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The role of discrimination, prejudice, and stigma in generating racial and ethnical mental health disparities in Sweden

1. INTRODUCTION

Sweden, like most other Western industrialized nations, has seen an increase in its share of immigrants in recent years. In 2018, nearly two million people were foreign-born (Statistics Sweden 2019). Historically, Sweden had not always been this heterogeneous. In 1960, around 4% of the population was foreign-born (Andersson et al. 2010). Since then, advances in the economy, awareness of the large welfare system and promises of equality have made Sweden an attractive destination for migrants. Although many relocate to Sweden from other European nations, in 2010 48% of the non-native population came from non-European countries (Andersson et al. 2010). Given the recent wave of asylum-seekers from conflict zones, this figure has likely increased. Whilst governmental limitations on the intake of refugees were imposed, the number of asylum-seekers was still over 100'000 in 2018, indicating the need to develop national resources to the integration of those groups and to monitor their well-being (Statistics Sweden 2019).

Annually, the Public Health Agency of Sweden releases a report aimed at delivering a faithful picture of the physical and mental health status of those living in the country. In recent years,

it has consistently informed us of unequal levels of ill mental health between native and foreign-born groups (Folkhälsomyndigheten 2017; Folkhälsomyndigheten 2018; Folkhälsomyndigheten 2019). Additionally, the publications indicate that the overall number of people suffering from mental health issues is steadily rising (Folkhälsomyndigheten 2018).

The issue of racial and ethnic mental health inequality is not just inherent to Sweden but is also present in other Western nations. For instance, mental health disparities between natives and minority groups are a trivial issue in the United States (U.S. Department of Health and Human Services 2001). Sociologists, psychologists, and economists have all attributed the root cause of this disparity to various dimensions of human life, their focus being the investigation of the ways particular social arrangements impact psychological states (Horwitz 2002). To some, belonging to a minority group is often correlated with lower income, higher unemployment and lower education (Wilkinson 1997; Jackson et al. 1996). In this view, ethnic mental health inequality is the by-product of social inequality, dictated by structural and institutional constraints. However, some would argue that looking at health inequality within the realm of "upstream" explanations, related to the share of knowledge and power, could result in neglecting what happens "downward", in the social-psychological mechanisms that govern the internalization of life experiences (Schnittker and McLeod 2005). In this framework, studies have proposed that migration per se is a stressful experience that comes at a mental and social cost (Bhugra 2004). If considered many migrants in Sweden are asylum-seekers who have recently experienced traumatic life events, it could easily be understood why minorities might report higher levels of mental illness. Similarly, language barriers might limit help-seeking for minorities and lead to social isolation. An additional explanation could be that foreign cultures are generally less open about mental illnesses and therefore less likely to seek treatment due to skepticism of the healthcare system or the unwillingness to recognize one's condition (U.S. Department of Health and Human Services 2001).

Whilst it is probable that all the above-mentioned factors contribute to some level to disparities in mental health across natives and foreign-born groups, this paper focuses on the mechanisms where discrimination, through its internalization or perpetration, generates mental health outcomes that particularly target ethnic minorities. The relevance of this proposition is twofold. The first purpose is to explain racial and ethnic mental health inequality through the interaction between individuals and their environments. There has been a shift in research where health disparities were traditionally mostly attributed to socioeconomic status (SES), to now posing a greater emphasis on psycho-social factors and their ability to generate large-scale phenomena (Schnittker and McLeod 2005). This paper places itself within this framework, explaining several mechanisms behind the disproportionate reporting of mental illness in minority communities. This is not to exclude the power of institutions or the material dimension of life in affecting individuals, but rather to highlight, in a multi-level fashion, the role that socio-cultural situations play in generating behavior, and the macro-consequences these mechanisms can lead to. The topic is explored through three different approaches: rational choice theory, social psychology, and cultural sociology. Three hypotheses are advanced, in line with the three perspectives, that can be regarded as complementary to each other. The second purpose is related to the current socio-political context. As more and more people seek access to Sweden, their integration through social inclusion and the provision of equal economic opportunity is a central issue. The increasingly favorable view of minorities as an economical or cultural threat that comes at the cost of native's quality of life and identity has brought a surge in hostility towards minorities. Research should, therefore, shed light on various ways individuals' perpetration of discrimination and the recipience of it can cause harm to communities.

2. LITERATURE REVIEW

Discrimination can be described as the practice of denigrating individuals or groups through beliefs, attitudes, and choices based on individuals' physical traits or ethnic affiliation. Racism and discrimination can be inflicted on and by both institutions and people, deliberately or not (U.S. Department of Health and Human Services 2001). Clark et al. (1999) report that minority groups regularly experience denigration by the majority group, and that those events have negative psychological and physical consequences. Studies have for instance bridged racism with hypertension among African Americans (Krieger & Sidney 1996; Krieger et al. 1997). Williams et al. (1997) report that feeling discriminated leads to lower well-being and self-reported ill-health, suggesting that beyond the discriminatory experience is a negative internalization process with harmful consequences. Similarly, Rumbaut (1994) describes how perceiving racial prejudice can lead to depression in children of immigrants.

Mental illnesses are the result of complex dynamics among biological, psycho-social and cultural factors. Generally, mental ill-health is determined by subjective experiences of depression, anxiety, mood disorders, stress, and addictive behaviors. Sometimes, the combination of discriminatory events with processes of stigma can also lead to unhealthy mental states (Link and Phelan 2001). Stigma, as defined by Goffman (1963), is an attribute or a characteristic owned, or presumably owned, by an individual, that negatively impacts the bearer's reputation (Link and Phelan 2001). Stigma can actively discourage individuals from seeking help, through mistrust of public services or active avoidance of stereotyping environments (Vogel, Wade, and Hackler 2007). Essentially, it differs from discrimination as the latter brings attention to the perpetrator, as opposed to the victim, as in the case of stigmatization (Link and Phelan 2001).

2.1 Rational Choice Theory, hypothesis I

One of the starting points to define discrimination and assess its implications on foreign-born groups is through Becker's (1957) *The Economics of Discrimination*. In the book, Becker introduces the concept of taste-based discrimination and applies it to the labor market. He explains that employers and customers possess preferences, or a taste, for the type of individual they have to work with, mainly to the disadvantage of women and racial minorities. Becker operated within the field of rational choice theory (RCT), an economic framework aimed at explaining human behaviour. RCT relies on "methodological individualism", the fact that all phenomena should be explained in terms of the actions of individual agents (Hechter 1987). Agents' action is "purposive" (i.e. intentional) and dictated by a rational propensity to maximize profit and utility, given the constraints imposed by preferences, beliefs, costs, and opportunities (Friedman and Hechter 1988). Becker's (1957) steppingstone comprised the formalization of racial preferences, describing individuals as averse to cross-racial interaction. In Beker's (1957) theory, employers' taste-based discrimination against minority workers generates a cascade effect of negative consequences. For example, minority workers might start seeking employment in sectors where discrimination is less prevalent. Similarly, they might accept a lower salary for the same work as a white employee, or else they might be paid the same but to the cost of having to be more productive. Even if the employer is non-prejudiced, the firm might be conscious of its customers' racial preferences, therefore choosing to preserve ethnic homogeneity in the workplace. Taste-based discrimination can also be analyzed through Kahneman's (1979) and Tversky's (1981*)* prospect theory, which models decision-making under risk. The model indicates that more value is given to the possibility of facing losses than acquiring gains. Employers, upon choosing whether to hire a minority worker and given their aversion to cross-racial interaction, put more weight on the losses that can arise from the choice of hiring that individual instead of the gains they can acquire from

the worker's abilities. Ultimately, prospect theory reminds us that decisions are made intuitively and limitedly because humans' cognitive capacity is restrained by time and emotions (Kahneman 2003). This interpretation of rational choice theory encompassing cognitive limitations is known as "bounded rationality" (Kahneman 2003) and derives from Herbert Simon's (1990) earlier theory of decision-making as "satisficing", which entails that we make choices returning sufficiently satisfying outcomes, instead of weighing all costs and benefits as presupposed by traditional RCT. So far, I have explained how discrimination by employers puts minorities at a socioeconomic disadvantage. This socioeconomic disparity is reflected in Swedish population register-data (Statistics Sweden 2019). Aversion to cross-racial interaction is here used as a pre-existing attribute of the population that serves the purpose of explaining socioeconomic disparities among foreign-born and natives. However, SES alone is an insufficient explainer of mental health disparities: it is rather more relevant to ask, what is it about social inequality that generates mental illness? Through RCT, I propose that disadvantaged individuals develop mental illness after a deliberate and unsuccessful attempt of relieving themselves from stressors arising from their socioeconomic position (SEP).

As RCT presupposes that agents operate purposively to maximize utility, it might become intellectually challenging to link deliberate action with detrimental behaviors that foster mental illness. In fact, the application of RCT to the field of medical sociology is rather underdeveloped (Hechter & Kanazawa 1997). However, a valuable starting point is provided by Thoits (1994), who proposes that psychological symptoms are the outcomes of unsuccessful intentional action aimed at resolving stress derived from losing one's job or experiencing love related problems. In her view, psychological conditions are the result of stressors that people try but fail to resolve. She demonstrates how those who succeed in reversing the condition that sourced their stress significantly reported better mental health. Researchers have long argued that living in poorer conditions brings along higher experiences of crime, violence, and poverty

that generate stress, which in turn can lead to mental illness. For example, Brydsten et al. (2018) have shown that fear of unemployment, experienced disproportionally by poorer individuals, negatively impacts mental well-being. Finally, low SES can be expected to provide stress through "status anxiety", the comparison with others, and "relative deprivation", the feeling of poverty as a result of the comparison (Wilkinson 1997). And, after all, discrimination per se can be deemed a stressful experience for the recipient of it, adding to the number of stressors in one's life (Clark et al. 1999).

In this section, we have explored through RCT how discrimination creates socio-economic inequality among native and foreign-born individuals and, fundamentally, how lower SES generates mental ill-health. As explained above, failure to solve stressors has negative psychological consequences. This leads to our hypothesis H1: due to the harmful consequences of financial constraints and relative deprivation on the psyche, *foreign-born groups who fail to change their socio-economic condition are expected to be reporting higher levels of mental ill-health*.

2.2 Social psychology, hypothesis II

One of the essential attributes of discrimination is that it arises across distinguished social groups. Feelings of belonging to either the minority or majority group lead to discrimination and stereotyping at the intergroup level (Brewer 1979). Intergroup dynamics are the direct consequence of humans' ability to form group identities that serve subjective and social purposes, ranging from solidarity to exploitation (Brewer 1979). Identities, per se, can be personal, social and collective (Stryker and Burke 2000). Whilst the greater the competitive interdependence between groups the higher the hostility from in-group to out-group members, intergroup contact under certain conditions can reduce prejudice (Allport 1954). For example,

Pettigrew (2008) suggests that cross-group contact and friendship-formation are powerful ways to enable empathizing with the outgroup. Generally, scholars have associated feelings of affiliation to groups as having a positive effect on health or mental health (Cross 1991). Others would argue that the same affiliation could increase stigmatization and damage mental health (Schnittker and McLeod 2005; Penn et al. 1993). Because one individual can simultaneously hold many identities, the salience and centrality of the racial and ethnic identity in one person can be determinant of the consequences of discriminatory experiences on mental health (Thoits 1999; Schnittker and McLeod 2005).

When foreign-born individuals seek treatment or diagnosis, differences in group affiliation between the clinician and its patient can have powerful consequences. Some studies show that clinicians reflect their racial culture of origin as well as their socioeconomic status (Epstein and Ayanian 200; Whaley 1998). Additionally, Whaley (1998) suggests that they inadvertently reflect the discriminatory attitudes of their culture. Clinicians can, therefore, misdiagnose minorities due to racial or ethnic bias and stereotyping, deliberately or not. Failure in obtaining a fair and therefore successful diagnosis can, in turn, generate mistrust of public health services. Mistrust, often, is already present as the result of historical persecution and as well as direct experiences of discrimination (U.S. Department of Health and Human Services 2001). Clinicians' struggle to relate to foreign groups can lead to failure in diagnosis, treatment and prescribing drugs (Giles et al. 1995). For example, Bond et al. (1988) found that young African Americans were deemed more aggressive than whites despite behaving similarly. Jenkins-Hall and Sacco (1991) showed that therapists interpreted an African American's depression as more severe than the one of a white client despite displaying similar behavior. Another remarkable study showed that poorer patients were given less effective treatment because medical staff deemed them to be less willing to improve their health and less capable of understanding the implications of their condition (Lutfey and Freese 2004). Because the interaction between

clinicians and patients is brief and fleeting, medical appointments simply do not provide enough meaningful contact to reduce prejudice from one group to the other. Meaningful contact, under Allport's (1954) theory, is comprised of equal status of the groups, authority support, intergroup cooperation and common aims (Pettigrew 2007). We can, therefore, hypothesize that under meaningful contact with minorities, medical staff should be better able to empathize with foreign-born groups and ultimately provide more accurate diagnosis and prescribe better medication. Higher contact with natives should likewise enable foreign-born groups to trust clinicians and public health services, leading to higher treatment-seeking rates among minorities. This leads to our second hypothesis H2*: i) treatment efficacy is lower when medical staff has insufficient meaningful contact with foreign-born groups; ii) treatment-seeking is lower when minorities have had insufficient meaningful contact with natives.*

2.3 Cultural Sociology, hypothesis III

The analysis of ethnic inequality is inevitably a question of culture. Culture, broadly, can be defined as "a shared set of beliefs, norms, and values" (U.S. Department of Health and Human Services 2001). Traditionally, culture was understood as a predefined source of social rules and understandings that were acquired by individuals via "socialization" (Bourdieu 1984). In this view, individuals were born in a culture that shaped their desires and behavior (Weber 1930; Parson 1951). Culture itself was mostly understood as coherent and structured, in Swidler's (1997) words a "seamless web" (DiMaggio 1997). However, this view has been substituted by a more complex definition of culture as fragmented across individuals, due, for instance, to socio-economic and religious differences. Culture is created inter-dependently through social interactions where we constantly draw new meanings and adjust our behavior based on the reactions we get from our actions. This process was described by Blumer (1969) as "symbolic

interactionism". Both Vaisey (2009) and DiMaggio (1997) report that culture has recently been reinterpreted as a source of justifications that enable us to make rational sense of our preferences and choices (Swidler 1997).

When addressing the issue of ethnical mental health inequality, the culture of origin of ill individuals is important because it shapes how they interpret their psychological condition, whether they seek help, the coping mechanisms they use and the amount of stigma they give to mental health (U.S. Department of Health and Human Services 2001). Generally, differences in cultural values and norms across groups can be partly attributed to homophily, which is the tendency of individuals to form relationships with similar others (McPherson 2001). Social network sociologists have observed how anything from diseases to cultural taste spreads through the clustered structure of social interactions (Bearman 2004; DellaPosta et al. 2015). Homophily can be a heavy determinant of segregation, both in social relations and in residential settings (McPherson 2001; Schelling 1978). In Schelling's (1978) notorious model, racial preferences in the neighborhood are the fundamental cause of residential segregation. As I will propose below, homophily can in fact damage one's quality of life by limiting individuals' exposure to opportunities and information (Rostila 2010).

A study in Sweden by Rostila (2010) has observed that homophily in migrants causes foreign-born groups to have worse health than natives. Particularly, he assessed that those migrants who belonged to social networks with higher numbers of natives enjoyed better health than more isolated foreigners. One way in which discrimination can negatively affect mental health is through incentivizing migrants to avoid stereotyping environments, therefore directly impacting the degree of their homophilous tendencies. Highly segregated social networks can lead migrants to have less social capital, which is the amount of information and opportunities brought by the collective. Thus, discrimination from the majority group can inadvertently hinder the "strength of weak ties", which is the importance of acquaintances in providing useful

information and opportunities (Granovetter 1973). Experiences of discrimination can, therefore, enhance homophilous behavior in minority groups, due to the unwillingness of foreign-born groups to form bonds with natives to avoid stereotyping environments. Following this logic, discrimination leads foreign-born groups to belong to less-informed social networks. Crucially, having less social capital limits minorities' abilities to seek help when in need of diagnosis or treatment, but it can also contribute to minorities' inability to reduce stress as advanced in the rational choice section of this paper. This is the premise for our third hypothesis H3: *foreign-born individuals who report higher levels of discrimination are more likely to belong to more segregated groups and experience higher levels of mental illness*.

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