dad's been addicted to drugs his whole life. And so he's like had addiction issues... and so now, learning and reading	Feels education has helped her to understand addiction as an MI and not as a personal fault. This allows her to separate emotions from reality when dealing with MI in her immediate family.	**More likely to search for a reason behind problematic MI behaviors**	*New dimensions*

about it, but growing up it was just like "You're terrible" and like everything wrong is because of you and how it like affected me. Then coming here and like learning about what addiction really is and the impact it has on learning about it. Like I didn't go through it, if that makes sense, like when I'm in class and I read that children of addicts will be X Y and Z … Now I can think, "okay that makes sense... So instead of making it so personal… I am able to separate my emotional stuff and what's facts and real."			
"Well I think just learning about--within this program-- just diverse populations, and in terms of supporting rather than, I guess, just critiquing. Through this degree, I can maybe help support people who are maybe going through some kind of mental illness lifestyle? For me the biggest thing is to try to understand."	Because of higher education, feels an increased desire to support people with MI rather than judge or criticize.	**Perspective about people with MI was expanded to incorporate accepting attitudes**	*Perspective shift towards acceptance*
"I think it made me realize my difficulties in fitting into that traditional lifestyle and that it's not because I'm a bad person or because I like have something wrong with me. It's just not the right path for me. And that didn't come to me until college unfortunately."	Feels college increased acceptance of MI and she thinks of it less as deviant behavior.	**Perspective about people with MI was expanded to incorporate accepting attitudes**	*Perspective shift towards acceptance*

"I think I have a lot more sympathy and understanding for mental illness after going through college because you see all sorts of breakdowns in college."	Feels increased understanding and sympathy after experiencing emotional relationships with peers.	**Trusted relationships with peers and professors**	*Experiential knowledge*
"The more educated that I have become and the more exposure that I've had to different things and different ideas and different viewpoints-- has made it easier for me to understand mental illness and also has taken away the stigma."	Feels increased exposure to peers and knowledge broadened her perspective and helped her better understand people with MI.	**Trusted relationships with peers and professors**	*Experiential knowledge*
"Especially in, I feel, like psychology. Learning a lot about different things related to mental illness or just that field in general. I think has made me more understanding of not just mental illness as a thing, but like people in relation to mental illness."	Feels learning about psychology in higher education helped to humanize MI.	**More likely to search for a reason behind problematic MI behaviors**	*New dimensions*
"It made me more sensitive towards the issue and more open about it and has kind of helped me to move back towards that direction, kind of like as a career. Like, before college, I never would have thought of working in a mental health facility like I do now. But after graduating, I was like okay, like there's a lot more to this than just someone with a mental illness. Like there's a lot of other factors that go into that too, and so I think the	Feels she gained a more accurate understanding for the complexities of MI and thus gained an increased acceptance of MI and desires to help.	**Provided language to accurately describe MI**	*New dimensions*

education made it less of a mystery -- mental illness. It made it more of like a thing that you can learn about and talk about and understand. And you can see people for who they are instead of just someone with a mental illness."			
"Just because my family did it, I'm still learning more that I can put into my own life. So this education, I need this. And this education helped me to better understand the diseases and mental illnesses and also to find more resources to help. If I didn't have this education, I would just be…. I would call it basic knowledge. So this education has enlightened me to help my family more."	Feels education has given her a clearer understanding of the complexities of MI, which she can apply to her career and family life.	**More likely to search for a reason behind problematic MI behaviors**	*New dimensions*
"It's opened more doorways. The education helped me with cultural diversity. And how to approach different cultures that have mental illness."	Feels education provided necessary new knowledge about how to understand cultural diversity in relation to MI.	**Provided language to accurately describe MI**	*New dimensions*
"If it hadn't been for [this university], I couldn't even help more with my daughter and the people I outreach. This is preparing me big time."	Feels higher education has given her knowledge to aid in her personal life and better support her immediate family with MI.	**Increased understanding of self in relation to MI**	*Increased self awareness*
"Well, I obviously didn't understand why when I was younger. I just thought, ok, listen to mom and dad. But obviously, like I said, I've grown up and especially	Recalls parents did not value open expression of her ethnic background. Experience in higher education has caused resentment towards parents for raising her this way.	**Increased understanding of self in relation to MI**	*Increased self awareness*

in college like learning the importance of diversity and like expressing who you are… it makes me upset that that's how they raised me and to be kind of ashamed of what race, ethnicity, orientation, like everything… We definitely butt heads about that. Yeah, I guess it's really opened my eyes of why certain events like took place when I was younger because I looked at myself as just white and people saw me as white with my blue eyes."			

Following the sequential steps in the coding process, an exhaustive description was then created which included all of the emergent themes and their corresponding theme clusters uncovered in step three and four. The resulting exhaustive description of higher education was as follows:

Higher education impacts an individual's perception of people with mental illness (MI) by causing a perspective to shift towards acceptance. This involves an expansion in perspective to incorporate accepting attitudes. Additionally, higher education provides experiential knowledge about people with MI though hands on work exposure and trusted relationships with peers and professors. Exposure to higher education also leads to a renewed sense of self-awareness through an increased understanding of self in relation to mental illness. Lastly, higher education impacts an individual's perception of people with MI by illuminating new contexts to mental illness including a new language to accurately

describe MI, a deeper understanding of systemic issues impacting MI, and a higher likelihood to search for the reason behind problematic MI behaviors.

Next this exhaustive description was abridged into a fundamental structure of the lived experience of higher education on perceptions of people with mental illness. In this step, I focused in on only those aspects believed to be essential to the structure of the phenomenon (Morrow, Rodriguez & King, 2015). During the interviews, the majority of participants mentioned a positive change in attitude, thus this was important to capture in the essential structure. Participants reported a change in attitude most often through an increase in acceptance and becoming more self-aware. Participants gained acceptance and self-awareness through topics they learned in classes, relationships with professors and peers, and working directly with the community. In the resulting fundamental structure, I expanded on how these factors influenced participants' self-awareness and acceptance, so that readers may see what mechanisms caused the attitude shift.

As a result, the fundamental structure of higher education in my study is as follows:

Higher education impacts an individual's perception of people with mental illness by influencing an expansive shift in perception to include attitudes of acceptance and self-awareness. Individuals attribute their increased attitudes of acceptance to both experiential knowledge and concepts learned in class. Individuals gain experiential knowledge through relationships with peers, professors, and experience working directly with the community. Classes also illuminate the varied contexts within mental illness and provide a new language and rationale in which to understand human behavior.

Research Question Two

Question 2: How does ethnicity impact perceptions of people with mental illness?
To understand the lived experience of ethnicity, participants were asked to describe a situation in which the cultural values or beliefs associated with their ethnicity or race may have influenced their perceptions of people with mental illness. Again, after participants provided details about the situation to exhaustion, they were asked to elaborate on how this experience affected their life. Asking all participants to explain a personal experience with higher education aided in the determination of significant statements later on. During my analysis, I highlighted all statements that directly pertained to the participants' experience with ethnicity and considered those to be significant statements (#1 on Table 5).

To explore the impact of ethnicity on perception, the same diverse mix of participants shared their experience in the interviews. To account for potential contrasts in the experience of ethnicity and race for white individuals versus non-white individuals, three white students and seven non-white students were recruited. After identifying all statements that mentioned the participants' experience with ethnicity, I recorded each significant statement in an Excel document for further review. Upon reviewing significant statements in the Excel document, I thought back to my conversation with each participant. After spending up to an hour talking with each participant, I felt as though I understood any additional context that might further explain a participant's response. If I did not feel that I understood, I asked clarifying questions during the interview and recorded their responses accordingly. As such, the formulated meanings reflect my attempt at bringing fourth the simplified essence of a large quotation, given my knowledge of the full interview conversation with the participant.

Moreover, after all significant statements had been assigned a formulated meaning (#2 on Table 5), I looked for patterns in all of the formulated meanings. For example, several participants mentioned emotional restriction in their families and a clash of cultural values with open emotion expression in therapy. Additionally, several participants also mentioned experiencing stigmatizing attitudes or language in their families. In the end, the ideas or topics mentioned most often by participants became the cluster themes. Additionally, I kept the theme clusters in language as close to the participants' responses as possible. The cluster themes for ethnicity were as follows: *family value of respect and compassion for all people*; *strong family bond influences treatment of people with MI within the family*; *recalls emotionally restrictive family values*; *feels his or her views differ from that of others of their race*; f*eels negative influence of family values today on perception of MI*; *associations of shame with MI in family*; *felt clash of cultural values with MI treatment*; *feels positive influence of family values today on perception of MI*; *family used stigmatizing language around MI*.

After nine theme clusters were determined (#3 on Table 5), I analyzed all of the theme clusters for possible overlap. For example, three clusters: family value of respect & compassion for all people, strong family bond influences treatment of people with MI within the family, and feels positive influence of family values today on perception of MI, all seemed to describe positive cultural values that participants learned from their families. Based on significant statements these cultural values learned from the family felt positive because they influenced participants' compassion towards people with mental illness. As such, one emergent theme is: *cultural values influenced by compassion* (#4 on Table 5).

Next, I considered what the themes, feels negative influence of family values today on perception of MI, associations of shame with MI in family, and family used stigmatizing language around MI, may have had in common. All of these themes described a negative cultural value that participants learned from their families. This negative cultural value influenced shame that participants felt surrounding mental illness either in adolescence of in adulthood. As such, a second emergent theme pertaining to ethnicity is: *learned shame-based MI stigma*.

Moving forward, I considered what theme clusters: recalls emotionally restrictive family values, feels his or her views differ from that of others of their race, and felt clash of cultural values with MI treatment, may have had in common. I felt two of these theme clusters spoke to emotional restriction via family norms. In one theme, participants directly described emotional restriction and not being allowed to openly talk about mental health issues. In the second theme, participants describe how their family's cultural values did not align with the emotional disclosure involved in therapy. As such, a third emergent theme is: *cultural value of emotional restriction*.

Lastly, several of the participants described feeling their views about mental illness differed from the traditional views of others of their same race. This concept did not fit into any of the other emergent themes, but captured an important component of how ethnicity impacts perceptions of mental illness for participants in this study. As such, a fourth emergent theme is: *distanced self from stigmatizing ethnicity-specific biases*. Below is a table that expands upon each cluster theme and emergent theme for every significant statement and formulated meaning pertaining to ethnicity.

Table 5

Ethnicity			
1. Direct Quote	**2. Formulated Meaning**	**3. Theme Cluster**	**4. Emerging Theme**
"Since my grandma raised me, she always taught me to be compassionate and understanding-- what a person might be going through before judging them right away. I think they were more like acts of compassion. I guess, I'm not quick to judge necessarily. Not understanding something doesn't mean it's horrible or the person is like completely insane."	Relationship with grandmother centered about cultural value of compassion, which helped her to reduce judgment of others.	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*
"And I was like, 'Grandma what are you doing?' And she said 'boiling eggs'. Then once it's done, she walked back to the market with me and she gave the lady boiled eggs. And I was like, 'grandma why'd you do that?'. She said, "Well if someone's hungry, then you give them food. And that was a story or an experience that has always stuck out to me."	Grandmother taught her compassion towards all people as a value.	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*
"Maybe [my grandma's] way of life and her religion might have influenced her to value compassion…. She taught me... really taking it slow and understanding someone else before you are	Participant contemplates why grandmother valued compassion and how this influenced how she treated others.	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*

quick to judge."			
"I guess, I think that generally is not my business, and I should be respectful of them regardless of the situation-- that's how I was taught to interact with people."	Learned family value of respect for others that she applies to her relationships with people with MI today	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*
"I think that it was most likely more of an upbringing thing. I don't think it was specific to 'treat people with mental illness this way,' it was more just treat everybody this way. And if you see something outstanding… don't necessarily like, judge them."	Learned family value of respect for all people while growing up- not specifically just people with MI.	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*
"I think it's made me actually like way more open to opportunities cause I'm less judgmental and like, 'oh, I don't want to be there'.	The influence of her family's value of respect for all people makes participant feel like she is open to more opportunity when working with people with MI.	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*
"My parents are both doctors and my siblings are doctors-- psychologists. So there has been tolerance for mental illness in my family."	Family's career track (medicine) influenced tolerance for people with MI.	**Feels positive influence of family values today on perception of MI**	*Cultural values influenced by compassion*
[In reference to mental illness in her family] I mean fine is relative, of course. I'm sure it would have emotionally strained them, but it wouldn't have been an issue that breaks my family apart."	She believes her family would treat her with the same sense of compassion if she had experienced a mental illness.	**Strong family bond influences treatment of people with MI within the family**	*Cultural values influenced by compassion*

"My mom's mom died like… suddenly making Thanksgiving dinner. And she just was happy while she was doing it but she also had manic-depressive and Alzheimers, and she just was allowed to do her own thing when she died. And that's really sad but like, at least, she could die doing something she loved and we didn't stop her from being who she was because, we said you have manic depressive and Alzheimer's and you have to go to an old person's home."	Recalls family did not restrict lifestyle of family members who had MI but desired to allow them to live their life to the fullest.	**Strong family bond influences treatment of people with MI within the family**	*Cultural values influenced by compassion*
"Then, just specifically from how I was raised…. I just come from a very dominant family and so to not talk about feelings or emotional distress was kind of more supported than to talk about that… and so I think that there are a lot of hidden mental illnesses that I don't really know about or recognize."	Recalls it was the family norm to not talk about emotional distress. Participant feels this may have lead to unrecognized MI in her family.	**Recalls emotionally restrictive family values**	*Cultural Value of Emotional Restriction*
"Comparing the ones who take those traditions or like cultural norms versus my immediate family or like my extended family that lives here versus overseas. There's a little bit of a difference but I wouldn't be able to speak on that because I don't exactly know…"	Participant hypothesizes that her extended family that currently lives overseas adheres to stronger cultural norms regarding MI than her immediate family who lives in the U.S.	**Recalls emotionally restrictive family values**	*Cultural Value of Emotional Restriction*

that's just my assumption."			
"[Regarding how her family views MI] I think it would just be the stigma of either like emotional or vulnerability and weak."	Recalls family norms were restrictive against emotional vulnerability & thought of it as a weakness.	**Recalls emotionally restrictive family values**	*Cultural Value of Emotional Restriction*
"Because it was really really hard for me to talk about myself… I don't want to be seen as weak or whatever the case may be. "	Recalls a fear of discussing her own vulnerabilities out of her of being seen as weak by her family.	**Recalls emotionally restrictive family values**	*Cultural Value of Emotional Restriction*
"I got exposure from like my aunts and my uncles and my cousins and my grandparents and we were together like 95% of the time so, I only got like that communication aspect of like-- talk about your emotions and talk about your feelings and like-- this is what mental illnesses is, just a little portion of the time from my extended family. Just what my Mom and Dad's values were and then going to like a super dominant part of my family… and like hiding those like imperfect perfections or performance."	Recalls hiding vulnerabilities and emotions from her extended family more than her parents out of fear of being seen as weak or imperfect.	**Associations of shame with MI in family**	*Learned shame-based MI stigma*
"I mean, I feel like because I'm in this field, that my perceptions are different than like people that are typical of my background. I know when I was younger I used to think they were crazy, but I just see them as people	Feels her perceptions about people with MI are different from others of her same race. She recalls having stigma towards mental illness when she was younger, but now being in the field of psychology, she has	**Feels his/her views differ from that of others of that race**	*Distanced self from stigmatizing ethnicity-specific biases*

now... Like they [a black family she worked with] didn't even know what to do, they didn't know what she had. And I think that's more typical of black people-- they don't really understand mental illness."	changed her opinions.		
"They [her family] said another one was, like, crazy. Maybe I picked up that language from that."	Feels she picked up negative language about people with MI from her family.	**Family used stigmatizing language around MI**	*Learned shame-based MI stigma*
"We've butt heads because I see things differently than them. Like I was saying, they just see mental illness as crazy, and they don't really understand it. Whereas I try to explain to them."	Feels her family holds more stigmatizing views regarding MI than she does and she tries to correct this today.	**Feels his/her views differ from that of others of that race**	*Distanced self from stigmatizing ethnicity-specific biases*
"Yeah, I think at times that sticks with me, especially if I'm like with them and I see somebody with mental illness or something. Maybe I can see myself like revert back into the old habits of 'they're crazy'."	"Feels sometimes her family's stigmatizing views towards people with MI can still influence her today, primarily when she is with her family.	**Feels negative influence of family values today on perception of MI**	*Learned shame-based MI stigma*
"I think the impact that [family values] sticking with me has had on my life, I mean it feels negative. But I think it makes me want to-- makes me want to do better, so I'm not stuck in that mindset."	Feels family's stigmatizing views are a negative influence and she works to distance herself from their beliefs today.	**Feels negative influence of family values today on perception of MI**	*Learned shame-based MI stigma*
"My parents have raised me to always identify as white or Caucasian to	Recalls parents raising her to identify as white, so she could	**Feels negative influence of family values**	*Learned shame-based MI stigma*

get like better help, I guess. Cause I'm actually Native American, Black and Mexican and Polish, but they've raised me to not identify that way. Minorities don't necessarily get the best help and are often looked over, so in identifying as Caucasian, then that's what they've kind of trained me to do to get the better help, which is really sad."	receive better help because her parents believed she would be overlooked if she identified as a minority.	**today on perception of MI**	
"Yeah they [my parents] do not believe in mental illness, like they just believe like stuff happens it's part of life and you need to get over it. Like as far as depression-- my mom does not believe in depression, she's like you just need to go exercise and run it off. So that's why my sister and I have struggled so much because we don't have that family support."	Recalls parents did not believe in MI and felt it was something to get over. This strained her relationship with them due to perceived lack of family support.	**Associations of shame with MI in family**	*Learned shame-based MI stigma*
"I have PTSD, and they [parents] has been like on me for years, like why you not getting better? This seems like you're kind of using this as an excuse to be lazy or, you know, whatever other things they can come up with. So for years they've tried to just look past it and like I almost feel guilty for lagging so much."	Recalls parents regarded her MI as an 'excuse to be lazy'. This caused participant to feel a sense of guilty.	**Associations of shame with MI in family**	*Learned shame-based MI stigma*

"I grew up Mexican. In like a Mexican household and was more influenced by that. Like I don't know if it's just specifically my family, I don't want to speak for the entire group of Mexican people, but I think that there's like a negative connotation and stigma around mental health. It's not something that's talked. I think Mexican culture has a really-- you just work hard and that's what matters. And anything emotional just gets in the way. At least in my family, but my family also immigrated here. So, I guess there wasn't really time to be concerned about other stuff. Like my grandma came here and that was her focus, so then that's how my mom was raised then like she raised me like that."	Recalls her family valued hard work and felt emotional distress got in the way of working hard. This mindset was passed down through the generations in her family.	**Recalls emotionally restrictive family values**	*Cultural Value of Emotional Restriction*
"I think it's played like a really negative role in my life and in the sense of like-- I also grew up in a really unstable and chaotic, and like traumatic household. Like not growing up with my dad's side of the family around. They were all black. There was just a lot of bad… but like it was very unspoken and like no one talks about it, it was just like 'Oh they have issues' and 'Pull it together' type of thing.	Recalls family did not acknowledge mental illness on her father's side. Participant also felt like she couldn't express any mental health issues because family her family was unwilling to talk about anything emotional or mental health related.	**Recalls emotionally restrictive family values**	*Cultural Value of Emotional Restriction*

So when I was experiencing like mental health stuff, especially like in high school and stuff it was just like…. 'Get up, go to school'. That was just, what you did. There was no like… even talking about it."			
"I don't know the long held beliefs in terms of Mexican culture. So it's hard for me to say how much of a long-term impact that has had on me. I'm sure it's like any other culture, or at least most cultures, that they used to believe that mental illness is something you shouldn't talk about. Or, the lack of talking about it creates barriers to receiving help."	Participant doesn't feel strongly influenced by traditional cultural beliefs about mental illness of Mexican culture but is aware that they exist.	**Feels his/her views differ from that of others of that race**	*Distanced self from stigmatizing ethnicity-specific biases*
"But when it comes to my own self, and understanding mental illness, it's still the same thing of keep pushing through and get to the next goal, or whatever. Just like push it under the rug and like since like that's just the pattern of my family I have adopted. So as much-- it's kind of hypocritical-- because I can tell people to get help, but that's not like the reality for me because of the culture of my family."	Feels she will support peers with MI issues, but her family's values still influence her own relationship with MI. She feels she has adopted the pattern of 'just keep pushing through'.	**Feels negative influence of family values today on perception of MI**	*Learned shame-based MI stigma*
"Personally, on my side, I just have felt that it's okay to talk about your feelings.	Participant feels comfortable talking about emotions/feelings,	**Feels his/her views differ from that of others of that**	*Distanced self from stigmatizing ethnicity-specific biases*

I think in the Mexican culture… historically, people didn't talk about their feelings, just in general. Which I'm sure can have an influence on wanting to talk about things you're struggling with. There's probably some kind of cultural underpinning where people believed mental illness was of the devil -- and that's a pretty big thing like [in] Mexican culture the devil's usually at fault for a lot of things. So I think that's one of the things that can be taken away."	which he feels is not in alignment with the traditional values of his culture that often do not understand the true cause of MI.	**race**	
"I don't think we really talked a lot about mental illness issues in general. But, spiritually though, I grew up in a Christian household. I think people can, you know, think mental illness is something to be healed. So that's something that I've heard, you know, growing up in that kind of household. But personally, I think mental illness is a part of people and not necessarily something that can be-- prayed away? That sounds weird to say, but I think it's an important part of people, and people are shaped and born differently. And addressing that kind of, mental health issue in more proactive ways is important. Like can you live with it rather than trying to eradicate it?"	Doesn't recall talking about MI specifically in his family - but family and his culture were influenced by Christianity. Recalls his family sometimes believed MI was something could be healed or 'prayed away'. Participant doesn't agree that MI needs to be healed but is something that should be learned to live with.	**Feels his/her views differ from that of others of that race**	*Distanced self from stigmatizing ethnicity-specific biases*

"I'm very different from, I think a lot of my family and the way I perceive mental illness maybe. I'm sure they had some kind of influence, but I think I've broken from the way that they see things maybe. In terms of understanding and compassion, and wanting to understand what people go through-- that's something that I grew up with. So that influence, I mean, I just carry, you know. About understanding issues or just people going through issues. And I was in a supportive household, so that's another issue. Like, I think I'm supported in that capacity also and that had an influence on me and the way that I perceive diverse groups of people."	Participate perceives his views about mental illness to be different from his family today, and he no longer feels influenced by them in negative ways. He only feels his family's influence in valuing compassion and support for others.	**Feels positive influence of family values today on perception of MI**	*Cultural values influenced by compassion*

"When I was really young, I thought going to therapy was for 'crazy people'. But that was largely reflective of my Iranian background. My parents didn't really understand therapy either. Like, when I went into therapy when I was older, I actually like had to hide my bills and stuff cause I was living at home. Because I didn't want them to get the wrong perception that something was wrong with them or they did something wrong. They think that any problem on their child is a reflection of their upbringing."	Recalls stigmatization of therapy as a child influenced by parent's beliefs. She remembers hiding therapy bills to shelter parents from thinking they were at fault for her MI.	**Associations of shame with MI in family**	*Learned shame-based MI stigma*
"It was actually daunting to them for me to ask to go to therapy and that was like a really big deal, but they started to understand its value over time. But it was surprising because they've both come from higher education themselves and like you know, they're good people, they just don't understand all forms of mental illness. Even the smaller forms like anxiety or depression. [Because of this] I think it took me a long time to understand what kind of help I needed to have like mental balance."	Recalls that it was difficult for parents to understand the value of therapy for MI. She believes her parent's cultural values continue to hold a strong influence on them regarding mental illness, despite their education level.	Felt clash of cultural values with MI treatment	*Cultural Value of Emotional Restriction*
"Like the family that I grew up in being super aware of mental illness	She believes her experience may be different from other	**Feels his/her views differ from that of**	*Distanced self from stigmatizing ethnicity-specific*

and that. Kind of shaped how I thought about it and how I viewed it, but I think that my experience would be unique compared to other white families and other white people in general."	white families because her family had more self-awareness regarding MI.	**others of that race**	*biases*
"I grew up as a close family. Family takes care of family. It was a farming community. So my family-- I've taken care of three generations. Family takes care of family. You take care of your elders. That's just a normal. That's just what we did. And we accepted that mental illness is in our family. So we don't just take it. We make that person work hard to be in the real world, so we push them and find different ways to keep going and not give up and to keep trying. It's a strength in our family."	Participants strongly values family – which has been passed down through the generations. This influenced the care and perception of family members with MI – adopts a mentality of acceptance of M.I, but also just keeps pushing through.	**Strong family bond influences treatment of people with MI within the family**	*Cultural values influenced by compassion*
"I think that I'm more optimistic about people's behaviors and abilities because of this. I like to think that I am more optimistic about things. Like, I have friends who just don't even bother to look at the homeless man or offer--- like I don't give them money-- but I definitely like to talk to them or ask them if they're hungry."	Feels family's value of compassion for others influences her optimism today for people impaired by physical and mental disabilities.	**Family value of respect/ compassion for all people**	*Cultural values influenced by compassion*

Following the sequential steps in the coding process, an exhaustive description was created which included all of the emergent themes and their corresponding theme clusters uncovered in step three and four. The resulting exhaustive description of ethnicity is as follows:

The impact of ethnicity on an individual's perceptions of people with MI is a learned cultural value of emotional restriction. This emotional restriction may have been learned from the family, whose cultural norms did not understand the value of mental health treatment. Additionally, some individuals recognize that shame-based MI stigma in early family life impacted their perception of people with MI Some individuals experienced their family associating mental illness as shameful, and others experienced their family's use of stigmatizing language about people with MI. Other individuals notice the stigmatizing attitudes learned from their family may negatively impact their perception of people with MI into adulthood. Individuals often express a desire to distance themselves from these traditionally stigmatizing views. On the contrary, some individuals experience their ethnicity as a positive impact on perception of people with MI. Some individuals experienced family values that recognized the humanity in people with MI. These individuals experienced a family value of respect and compassion for all people. Other individuals have a strong family bond, which influences how they perceive people with mental illness within the family. Others feel the positive influence of their family's values influences how they perceive people with MI today. Lastly, individuals with an awareness that their perception is less stigmatizing than others of their race also impacts how some individuals perceive people with MI because they see their own views as different.

Next this exhaustive description was abridged into a fundamental structure of the lived experience of ethnicity on perceptions of people with mental illness. In this step, I again focused in on only those aspects believed to be essential to the structure of the phenomenon (Morrow, Rodriguez & King, 2015). Given the variety of ethnicities represented in this study, responses widely varied. Some individuals reported the cultural values of their ethnicity influenced early stigma towards people with mental illness, while others reported that their cultural values influence how they treat all people and thus people with mental illness are not treated any differently. To ensure a variety of experiences, both positive and negative, were captured in the essential structure, I examined what role ethnicity seemed to be playing in the lives of the participants in my study. For the majority of participants, cultural values learned in childhood influenced their fundamental values as adults. These early cultural values predominantly included emotional restriction and compassion for others. Thus, the fundamental structure of ethnicity in this study captures both the positive and negative impact of ethnicity-specific perceptions about mental illness and speaks to how some participants continue to be impacted by ethnicity-specific perceptions in adulthood. As a result, the fundamental structure of ethnicity in my study is as follows:

Ethnicity impacts individuals' perceptions of people with mental illness by influencing their fundamental values. Ethnicity-specific values learned in early life from the family often include emotional restriction and compassion. Lack of adherence to cultural values led to shame-based stigma. Individuals who experienced tolerant family attitudes toward mental illness report a positive impact of ethnicity on their perception of people with mental illness, which continues to impact perception into adulthood.

Individuals who experienced constraining family attitudes towards mental illness report greater self-awareness of the negative impact of ethnicity-specific biases on their perception of mental illness and a desire to distance themselves from these biases.

Research Question Three

Question 3: How does the intersection of higher education and ethnicity influence perceptions of people with mental illness? To explore the impact of the intersection of higher education and ethnicity, participants were asked if they felt there were any intersections between the cultural values and beliefs of their ethnicity/race and their experience with higher education that has influenced how they perceive of people with mental illness. Participants were then asked to describe a situation in which they experienced this intersection and then to elaborate on how the experience impacted their life. Asking all participants to explain a personal experience in which higher education and ethnicity may have intersected to influence perception aided in the determination of significant statements later on. During my analysis, I highlighted all statements that directly pertained to the participants' experience with the intersection of higher education and ethnicity and considered those to be significant statements (#1 on Table 6).

After identifying all statements that mentioned the participants' experience with the intersection of higher education and ethnicity, I recorded each significant statement in an Excel document for further review. Upon reviewing significant statements in the Excel document, I thought back to my conversation with each participant. After spending up to an hour talking with each participant, I felt as though I understood any additional context that might further explain a participant's response. If I did not understand, I asked the participant clarifying questions during the interview and noted their responses. As such,

the formulated meanings reflect my attempt at bringing fourth the simplified essence of a

large quotation, given my knowledge of the full interview conversation with the

participant.

Next, after all significant statements were assigned a formulated meaning, (#2 on

Table 6) I then looked for patterns in all of the formulated meanings. For example,

several participants mentioned an increased understanding of the influence of their family

in how they perceive people with MI and feeling a sense of opposing personal values

from their family.

Additionally, several participants also mentioned clearer perceptions of mental

illness variations within their own culture/race and a clearer understand of the influence

of cultural norms on perception of mental illness. In the end, the ideas or topics

mentioned most often by participants became the cluster themes. Additionally, I kept the

theme clusters in language as close to the participants' responses as possible. The cluster

themes for the intersection of higher education and ethnicity were as follows: *behavior*

divergent from one's cultural norms is not necessarily mental illness; *warring values*

between self and family; *increased understanding of the influence of family level factors*;

positive change in perception of people with MI that now differs from family; *clearer*

perception of mental illness variations within one's own culture/race; *sees no*

intersection; *family values mirrored what she/he learned in school to influence*

perception; and *family indirectly influenced the intersection*.

After eight theme clusters were determined (#3 on Table 6), I analyzed all of the

theme clusters for possible overlap. For example, three clusters: behaviors divergent from

one's cultural norms is not necessarily mental illness; warring values between self and

family; and positive change in perception of people with MI that now differs from family, all seemed to describe a change in participants' perceptions about people with mental illness from beliefs they grew up with in their family. Participants seemed to break away from their original cultural beliefs about mental illness because they no longer aligned with the stigma as a result of their experience with higher education. As such, one emergent theme is: *difficulty accepting ethnicity-specific biases* (#4 on Table 6).

Next, I considered what the themes: increased understanding of the influence of family level factors; family values mirrored what she/he learned in school to influence perception; and family indirectly influenced the intersection, may have had in common. All of these themes described a newfound awareness of the influence of family on their perceptions of people with MI. Through the intersection of higher education and ethnicity, participants became more aware of how early cultural values held by their families may have both directly and indirectly influenced their perceptions of people with MI. As such, a second emergent theme is: *increased awareness of the role of family*.

Lastly, I considered what theme clusters, clearer perception of mental illness variations within one's own culture and no intersection, may have had in common. Both of these cluster themes seemed to describe different experiences. For some participants, the intersection of higher education and ethnicity provided a mechanism to better understand their own culture. For other participants, there was no visible intersection between higher education and ethnicity in their lives. As such, I felt both of these cluster themes should stand on their own as emergent themes. Thus, a third emergent theme is, *no intersection*, and a fourth emergent theme is *increased understanding of one's own*

culture. Below, Table 6 expands upon each cluster theme and emergent theme for every

significant statement and formulated meaning pertaining to ethnicity.

Table 6

Intersection of Higher Education & Ethnicity			
1. Direct Quote	**2. Formulated Meaning**	**3. Theme Cluster**	**4. Emergent Theme**
"Having my family background and taking care of elders in my families. This education-- I took a degree in gerontology, and now with this social work-- I want to help. Helping people with mental illness."	Cultural value of caring for family with MI influenced her to pursue higher education and eventually a career in helping people with MI.	**Increased understanding of the influence of family level factors**	*Increased awareness of the role of family*
"Well I think that there's a lot of emphasis or has been a lot of emphasis in my family and, kind of, where I grew up on higher education. And the expectation of that you do go to college at least. So, I guess, that kind of had an influence on the education piece, which then lead to how I perceive mental illness now."	Recalls that her family valued higher education, which contributed to her increased knowledge about MI and now influences her perception today.	**Family indirectly influenced the intersection**	*Increased awareness of the role of family*
"I mean it changed everything. Like I didn't want to be a lawyer anymore. I toyed with the idea of like not having children, which is like a really big deal in my culture. Like to say-- to like veer off of the traditional female roles was a	College made her realize she wanted to explore a different future for herself-- which did not align with the traditional values of her culture. This caused her to experience mental health issues and she began to see the value in therapy for the first time.	**Behavior divergent from one's cultural norms is not necessarily "mental illness"**	*Difficulty accepting ethnicity-specific biases*

big deal. So I did things like seek help and talk to therapists instead of just like relying on my parents' opinions or the people around me who are very similar to me. It was nice to have other opinions."			
"You see people like under high stress and all these other situations-- and the way that my background described it to me is like-- just keep pushing through this, like nothing is that big of a deal. Especially when your parents come from a revolution background. Like what the fuck are you going to tell them to be like, 'Yeah, today I just had a really hard day and I don't want to do my work, I just want to cry in my bed.'? They would be like-- "I don't understand that-- like you have to keep pushing'. There's just not usually an excuse to allow you to take a break. To take a big break like that. So I feel like that was part of it."	Feels college helped her recognize how her cultural values influenced her behavior and perceptions of mental health. Being in college allowed her to create space from the values that she did not identify with and normalized her own experience as a person with mental health issues.	**Behavior divergent from one's cultural norms is not necessarily "mental illness"**	*Difficulty accepting ethnicity-specific biases*

"It was nice to be around people in college-- that were so far off from the norm. You know what I mean? Like 'normal' is like a very weird term and like it was cool to see other people-- well, not cool--but it was nice to see other people struggle in the same ways that I did because it made me feel less crazy myself."	Feels the intersection of college and cultural values provided context for her family's stigma about MI, and she was finally able to see other people may experience MI. Felt normalizing.	**Behavior divergent from one's cultural norms is not necessarily "mental illness"**	*Difficulty accepting ethnicity-specific biases*
"I feel like everything I really love today is a reflection of my warring values between the two. Like in college, I had like a really big identity crisis and I still continue to have that cause I was still hiding pieces of myself from my family."	Today, she feels warring values between traditional cultural values of her family and her Western upbringing. She still does not feel fully comfortable expressing opinions/feels guilt for behavior due to perceived lack of understanding from parents.	**Warring values between self and family**	*Difficulty accepting ethnicity-specific biases*
"The individual is influenced by a variety of environmental factors. Microsystems being one of them-- so like, families. I think that's where they intersect. The family-- I understand that is how the individual is influenced by. I understand the family influence within that system component. I understand a little	Feels cultural values and higher education intersect to influence perception at the family level. Increased understanding of family and friend behaviors that may influence people with MI.	**Increased understanding of the influence of family level factors**	*Increased awareness of the role of family*

more about what can influence people. Like, there are things that I've realized in my own way, that families and friends do, that kind of-- make the mental illness issues a little harder to cope with, or deal with. So I can understand how, in a variety of other contexts, individuals that struggled with MI are influenced and affected by the communities around them. And policies."			
"[Regarding her cultural values] So I think, like, it was negative growing up and now I think positive has come from it because of like higher education."	Feels college helped her better understand the influence of her cultural values on how she thought about MI. Feels this is a positive impact.	**Behavior divergent from one's cultural norms is not necessarily "mental illness"**	*Difficulty accepting ethnicity-specific biases*
"So learning about all this stuff and like just different perspectives and learning about psychology-- like they [her family] don't have that understanding. So I think that that has… that plays like a roll and like how I understand everything because it's completely different from like how I grew up in like what I was taught from my family."	Feels an increased sense of awareness that her family's cultural beliefs about MI are not the only belief- but there are many other perspectives that are also valid.	**Behavior divergent from one's cultural norms is not necessarily "mental illness"**	*Difficulty accepting ethnicity-specific biases*

"I guess, maybe the only overlapped I can think about is like also having been able to like pursue higher education has also educated me more about my culture. What it means to be a minority and like how-- for example, what I just said. My dad grew up in a low economic household and has been low economic his whole life. And all of these things that could have influenced that. And not like as an entire culture-- like Black culture. But even then, the Mexican side too-- like learning about that in sociology or whatever. Like higher education has educated me more about my culture and like I don't think it's ever been 'Ok these two factors are directly learning about mental illness'. But I think to me, in my head, they are related."	Feels she can now see the connection between culture and mental illness based on what she learned in college. Greater understanding of factors specific to her own minority group that may influence manifestation of MI.	**Clearer perception of mental illness variations within one's own culture/race**	*Increased understanding of one's own culture*
"Then I also think just like… not, I guess, being a statistic in the sense of -- like, you know in community psychology, if you look at your mom's and dad's level of this and that you can measure how far	Feels college has made her more self-aware about societal factors that may make her at greater risk for mental health issues as a result of her ethnicity. She wants to pursue a different outcome for herself.	**Clearer perception of mental illness variations within one's own culture/race**	*Increased understanding of one's own culture*

you'll get in life? So that's what I mean when I say, 'I don't want to be a statistic'. I don't know if that's what it's like referring to, but I think that's impacted my life-- at least like this far like graduating in however long or whatever. Like I think that already getting me one step further than I could have been."			
"Yeah - there is an intersection, I would say that if I didn't get this higher education then I would be back where I was. Where like, I identify as white and I'm problematic and just basically the stereotypes of mental illness-- like they're violent, there's something wrong with them, and they can't be helped, or something like that. Whereas higher education has allowed me to like find myself and be more informed about mental illness and of course of other things-- that I didn't get from my parents or high school or anything."	Feels college helps her to understand her own ethnicity more and allows her to see herself as she truly is- a minority and someone with a MI- a contrast from how she was raised by her family.	**Warring values between self and family**	*Difficulty accepting ethnicity-specific biases*

"No. I don't think so [that there is an intersection]. No because I think the way I perceive it is more positive then I think what my race perceives it."	Feels there is no intersection between race and higher education for her because she does not identify with the traditionally stigmatizing MI norms of her race.	**No intersection**	*No intersection*
"Learning about mental health kind of moves you out of like-- the perceptions that, at least, my family has."	Learning about MI through higher education reduced the stigmatizing beliefs about MI she learned from her family.	**Positive change in perception of people with MI that now differs from family**	*Difficulty accepting ethnicity-specific biases*
"But I'm also, I think, have become more understanding of why and it's just like-- a generation circle and so you know what you know and that's what you do. And if you can't break out of that-- then how are you supposed to like learn new ways. Because I'm talking to my parents more about it and figuring out why-- there are a lot of things that nobody said or like why am I just finding out about something right now and like-- just like being able to ask questions. My experience with my two very good friends struggling with mental illness and like having my own mental-- that's all coming up now-- and I guess it's unfortunate like as a	Believes her family's stigmatizing beliefs about MI were influenced by a generational circle that was difficult to break out of and influenced what they knew. She resents her family for not being more open about MI and that she is just learning about it now.	**Increased understanding of the influence of family level factors**	*Increased awareness of the role of family*

senior in college that you're learning about all this now --within just the last 4 years and how it really, I think, has hindered an upbringing. But just knowing what I know now, I think it's valuable."			
"I'm trying to think, like, intersection wise, I mean. They both just well-- so my family gave me-- well taught me, compassion, empathy, socialization and so does school. But more than that, I don't really think there was much in terms of like vocabulary, but they both taught me just to be nice to people. Generally speaking that's what we can hope for everyone."	Feels things was has been taught through higher education mirror the cultural values she was taught by her family. Both of these influences intersect to influence how she treats all people.	**Family values mirrored what she/he learned in school to influence perception**	*Increased awareness of the role of family*
"Like treatment programs. Yeah a lot of its broken. And it's not the person's fault that they're not doing very well-- it's more like how can we be more compassionate. And not put everyone in the cookie cutter type of situation to be better. I think that's really reinforced my grandma's teachings of compassion and really understanding what a person is	Feels higher education has reinforced her desire to be compassionate to people with mental illness—a cultural value she learned from her grandmother.	**Family values mirrored what she/he learned in school to influence perception**	*Increased awareness of the role of family*

going through. Cause not everyone is the same-- and grounding that in a more educated model I guess."			
"Yeah, I think they do intersect. Like that relationship building and that compassion really needs to be strong before you can treat someone with mental illness or have a perception of someone with mental illness. If you're an incompatible clinician, you're not going to get anywhere. Or at the same time, like maybe the system is not as compassionate as the clinician, and then that's a negative intersection that clashes."	Feels compassion is needed to treat/work with someone with a mental illness. Compassion is something she learned from her family and through higher education.	**Family values mirrored what she/he learned in school to influence perception**	*Increased awareness of the role of family*
"I don't know if that just has to do with education or that's just like a moral value-- like maybe I have more empathy… And like I said I don't know if that just has to do with-- because I have a higher education."	Unsure if the change in her perceptions about people with MI is a result of her experience with higher education or if it has to do with her personal value of empathy – which she feels differs from her family.	**Warring values between self and family**	*Difficulty accepting ethnicity-specific biases*

Following the sequential steps in the coding process, an exhaustive description

was then created which included all of the emergent themes and their corresponding

theme clusters uncovered in steps three and four. The resulting exhaustive description of the intersection of higher education and ethnicity is as follows:

The intersection of higher education and ethnicity on perceptions of people with MI may lead to a positive change for some individuals as they experience an increased understanding of their own culture/race from knowledge gained about mental illness in college. This intersection may also cause some individuals difficulty in accepting the stigmatizing cultural beliefs about people with MI associated with their race. Some individuals begin to grasp that behavior divergent from their cultural norms is not always a sign of mental illness. Others may experience a sense of warring values between what they believe and what their parents believe about people with MI. Others recognize a positive change in their perception that now differs from their family's perception. Additionally, the intersection of higher education and ethnicity may highlight the role of family in how individuals perceive people with MI. Some individual's may experience an increased understanding of the influence of family-level factors, while others may only indirectly notice the influence of family. Others recognized the values they learned in college mirrored their family's values and thus influenced how they perceive people with MI. Lastly, some individuals do not recognize an intersection between their experience with higher education and their ethnicity because they do not identify with their culture's traditional views on people with MI.

Next this exhaustive description was abridged into a fundamental structure encompassing the intersection of higher education and ethnicity on perceptions of people with mental illness. In this step, I focused in on only those aspects believed to be essential to the structure of the phenomenon (Morrow, Rodriguez & King, 2015). During the

interviews, the majority of participants mentioned noticing a positive change in their attitudes about mental illness as a result of higher education. Higher education challenged any ethnicity-specific biases participants may have learned in childhood and caused a greater awareness of both internal and external factors that have influenced their perception. In the resulting fundamental structure, I expanded on how participants increased their self-awareness and recognized the impact of family on their perceptions of people with mental illness. As a result, the fundamental structure of the intersection of higher education and ethnicity in my study is as follows:

The intersection of ethnicity and higher education impacts a positive change in perceptions about people with mental illness, for those that recognize the intersection of these variables in their life. Through the intersection, individuals gain greater awareness of their own culture by examining the relationship between their ethnicity and mental illness. Individuals also become increasingly aware of the role of family in how they perceive people with mental illness through both cultural values and stigmatizing attitudes, and they describe their difficulty in accepting any ethnicity-specific biases. Individuals gain the ability to shape their perceptions for themselves and separate their values from the dominant values of their ethnicity and family.

Post Data Analysis Member Checking

Lastly, the final step in this process required returning all of the fundamental structure summaries to participants for review. I emailed nine out of ten of the original participants. One participant contacted me during recruitment by phone and did not provide me with an email address for follow up contact. I asked all nine participants for any feedback on the fundamental structures that arose and to let me know if my findings

matched their experience adequately. Four participants responded to my request for

feedback via email, and they all indicated that they had nothing to add to my structures

but some offered additional comments. One participant responded, "In terms of what I

spoke with you about, I believe it appears to be included within there. I don't have

anything to add." Another participant responded, "I like it-- all aspects here. I am going

to save this for my own reflection and positive encouragement with the times I seem to

struggle helping the older adults in my field of study." Finally, another participant

responded, "Maybe it's a generation and the digital age thing. I spoke to people a couple

generations from us (or just maybe one), and he said: it's incredible how young people

can speak openly about mental health, this was something we did not talk about."

Overall, all four participants who responded gave positive feedback and

acknowledged that my fundamental structures captured at least some aspect of their

experience with the topics under study; none suggested any modification to my

fundamental structures.

Discussion

In the preceding chapter, the presentation and analysis of interview data were reported. This penultimate consists of a summary of the study, a discussion of the findings, strengths and weaknesses of the research design; implications of my work will be considered in the final chapter of this thesis. In the pages that follow, results from each research question are expanded upon to provide a further understanding of how ethnicity, higher education, and the intersection of both influence attitudes towards people with mental illness. Findings from my study offer both new insights on the impact of these variables on perception, as well as offer an extension to the existing literature.

Summary of the Study

The purpose of this study was to explore how students' experience with higher education and ethnicity may have individually impacted their perceptions of people with mental illness, as well as to explore how the intersection of higher education and ethnicity may have impacted students' perceptions through qualitative research. As previous researchers had not examined the intersection of these variables on perception, descriptive phenomenological interviews provided a valuable method for capturing the essential essence of this poorly understood intersection, while staying as close to the raw data as possible. As such, participants were asked to describe an experience with higher education, their ethnicity, and the intersection of both that influenced how they perceived someone with a mental illness. Upon answering each of these questions, participants were asked to expand upon how each experience impacted their life. The format of these questions has been proven in previous phenomenological research to effectively capture

participants experience with a variable under study. Thus, the interview protocol used in this study provided a valid form of instrumentation.

The study included ten participants (five undergraduates, five graduates, 7 non-white students, 3 white students) purposively sampled to fulfill a quota of at least six different ethnicities within a population of students. This study included three research questions:

1. How does higher education impact perceptions of people with mental illness?

2. How does ethnicity impact perceptions of people with mental illness?

3. How does the intersection of higher education and ethnicity influence perceptions of people with mental illness?

All of these questions were answered qualitatively, and interview transcripts were coded and analyzed using Colazzi's framework for descriptive phenomenology (Morrow, Rodriguez & King, 2015; Shosha, 2012). Results of the data analysis were then returned to participants as a form of member checking to increase the credibility of the final results.

Major findings from this study include: students felt higher education provided them with new knowledge that helped shift their perspective towards acceptance of people with mental illness. This new knowledge that influenced the perception shift includes: direct experience working with people with mental illness, secondhand reports about mental illness experienced by teachers and peers, a new scientific language to describe and examine mental illness, and a broader understanding of systemic issues behind mental illness. Additionally, ethnicity seems to impact individuals' fundamental values, which in turn, influences how they perceive the outside world. The primary themes procured from the data indicate that ethnicity-specific fundamental values include

compassion towards others and/or emotional restriction. Lastly, the majority of

participants in this study identified a noticeable intersection of higher education and

ethnicity in how they perceive people with mental illness. The themes associated with

this intersection involve an increase in knowledge that led some participants to question

ethnicity-specific biases and an increased awareness of the role of family in how they

perceive and understand people with mental illness. Conclusions from the findings of this

study are discussed before implications are discussed and future research opportunities

are presented in the final chapter.

Assessment of Trustworthiness

As my study was qualitative in design, I considered Guba's (1981) four criteria in

both the design and execution of my study to ensure trustworthiness. Below is an

assessment of how each of the four criteria is satisfied within this study.

Credibility.

In this study, I utilized previously established research methods for both data

collection and analysis to build trustworthiness (Guba, 1981). For data collection, I

adapted the format of a previously utilized phenomenological interview by Englander

(2014) to fit the variables I intended to study. By strictly adhering to a descriptive

phenomenological framework, I ensured that my instrumentation actually measured what

I intended it to measure- participants' lived experiences. Further, to analyze interview

transcripts, I closely followed all of Colazzi's (1978) steps for descriptive

phenomenology analysis. Adherence to previously established research methods is a

strength of this study.

Additionally, I kept a reflexive diary to bracket any preconceived notions or

biases that arose before I started the interviews, after the interviews, and later during

analysis of the interviews. This diary helped me to keep track of initial impressions that

may have subconsciously influenced my analysis of participants' responses and later

theme development. Monitoring any changes in my beliefs about the topics understudy as

I completed more interviews helped to establish credibility. Despite my best effort,

documenting all changes in beliefs was not always possible. When abridging the

exhaustive descriptions of each variable into a fundamental structure, I was not always

aware of what preconceived notions may have guided my final decisions. In the future, I

would more actively engage in bracketing during this process.

Transferability.

To ensure findings from my study may be transferred to other populations, I have

provided adequate descriptive data on all participants. Shenton (2004) asserts that the

following information must be provided to ensure the reader has an accurate grasp on the

boundaries of the study. The number of organizations taking part in the study and where

they are based—in my study, one university based in Portland, Oregon participated. If

there are any restrictions in the type of people who contributed data—in my study,

participants were at least 18 years old and were required to be students at a university.

The number of participants involved—in my study, ten total participants were involved.

The data collection methods that were employed—I provided an exhaustive description

of the data collection methods employed in this study in the methods chapter. The

number and length of the data collection sessions—there were ten total data collection

sessions (interviews) in which participants were interviewed for 30 minutes to one hour.

Finally, the time period over which the data was collected—the corpus was collected over a span of two months.

Dependability.

To ensure similar results may be obtained if a future researcher replicated this study, I thoroughly documented the research design process and its implementation (Shenton, 2004). I detailed my process for creating the interview protocol and offered a step-by-step summary of how I analyzed each interview transcripts in accordance with a descriptive phenomenological framework. To increase dependability, the results of my project may have benefited from working with another researcher to ensure the methods and process I reported were clearly explained each step of the way. However, due to the nature of my thesis project, this was not possible.

Confirmability.

When I reached the interview stage of this study, I had already gained considerable knowledge about the topics under study from my prior research. Additionally, being the only researcher on this project, my findings ultimately ran the risk of investigator bias. With this in mind, I kept track of any thoughts and beliefs that felt influenced by previous knowledge during interviews. In an attempt to ensure confirmability of my findings, I reflected on my predispositions at every stage of the research process through reflective journaling in an effort to admit my beliefs and assumptions (Shenton, 2004, as cited in Miles and Huberman 1994).

Additionally, I engaged in member checking as the last step in my analysis. I returned each of the fundamental structures to nine out of ten participants to determine if my findings matched the participants' experiences. As the only researcher on this project,

member checking offered a method to verify the entirety and inclusiveness of my

findings to increase their accuracy. Overall, all participants who provided feedback felt

the fundamental structures captured at least some aspect of their experience, thus

improving the accuracy of my final results.

Overall, I made every effort to account for all four criteria of trustworthiness in

this study. As a novice researcher, I also acknowledge that there will always be room to

improve my process over time.

Discussion of the Findings

Previous research on the impact of higher education and ethnicity on perceptions

of people with mental illness is both inconclusive and limited within populations in the

United States. Some literature suggested people with higher education may be better at

hiding their negative attitudes or displaying more socially acceptable views (Arvaniti et

al., 2009; Barke, Nyarko, & Klecha, 2011; Phelan, Bromet, & Link, 1998; Mann &

Himelein, 2008; Yuan et al., 2016). Additionally, a trend in research findings suggested

cultural beliefs within different ethnic groups may impact perception formation and

stigmatizing beliefs about people with mental illnesses; however, there is a lack of

research on this topic in North America (Abdullah & Brown, 2011; Chen & Mak, 2008;

Ward, Clark, & Heidrich, 2009). The goal of my study was to expand on higher

education and ethnicity as individual variables that influence perception, as well as

explore the impact of the intersection of these two variables. This section discusses the

implications of the findings for each of the three research questions.

Research question one.

How does higher education impact perceptions of people with mental illness? In this sample, the findings resulting from research question one indicate that higher education does impact perceptions of people with mental illness for the positive. All four of the major themes associated with higher education demonstrate that students felt higher education provided them with new knowledge that helped shift their perspective towards acceptance of people with mental illness. This new knowledge that influenced the perception shift includes: direct experience working with people with mental illness, secondhand reports about mental illness experienced by teachers and peers, a new scientific language to describe and examine mental illness, and a broader understanding of systemic issues behind mental illness. These knowledge gains caused participants to feel an increased self-awareness that influenced attitudes of acceptance.

My findings are in line with conclusions drawn by Yuan et al. (2016) who found those who had completed some of a higher education degree demonstrated more accepting attitudes towards people with mental illness than those with lower levels of education. Arvaniti et al. (2009) found these attitudes of acceptance among university-level students to be expressed as less discriminatory and restrictive opinions regarding people with mental illness. While no students in my study directly reported that they discriminated against people with mental illness before receiving a higher education, some participants were able to reflect on how their opinions about people with mental illness have shifted to include increased empathy, a reduction in judgment, and a rationalization of certain behaviors.

Further, my results did not indicate or disprove that students with a higher education may be better at hiding negative attitudes or displaying more socially

acceptable attitudes towards people with mental illness as other researchers have found (Mann & Himelein, 2008; Phelan, Bromet, & Link, 1998). This may have been a weakness in the design of my study. Participants had the ability to respond to each question with minimal guidance, which may have resulted in some participants giving socially desirable responses. To strengthen the design of my study and account for socially desirable responses, I would have included a self-reflective prompt about higher education asking participants to consider if they have ever hidden their true feelings about mental illness from others.

Despite the limitation of this design, the ultimate goal of descriptive phenomenology is to explain a poorly understood phenomenon from the perspective of a person who has experienced that phenomenon firsthand. This requires the ability to trust that participants are telling the truth about their experience with the phenomenon. In my study, students demonstrated vulnerability in disclosing negative beliefs they may have held about people with mental illness in adolescence, the ways in which those beliefs may still impact them today, and a desire to separate themselves from early negative beliefs. Participants' willingness to be vulnerable may have also been influenced by their majors. Among students who reported their majors, seven students were found to be Psychology majors and one student was studying Social Work. Thus, the results of my study suggest that students who pursue Psychology or Social Work degrees, in particular, may be more open to discovering new ways of thinking, are self-aware of existing stigmatizing beliefs, and allow new knowledge to influence opinions and beliefs about people with mental illness.

Research question two.

How does ethnicity impact perceptions of people with mental illness? The findings from research question two indicate that ethnicity does impact perceptions of people with mental illness in both a positive and negative regard. Ultimately, ethnicity seems to impact individuals' fundamental values, which in turn, influences how they perceive the outside world. The primary themes procured from the data indicate that ethnicity-specific fundamental values include compassion towards others and/or emotional restriction. People who do not adhere to ethnicity-specific fundamental values are regarded with shame-based stigma in some families.

My findings are in line with Abdullah & Brown (2011) who found certain ethnicities to express mental health stigma as a result of their cultural values of family honor and concealment of emotions. Additionally, previous researchers found cultural minorities, specifically Black, Asian, and Middle Eastern cultures, to have higher rates of stigma toward mental illness (Abdullah & Brown, 2011; Chen & Mak, 2008; Ward, Clark, & Heidrich, 2009). The results of my study are partly congruent with these findings and indicate that the Iranian, Black, and bi-racial participates in my study all reported awareness of significant ethnicity-specific biases in their families. To provide context, Table 7 below provides examples of quotations from an Iranian, Black, and bi-racial participant in this study. (To maintain the confidentiality of the participants in my study and protect them from deductive disclosure, the Institutional Review Board requested that I remove specific, individual ethnicities from my final results. As such, my advisor and I considered the quotes below, jointly, and specific ethnicities were not noted in text but seen as consistent by the both of us.)

Table 7

"We've butt heads because I see things differently than them. Like I was saying, they just see mental illness as crazy and they don't really understand it. Whereas I try to explain to them."	"It was actually daunting to them for me to ask to go to therapy and that was a really big deal, but they started to understand its value over time. But it was surprising because they've both come from higher education themselves and like you know, they're good people, they just don't understand all forms of mental illness-- even the smaller forms like anxiety or depression. I think it took me a long time to understand what kind of help I needed to have mental balance."	"Like I don't know if it's just specifically my family, I don't want to speak for the entire [race], but I think that there's like a negative connotation and stigma around mental health. It's not something that's talked about. I think [my] culture has a really-- you just work hard and that's what matters. And anything emotional just gets in the way. At least in my family-- but my family also immigrated here. So I guess there wasn't really time to be concerned about other stuff. Like my grandma came here and that was her focus, so then that's how my mom was raised then she raised me like that."

In all three quotes, these particular participants reported that ethnicity-specific biases seemed to be a result of a lack of knowledge or understanding about mental illness in their families. Based on these responses, my results suggest a family's lack of knowledge about mental illness influences their use of cultural values as the primary frame of reality for understanding mental illness behaviors. These cultural values are then passed down through the generations of a family and influence the younger generation's perception. Some generational cultural values may be a positive influence and encourage compassion towards others, while others may be a negative influence and encourage emotional-restriction of mental health issues.

Further, my findings slightly differ from previous researchers that suggested Asian cultures tend to hold more stigmatizing beliefs about mental illness based on their attribution of personal failures as the cause of mental illness (Abdullah & Brown, 2011;

Chen & Mak, 2008). The results of my study indicated that participants of an Asian-ethnicity reported a learned cultural value of compassion or respect for all people, which in turn, they incorporated into how they viewed people with mental illness. Thus, the participants of Asian-ethnicity in my study seem to have less familial tolerance for ethnicity-specific cultural biases to influence their fundamental values of treating all humans with humility.

      Research question three.

      How does the intersection of higher education and ethnicity influence perceptions of people with mental illness? The findings from research question three indicate that the intersection of ethnicity and higher education impacts a positive change in perceptions about people with mental illness, for those that recognize the intersection of these variables in their life. The majority of participants in my study identified a noticeable intersection of higher education and ethnicity in how they perceive people with mental illness. The themes associated with this intersection involve an increase in knowledge that led some participants to question ethnicity-specific biases. Through the intersection of ethnicity and higher education, participants were better able to understand the role of family and the impact of their own culture in how they perceive and understand people with mental illness. Based on these results, the intersection of ethnicity and higher education led participants to an increased awareness of ethnicity-specific biases, and the influence these biases may have had on their perceptions about mental illness.

      While the majority of participants in my study felt the intersection of higher education and ethnicity was a positive impact on their lives, one participant felt there was no intersection between these two variables in her life and thus there was no impact. The

participant who reported no intersection felt that she no longer aligned with the ethnicity-specific biases commonly associated with her race, and thus she questioned if higher education or ethnicity truly impacted her perception, or rather, she simply possessed more empathy than others of her race.

As previously suggested, my results suggest a family's lack of knowledge about mental illness influences their use of cultural values as the primary frame of reality for understanding mental illness behaviors. Thus, as the students in my study gained more knowledge through higher education, they were able to implement this knowledge into their frame of reality for understanding mental illness behaviors. Thus, the intersection of higher education and ethnicity was reported as a conscious, positive motivator of change for most participants. For the participant who did not view the intersection of ethnicity and higher education as influencing her perception, but did report that her perceptions about mental illness has changed from her family's views, this result suggests higher education and ethnicity may act as an unconscious influence of perception shifts. As only one participant out of ten reported there to be no intersection between ethnicity and higher education, the results of my study still suggest the intersection of higher education and ethnicity positively impacts perceptions about people with mental illness.

Previous research studies have only examined the impact of both ethnicity and higher education in the medical student population (Korszun et al., 2012); thus, my study extends the current research by examining the impact of the intersection of these variables on non-medical students' perceptions of people with mental illness. As medical students make up only a small minority of people who obtain a higher education,

examining non-medical graduates and undergraduates increases the generalizability of my findings to the overall population.

Additionally, the current literature poses more questions than resolutions for future research on the impact of ethnicity and higher education on perceptions of mental illness. Chambers et al. (2010) noted that cultural differences seemed to significantly contribute to attitude differences in nurse populations regarding patients with mental illnesses. Ultimately, the researchers concluded that they had no true consensus on what factors influenced a positive or negative attitude towards people with mental illness due to the multifaceted nature of attitudes and knowledge gained (Chambers et al., 2010). Results from my study suggest that the intersection of higher education and ethnicity is highly likely to influence a positive attitude toward people with mental illness in non-medical student populations.

As can be seen, results from my study confirm that higher education often positively influences perceptions about people with mental illness by influencing attitudes of acceptance. Additionally, ethnicity influences a person's fundamental values, thus ethnicity may have a positive or negative impact on perception depending on the nature of the cultural value. Lastly, the intersection of higher education and ethnicity may positively impact individuals' perceptions of people with mental illnesses by increasing their awareness of the role of family, mental illness within their own culture, and the impact of ethnicity-specific biases in perception formation. My study adds to the current literature, as well as offers new findings that may help guide future research on public attitudes about mental illness

Conclusions

The purpose of this study was to explore how higher education, ethnicity, and the intersection of both of these variables may impact perceptions of people with mental illness. Results of this study illuminate how ethnicity influences early perceptions of people with mental illness, and later in life, higher education may challenge any ethnicity-specific biases. The intersection of higher education and ethnicity often leads to increased self-awareness when perceiving people with mental illness. This chapter illuminates how these findings add to the existing literature about the etiology of mental health stigma and may be utilized to influence teaching methods, develop new programs, and increase self-awareness. Additionally, this chapter presents suggestions for further research that may expand on higher education and ethnicity as variables that influence mental health stigma to aid in the creation and improvement of stigma-reduction interventions.

Implications for Practice

Public attitudes towards people with mental illness are impressionable, and they continue to be influenced by both conscious and unconscious bias (Stromwall, Holley, & Kondrat, 2012). This study analyzed two prominent demographic characteristics that have been shown to influence attitudes about mental illness: ethnicity and higher education. The findings from this study have implications for people interested in applying knowledge about public perception of mental illness to academics and policymaking.

For educators at the university level, this study offers insight into the positive effect higher education may have on students' perceptions of mental illness, and

illuminates the various strategies that may be most impactful changing negative bias. This study suggests that students should be exposed to courses that discuss mental health in order to broaden their understanding of the etiology of mental illness and the impact of ethnicity-specific biases on perception. Additionally, students should be encouraged to talk about mental illness with their peers and professors, as findings from this study suggest experiential knowledge gained from real world experience with mental illness is highly impactful. As findings from this study also suggest, many individuals grow up without the opportunity to discuss mental health due to ethnicity-specific biases or cultural values of emotional restriction. As such, college is often students' first exposure to scholarly conversations about mental illness and thus offers them a chance to think critically about mental illness for the first time. With these findings in mind, educators may decide to tailor their curriculum to bring more awareness to mental health and set formal stigma-reducing educational goals. Based on my findings in this particular sample of students, taking courses that explain the etiology of mental illness, challenge ethnicity-specific biases, and examine the origin of stigma may provide students with enough self-awareness to alter their behavior. Thus, I argue that colleges should consider creating a required mental health and stigma course that explores the topics listed above and provides students with the opportunity to reflect on their current beliefs about mental illness.

Additionally, results of this study may be useful to policymakers as they evaluate and revise existing U.S. federal government policies and programs in advancing higher education. This study provides further evidence that higher education offers students the ability to self-reflect on the influence of family and culture on their perceptions of people

with mental illness, which often results in attitudes shifting towards acceptance. Thus, additional grant funding and programs targeting first generation, low-income, and minority college students would be beneficial to encourage acceptance and reduction of mental illness stigma in the American workforce. Additional grant funding would benefit both the public and the government. The public benefits from more financial aid by receiving lower cost tuition and a chance to attend college. If more people are given aid to attend college, and they take mental health/stigma reduction courses, stigmatizing attitudes may be reduced. As a consequence of this, the government may benefit from more college graduates if stigmatizing public attitudes are truly reduced, and thus more people with mental illness could be accepted into the workforce. With more people employed, fewer people would need public assistance and more tax revenue would be generated.

To further explore the mutual benefit of people with mental illness joining the workforce, the Gheel model is examined once again. In Gheel, people with mental illness were allowed room and board with a foster family and given the opportunity to do meaningful work. Several researchers have noted the benefit of this mutual relationship to both the community of Gheel and the people with mental illness (Goldstein & Godemont, 2003; Van Walsum, 2004). For example, observations of the mentally ill during this time noted that moderate work and distraction were actually beneficial to their recovery (Goldstein & Godemont, 2003). Mentally ill individuals who were given modest jobs- such as cleaning or assisting around the house- were noted to be in improved mental states every month (Goldstein & Godemont, 2003). Thus, there is a clear benefit for some people with mental illness to be given the opportunity to work. At the same time, the

community also benefits on a social level. By closely incorporating people with mental illness into their communities, community members gained firsthand exposure to mental illness and were more likely to accept these people, rather than fear them; this can only happen on a wide scale if wide-scale destigmatization also occurs (Goldstein & Godemont, 2003).

As perspectives in the United States stand now, some members of society continue to fear people with mental illness rather than incorporate them into the community. This holds true especially in the workplace as the majority of individuals struggle to accept someone in a position of authority who has a mental illness (Pescosolido et al., 2013). Thus, one strategy for integrating mentally ill people into the community and, subsequently, the workforce is to increase the number of people who are able to attend college. As demonstrated by findings in this study, college has the potential to shift attitudes about mental illness and promote acceptance.

Recommendations for Further Research

The goal of this study was to investigate how higher education and ethnicity impacted public perceptions of people with mental illness. While many significant findings resulted from the analyzed data, this study is not without limitations. One limitation is that the majority of students who requested to participate in this study disclosed that they were either social work or psychology majors. Thus, these students had experience learning about mental illness directly through their classes. Findings from this study may have turned out differently had all of the participants in the study been business or science majors without a background in mental health.

Another limitation is in the design of the study. With my current descriptive phenomenological design, I did not include a measure for socially desirable responses. While participants were never directly asked if they held stigmatizing attitudes towards people with mental illness, the interview questions required participants to think about how they perceive people with mental illness. Thus, participants could have hidden any biased attitudes during the interview. To correct for this limitation, future studies may consider asking students to reflect on their experience with higher education within the interview and ask if they have ever hidden attitudes about mental illness for others. Alternatively, future studies may consider a mixed method design in which students are both interviewed and given a survey about their attitudes towards mental illness. The survey would contain a measure of social desirability, which would add to the validity of the final results.

Additionally, further research should expand on each theme uncovered in this study. For instance, findings from this study suggest higher education impacts perception of mental illness by shifting perspectives, providing experiential knowledge, increasing self-awareness, and illuminating new contexts. A deeper look at the theme, increasing self-awareness, may provide more specific insight into what mechanisms of self-awareness are influencing perception in higher education.

Another avenue of research might be to examine perceptions of mental illness in older adults who have a level of higher education. In this study, the majority of participants were traditional undergraduate students, and only one participant reported having children. As participants in this study primarily reported learning cultural values and subsequent ethnicity-specific biases from their parents and grandparents, there would

be value in examining the attitudes of an older generation. Older adults grew up with less

available knowledge and public acceptance of mental illness than today's generation.

Does the current generation of college students reflect fewer stigmas because mental

illness has been brought into the mainstream more than in past generations? Would there

be more evidence of lingering ethnicity-specific bias in older adults, rather than in

today's generation of students? A study of this nature would provide further insight into

how the influence of higher education and ethnicity may change over time.

Conclusion

The findings of this study expanded the work of previous researchers on the

impact of higher education and ethnicity on perceptions of people with mental illness, as

well as uncovered significance in the intersection of these two variables. This

investigation revealed that higher education provides students with the knowledge and

experience necessary to produce an expansive shift in their ability to accept others and be

self-aware. Additionally, ethnicity influences individuals' understanding of the etiology

of mental illness and, subsequently, the fundamental values they utilize as a frame of

reference for interacting with people with mental illness. Lastly, the intersection of

ethnicity and higher education is meaningful because individuals gain the ability to shape

their perceptions about mental illness for themselves and separate their values from the

dominant values of their ethnicity and family.

The current literature on attitudes towards mental illness notes that stigmatizing

attitudes still exist despite gains in knowledge and technology that explain the cause and

potential treatment for most diagnoses. Addressing stigma at the population level is

ineffective as variations between individuals' reflect attitude differences. Thus, stigma

should be addressed at the individual level and interventions should be influenced by

variables such as education level and culturally influenced values. This study

demonstrates the value of analyzing demographic characteristics from first-hand reports

of participants as a means to understand how stigma influences attitudes.

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APPENDIX A: Recruitment Flier

Share your Story about Race, Mental Illness & Higher Education!

A Research Study Conducted by Natalie Crocker: Graduate Student in Community Psychology

Eligibility criteria:
- Currently enrolled student at CU.
- All applicants must be 18 years of age or older to apply
- Applicants of all races and ethnicities are encouraged to apply to ensure diversity is represented in this study.

Purpose and what you will be doing:

The purpose of this study is to explore how two major components of a person's life may influence his or her perception of people with mental illness. The two factors of interest are experience with higher education (in this case, college and university) and ethnicity.

This study will explore how your experiences with formal higher education may have challenged, changed or influenced your perceptions of people with mental illnesses. This study will also explore how beliefs and values associated with your ethnicity may influence perceptions of individuals with mental illness. Lastly, this study will explore how formal higher education and ethnicity interact to influence perceptions.

To be in the study, you will participant in face-to-face interviews individually with Natalie. Interviews will take place in a private room in the library on the CU campus. During the interview, you will be asked to respond to several open-ended questions. You may decline to respond to any of these questions at any point.

Time Commitment:

Interviews are expected to last between 30 minutes and one hour

Contact the researcher:

To contact the researcher directly, please email: **ncrocker09@gmail.com** or text: **503-481-2788.** In your message, please list some days and times that you are available for the interview.

Thank you, and I look forward to hearing from you!

APPENDIX B: Informed Consent

Consent Form Research Study Title: The Impact of Ethnicity & Higher Education on Perceptions of Mental Illness

Principal Investigator: Natalie Crocker

Research Institution: CU

Faculty Advisor: Reed Mueller

CU – Portland Institutional Review Board Approved: March 20, 2018; will Expire: March 20, 2019

Purpose and what you will be doing:

The purpose of this interview is to explore the individual impact of both formal higher educational experiences and ethnicity on perceptions of individuals with mental illness, as well as to explore how formal higher education and ethnicity interact to influence perceptions. Because not all people identify with all aspects of the ethnic group they were born into, I will allow you to define for yourself how much you identify with your ethnicity, so I can learn about your unique experience.

I expect approximately 10 volunteers. No one will be paid to be in the study. I will begin enrollment on 3/14/2018 and end enrollment once quotas have been filled. To be in the study, you will participant in face-to- face interviews individually with the researcher. Interviews will take place in a private room on the University campus, and they are expected to last between 30 minutes and one hour. During the interview, you will be asked to respond to several questions. If you feel uncomfortable with any of the questions, you may decline to respond.

Risks:

There is minimal risk to participating in this study. To reduce any potential psychological distress resulting from questions about attitudes toward people with mental illness, you have the right to decline to respond to any questions or withdraw from this study at any time. Additionally, to attend to any potential cultural discomfort that may arise from answering questions about ethnicity, my intention is not to not use the findings from

this study to make assumptions about population homogeneity of any ethnic group. Instead, I will use the findings from my study as a tool to understand ethnicity as a variable that may influence perception.

There is also minimal risk in providing your information, however, I will follow the necessary steps to protect your information. Any personal information you provide will be coded so it cannot be linked to you. Any name or identifying information you give will be kept securely via electronic encryption or locked inside a locked drawer. Any recordings will be transcribed as soon as possible and once transcriptions are complete the recordings will be destroyed. When I look at the data, none of the data will have your name or identifying information. I will only use a secret code to analyze the data. We will not identify you in any publication or report. Your information will be kept private at all times and recordings will be destroyed as soon as possible and all other study documents will be destroyed 3 years after I conclude this study.

Benefits:

You may benefit from this research by knowing that your participation is contributing to the expansion of knowledge about factors influencing perceptions about people with mental illness. Further benefits of this study include an opportunity to understand the impact of formal higher education and ethnicity on perception formation in greater depth than previously examined. Results from this study may increase your self-awareness of previously unrecognized factors influencing your perceptions of people with mental illness.

Page **1** of **2**

Confidentiality:

_____ Participant Signature Date

_____ Investigator Name Date

_____ Investigator Signature Date

Investigator: Natalie Crocker email: ncrocker09@gmail.com c/o: Professor Reed Mueller CU – Portland

This information will not be distributed to any other agency and will be kept private and confidential. The only exception to this is if you tell me about abuse or neglect that makes me concerned for your immediate health and safety.

Right to Withdraw:

Your participation is greatly appreciated, but I acknowledge that the questions I am asking are personal in nature. You are free, at any point, to choose not to engage with or stop the study. You may skip any questions you do not wish to answer. This study is not required and there is no penalty for not participating. If at any time you experience a negative emotion from answering the questions, I will stop asking you questions.

Contact Information:

You will receive a copy of this consent form. If you have questions you can talk to or write the principal investigator, at ncrocker09@gmail.com. If you want to talk with a participant advocate other than the investigator, you can write or call the director of our institutional review board, Dr. OraLee Branch (email obranch@cu-portland.edu or call (503)-493-6390.

Your Statement of Consent:

I have read the above information. I asked questions if I had them, and my questions were answered. I volunteer my consent for this study.

_____ _____

_____ Participant

_____ Name

_____ Data

APPENDIX C: Debriefing Form

Study Title: The Impact of Ethnicity & Higher Education on Perceptions of People with Mental Illness

Thank you for agreeing to participate in this study. The general purpose of this research is to better understand if a person's ethnicity and/or experience with higher education have an impact on his or her perceptions of people with mental illness. As a reminder, any information you've shared with me today will be kept anonymous to protect your confidentiality. If, after our interview, you decide you would like to withdraw your responses from this study, please let me know via email within 48 hours.

During the course of our interview, we may have covered topics that brought up negative or uncomfortable thoughts or feelings for you. If you feel concerned or would like to talk to a professional, below are the counseling resources available.

University Counseling Services:

To make an intake appointment with a counselor, call the Counseling Directory line at 503-493-6499 and press 1. You can also stop by Student Services between 9 am and 5 pm Monday through Friday.

The Counseling Center is located on the lower level of Centennial Hall, in offices 8, 9, 10 and 11.

Non-university affiliated counseling services

Multnomah County Crisis Line and Project Respond:
Crisis support and mental health referrals 503-988-4888

Self-Help Online Brochures:
https://counselingcenter.illinois.edu/brochures

If you have further questions about the study, please contact me via email at **ncrocker09@gmail.com**. In addition, if you have any concerns about any aspect of the study, you may contact the director of our institutional review board, Dr. OraLee Branch (email: **obranch@cu-portland.edu** or call: **503-493-6390**).

Thank you again for your participation in this study. Your responses have made a significant contribution to my thesis project, and I appreciate your willingness to work with me.

APPENDIX D: Interview Protocol

Script prior to interview: *My name is Natalie, and I am a graduate student in the Community Psychology program. I will be interviewing you today to learn about your experiences with higher education, ethnicity and the intersection of both. I specifically want to know how your experiences with higher education and ethnicity may have influenced your perception of people with mental illness.*
During our interview, I will audio record our conversation on my phone, and later I will upload it to a password-protected computer. You may also see me taking brief notes during the course of our conversation. I will also be using a codename for you to protect your identity.
Before we begin, I will need you to review and sign this consent form. [Reviews aspects of consent form] Please let me know if you have any questions now or at any point during our interview.

Background information:
Date:
Identified ethnicity:
Grad/Undergrad?

Experience Questions:

1. **Please describe a situation in which you've had an experience or an interaction with a person with a mental illness.**

2. **Please describe a situation in which the cultural values or beliefs associated with your ethnicity or race may have influenced your perception of people with mental illness?**

    2a. How has this experience affected your life?

3. **Please describe a situation in which your experience with higher education might have influenced your perception about people with mental illness?**

    3a. What kind of impact did this have on your life?

4. **Do you feel there has been any intersections between the cultural values/beliefs of your ethnicity AND your experience with higher education that has influenced your perception of people with a mental illness? Please describe the situation.**

4a. What kind of impact did this have on your life?

Potential probing questions:
Can you tell me more about that situation?
Exactly what happened?

Post Interview Comments or leads:

CONCORDIA
UNIVERSITY

-PORTLAND, OREGON-

DATE:	March 20, 2018
TO:	Natalie Crocker
FROM:	Concordia University - Portland IRB (CU IRB)
PROJECT TITLE:	[1185001-1] The Impact of Ethnicity & Higher Education on Perceptions of People with Mental Illness
REFERENCE #:	PSY-2018125-RMueller-Crocker
SUBMISSION TYPE:	New Project
ACTION:	APPROVED
APPROVAL DATE:	March 20, 2018
EXPIRATION DATE:	March 20, 2019
REVIEW TYPE:	Expedited Review

Thank you for your submission of New Project materials for this project. The Concordia University - Portland IRB (CU IRB) has APPROVED your submission. This approval is based on an appropriate risk/ benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission. Attached is a stamped copy of the approved consent form. You must use this stamped consent form.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of March 20, 2019.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact OraLee Branch at (503) 493-6390 or obranch@cu-portland.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Concordia University - Portland IRB (CU IRB)'s records. March 20, 2018