Racism and Mental Health – A Cycle of Victimisation

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Abstract

Racism has been shown to be a serious issue in German society. The effects of racism on its survivors include psychological distress, anxiety and depression. Nevertheless, research has reported an underutilisation of mental health care among racialised individuals. Evidence shows that racialised individuals are deterred from accessing mental health care, due to fear of being discriminated against. A representative study report conducted by the German Centre for Integration and Migration [DeZIM] (2023) shows that there is a negative relationship between racism and mental health as well as a presence of internalised access barriers to mental health care. The current study attempts to find similar results, as was found in the study report by DeZIM (2023). Thus, the current aim is to establish a positive association between racism and symptoms of mental illness and investigate the implications this may have on accessing mental health care. This cross-sectional research is based on a purposive sample (*N=101*). In order to conduct the current study, the Everyday Discrimination scale and the Hospital Anxiety and Depression scale were employed. Next to that, the questions regarding internalised access barriers were derived from the DeZIM report. The findings indicate a weak negative association between racism and anxiety ($\tau = -0.26$, $p < .01$), while no association was found between racism and depression ($\tau = 0.06$, $p = 0.45$). In addition to that, participants who experienced above-average anxiety and/or depression symptoms showed relatively fewer internalised access barriers compared to those with below-average symptoms. The results may indicate effective coping strategies in mitigating the effects of racism. Moreover, the current sample shows resilience when combating racism, which may be reinforced by efficient environmental resources, a stable ethnic identity and social support. Regarding internalised access barriers, the current sample shows a presence of unmet needs, a higher baseline for anxiety and depression, and internalised stigma. More importantly, however, structural stigma and Othering processes may create additional barriers that influence the help-seeking behaviours displayed by racialised individuals. Practical and scientific recommendations are presented.

Keywords: racism, racial discrimination, racialised individuals, mental health, anxiety, depression, internalised access barriers

Racism and Mental Health – A Cycle of Victimisation

Introduction

"Germany has a racism problem", said Lower Saxony's governor, Stephen Weil in 2018 (Welt, 2018). But how big is this problem? More importantly, what are its consequences on German society? According to Dr. Naika Foroutan, the director of the German Centre for Integration and Migration Research (DeZIM)[1], "the intensity and consequences of experienced discrimination are unevenly distributed in Germany. The most frequently affected population groups are […] Black, Asian and Muslim people." (DeZIM, 2023). A representative study conducted in 2021 by the National Discrimination and Racism Monitor (NaDiRa) of the DeZIM Institute, showed that racism continues to be a serious issue in Germany affecting a large percentage of the German population. The study (titled *Racist Realities*) suggests that 90% of the German population acknowledges the reality of racism in German society (DeZIM, 2021). Moreover, the study showed that the majority of citizens of colour have experienced racism, with the dominant victims being Black, Asian and Muslim individuals. These groups, as the dominant target of racism, are often referred to as racialised individuals (DeZIM, 2021). Thus, the prevalence of racism in Germany is apparent, and the reality of it is acknowledged by the majority of the German population.

Racialisation is a process of assigning cultural and physical disparities between individuals and groups, belonging to different *races*, and essentially describes a process of racial categorisation. Moreover, it is a process in which racial attributions are connected to certain social problems where race is perceived as the cause (Murji & Solomos, 2004). Generally, the process of racialisation is initiated by members of a dominant social group, in order to classify the *Other*, i.e., minoritised groups, as inferior (Perry, 2002). In essence, racialisation is an attempt to emphasise one's superiority over another, thus maintaining perceived borders between races (Perry, 2002). The concept of racialisation is derived from the concepts of race and racism, which are social concepts rather than biological truths. Racism refers to "any set of beliefs that organic, genetically transmitted differences (whether real or imagined) between human groups are intrinsically associated with the presence or the absence of certain socially relevant abilities or characteristics" (van den Berghe, 1967, p. 11). Thus, racism indicates perceived differences between social groups that present believed grounds for distinction and the inferiorisation of a certain social group.

[1] The DeZIM Institute is a scientific research organisation in Germany with multiple branches that are primarily focused on the topics of migration, integration, social conflict, and racism (DeZIM, n.d.).

The terms racism and discrimination are often used interchangeably (e.g., Brondolo et al. (2005)). However, racism describes an ideological system that perceives one race as inferior to another, maintaining hierarchical differences between socially constructed concepts (van den Berghe, 1967). Discrimination, on the other hand, describes behaviours in which individuals are treated differently due to their affiliation to a certain social group. Concerning these concepts, racial discrimination defines prejudicial behaviours towards certain individuals or social groups due to their race (Taleb & Dahdouh, 2016). Therefore, whereas racism describes a complex, cognitive and hierarchical structure, racial discrimination encompasses the execution of behaviours that are based on racist beliefs. In essence, these concepts are complex, interrelated notions, that are socially constructed and mutually dependent.

Does Germany have a Racism Problem?

Germany has a long history of racism and racial discrimination, through which several processes of racialisation were visible. Indeed, multiple racist ideologies shaped German society during the 20th century, including eugenics and national socialism. Eugenics is a hereditarian science in which the procreation of *superior* individuals was promoted, while the extinction of *inferior* individuals was advocated. These *inferior* individuals were, among others, ethnic minorities. In the same way, the national socialist ideology built upon the work of eugenics and initiated the process of eugenic sterilisation, i.e., the sterilisation of *inferior* individuals (Allen, 1997; Dyck, 2014; Fenner, 1996; Menie, 2020). These ideological movements followed the process of infra-humanisation, whereby individuals show more positive attitudes towards members of their own social group (i.e., ingroup favouritism), while simultaneously showing more negative and derogating attitudes to other social groups (i.e., outgroup derogation) (Leyens et al., 2003). Therefore, processes of racialisation were evident in Germany, whereby the superiority of one group was promoted through the dehumanisation of another group.

Although most of these ideologies have since been disputed and disregarded, similar contemporary trends of racism and racial discrimination are prevalent. In her literature review, Lewicki (2018) reports that almost half of Germany's population agreed with anti-Muslim opinions. Furthermore, she reports an increase in attacks in 2016 on mosques as well as refugee institutions compared to previous years (Lewicki, 2018). In addition to that, the ongoing civil war in Syria caused millions of people to flee the country and seek refuge in countries such as Germany. Although the Syrian refugees received help and support, the animosity and hostility from a part of the public were visible (Lewicki, 2018). In fact, the so-

called ‘Mitte’ study, a representative study conducted every two years, reported a growth in extreme right-wing beliefs in 2016 compared to previous years. These extreme right-wing beliefs were mostly targeted at Muslims and asylum-seekers (Decker et al., 2016). More recently, in 2023, the Mitte study showed that the prevalence of extreme right-wing beliefs within the German population has doubled since 2016 (Zick et al., 2023).

On the contrary, more positive attitudes towards refugees fleeing from the Ukraine-Russia war were apparent. Dražanová and Geddes (2023) suggest welcoming support from the German government, as well as the population regarding Ukrainian refugees. Next to that, media outlets have reported more concern and generally more humanistic accounts of the Ukraine-Russia war. For example, in an interview with the British Broadcasting Corporation (BBC), a politician said, “European people with blue eyes and blond hair being killed.”, while a US news anchor for the Columbia Broadcasting System (CBS) News said, “This isn’t a place, with all due respect, you know, like Iraq or Afghanistan that has seen conflict raging for decades. You know, this is a relatively civilised, relatively European… city.” (MSNBC, 2022). The compassionate and increased media coverage of the war and Ukrainian refugees has been criticised and deemed racist when compared to the lack of media coverage for the wars in the Middle East (Allsop, 2022). In correspondence to the infra-humanisation processes during the eugenics movement, these reports show evidence of ingroup favouritism and outgroup indifference. This not only affirms the process of infra-humanisation but also re-affirms the severity of the racism problem in predominantly White countries.

The Effects of Racism on Mental Health and Mental Health Care Barriers

There are numerous consequences of racism for its survivors. Besides the initial reaction, which is oftentimes a combination of anger, embarrassment, shame and frustration, more long-term consequences of racism have been reported (Carter & Forsyth, 2010; Webster, 2021). According to Earnshaw et al. (2016), everyday racial discrimination can have detrimental effects on the survivor’s physical health, including an increased risk of chronic pain conditions, hypertension and cardiovascular diseases. Next to that, the consistent confrontation with racism and racial discrimination can have emotional effects on the survivor, whereby the affected individuals may cope with infuriation, aggression and distress (Griffin & Armstead, 2020; Nandi et al., 2016). A more commonly reported effect of racism, however, is its effect on mental health. Indeed, research consistently reports the negative impact of everyday racism on mental well-being, with Paradies et al. (2015) suggesting a greater effect of racism on mental health compared to physical health. Following the experiences of racism, the risk of developing psychological disorders, especially mood

disorders, increases (Schouler-Ocak & Moran, 2022). A representative study, conducted in the United Kingdom, showed that frequent exposure to racism is related to worse mental health, fear of future discrimination and avoidance of certain places (Wallace et al., 2016). Similarly, studies have shown that everyday racial discrimination is positively related to symptoms of depression (Earnshaw et al., 2016; Pascoe & Richman, 2009). Thus, research consistently illustrates the widespread negative impact of racism on the mental health of survivors. Consequently, this suggests psychological distress and an increased risk of developing mood disorders as a common response to racism.

The psychological effects of racism on members of racialised groups have been thoroughly established, whereby research consistently illustrates how regular experiences with racism increase the probability of developing mood disorders. However, there exists an underutilisation of mental health care services for racialised individuals. Evidence shows that racialised individuals delay and/or refuse to seek mental health care, due to the fear of being discriminated against (DeZIM, 2023). Moreover, multiple studies illustrate that the fear of being discriminated against within the mental health care system is a determining factor influencing help-seeking behaviour (Dumke et al., 2024; Kapadia, 2023). A representative study report conducted in 2020 showed that 64% of Afro-Germans have experienced racial discrimination within the health care system, including the mental health care system. This included reports of not being taken seriously as well as structural discrimination concerning access to health care (Aikins et al., 2021). In addition to that, a representative study conducted by Dumke and Neuner (2022) showed that, on average, psychotherapists have relatively more therapy-deterring attitudes towards refugee patients than German patients. Here, the process of ascribing more negative and stereotypical attributes to refugee patients was positively associated with fewer patients with a migration background. Thus, various racialisation processes are in progress that deter racialised individuals from seeking care. These processes pose a risk for the dual victimisation of racialised individuals, whereby they are victimised through regular experiences with racism. These lead to the potential development of mood disorders, and in the inquiry of mental health care, they are victimised again through racial discrimination within the mental health care system. Ultimately, these processes reinforce the underutilisation of mental health care services for racialised individuals.

NaDiRa – Racism and its Symptoms

In the study of racism and racial discrimination, it is essential to investigate the subjective experiences of the survivors, as this provides more insight into the personal perception of racism, the variety of experiences and the harmful impact of it (DeZIM, 2023).

Much research has been performed on these subjective experiences, stressing the importance of acknowledging personal encounters with racism to establish the urgency of the topic (see Aikins et al., 2021; Griffin & Armstead, 2020). One such examination is the large-scale study report done by DeZIM through NaDiRa in 2023 which provided insight into the subjective perception of racism (DeZIM, 2023). This representative study report, titled *Racism and its Symptoms*, employed a multi-method approach, including quantitative surveys and a field experiment. The first part of the report suggests that, on average, racialised people experience more discrimination compared to non-racialised people, whereby the majority identified skin colour, religion and German language skills as the main causes.

The second part of the report was related to the relationship between racism and health and showed that people who experience racism regularly rate their mental health on a moderate level, while individuals who do not experience racism rate their mental health as good. Moreover, the findings suggest that an increase in experiences of racism increased the number of symptoms of depression and anxiety. The third subsection shows three main findings namely (1) racialised people were more likely to delay seeing a doctor or to refuse it altogether due to fear of discrimination, (2) racialised people were more likely to give up the search for a psychotherapist, and (3) racialised individuals report that medical complaints are not taken seriously more frequently than non-racialised individuals. Thus, the study report highlights the widespread presence of racism in Germany, the subjective perception of it, and its negative impact on racialised individuals, especially regarding their mental health.

The current study expects to find similar results as the NaDiRa study report from 2023, by employing similar instruments as have been used in the study. More specifically, this study is primarily going to assess the negative effect of racism on mental health, and the delay or refusal to seek mental health care due to the fear of being discriminated against. In this instance, the latter is conceptualised as an internalised access barrier to mental health care[2]. In order to assess these factors, the following research questions are posed: “To what extent do experiences of racism impact the mental health of racialised individuals? (R1)” and “To what extent do racialised individuals, with above-average anxiety and/or depression symptoms, experience internalised access barriers to mental health care? (R2)”. In order to answer these questions, the following hypotheses are stated: (H1) The more frequently racialised individuals experience racism, the more symptoms of anxiety are present. (H2) The more frequently racialised individuals experience racism, the more symptoms of depression are

[2] For the purpose of this study, mental health care is conceptualised as general psychological care, including psychological counselling, psycho-social counselling, systemic counselling, emotional counselling, spiritual counselling, psychotherapy, and psychiatry.

present. (H3) Racialised individuals, who have above-average symptoms of depression and anxiety, experience more access barriers when seeking mental health care. The current research attempts to direct attention to how contemporary racism in Germany may cause a more pronounced social problem due to its possible negative consequences on mental health and mental health care. Moreover, the current study attempts to illustrate how racism and racial discrimination in the inquiry of mental health care pose a potential risk of the dual victimisation of racialised individuals. Thus, the aim is to investigate the subjective perception of racism, its impact on mental health and the possible implications to mental health care.

Methodology

Design

The present study utilises a between-subject, cross-sectional research design, and for that, a quantitative research approach is employed. The current aim is to establish a positive relationship between experiences of racism and symptoms of depression and anxiety. For this purpose, the independent variable is *Experiences of Racism*, while the dependent variables are *Anxiety* and *Depression*, respectively. The second objective is to establish a relationship between the need for mental health care and internalised access barriers. For that, the variables are *Anxiety*, *Depression* and *Internalised Access Barriers*.

Participants

The current research study encompassed a purposive sample of 132 participants[3]. Table 1 shows the demographical information collected from the participants, including age, gender, ethnicity, nationality, and country of residence. From the sample of 132 participants, 31 were omitted as they did not comply with the inclusion criteria and/or did not complete the whole survey. Regarding the inclusion criteria, participants had to have a migration background and be long-term residents in a predominantly White country (e.g., Germany). Next, participants had to be 18 years or older, to adhere to ethical regulations. Ultimately, this led to a working dataset of 101 participants.

Table 1

Demographic Information

Demographics	N	%

[3] In order to estimate the optimal sample size, an a priori power analysis was conducted with a significance level of $\alpha = 0.05$ and a power = 0.9 to achieve a medium effect. The analysis yielded an optimal sample size estimate of n = 85.

Gender		
Male	18	18.0
Female	83	83.0
Ethnicity		
African	44	46.3
Asian	10	10.5
Mixed	15	15.8
Middle Eastern	13	13.7
Eastern European	3	3.2
South American	2	2.1
Other/Unknown	3	3.2
Nationality		
Western European	61	61.0
Eastern European	6	6.0
Southern European	3	3.0
Dual Nationality	10	10.0
African	14	14.0
Asian	6	6.0
Country of Residence		
Germany	47	46.5
Netherlands	33	32.7
United Kingdom	11	10.9
Other	10	9.9
Age	Range = 18 - 39	

Materials

Several tools were utilised to conduct the current study. Firstly, to distribute the survey, and collect data, the online survey platform Qualtrics was used. Next, several pre-existing scales were employed to assess the variables of interest (i.e., *Experiences of Racism*, symptoms of *Depression* and *Anxiety*, and *Internalised Access Barriers* to mental health care). For each scale, there was a German and English translation, so that there was both an English and German version of the questionnaire.

Everyday Discrimination Scale

The first scale that was included was the Everyday Discrimination Scale by Williams et al. (1997). This instrument measures routinely experienced acts of discrimination, i.e., daily prejudiced treatment, and was employed for the study conducted by NaDiRa (DeZIM, 2023; Williams et al., 1997). As established above, literature continues using racial discrimination and racism interchangeably, thus, although the scale specifically mentions discrimination, rather than racism, the scale is used with caution. In total, two questions with multiple statements were used as they presented relevant to the current study. The first question focused on the experiences of racism in different contexts. The first question is a six-point Likert scale, where responses range from '0' (never) to '6' (almost every day). In total, there were eight statements related to the frequency of racism experiences, with values ranging from ‘0’ to ‘48’. The second question assessed the perceived causes of the discrimination highlighted before. Question two is a multiple-choice question, where participants have to choose one of five possible reasons for their experienced discrimination. In order to maintain the precision of the study’s objective, one statement in the first question was removed, while 10 options within the second question were removed or adapted. Finally, the internal consistency of the Everyday Discrimination Scale, including the first and second questions, is good (α= .76).

Hospital Anxiety and Depression Scale

Subsequently, the Hospital Anxiety and Depression Scale (HADS) was used to measure the symptoms of anxiety and depression and their severity (Zigmond & Snaith, 1983). This instrument is a self-rated mental health assessment and consists of 14 items and two subscales. Each subscale consists of seven questions, either related to symptoms of anxiety or symptoms of depression. The HADS is a four-point Likert scale, whereby '0' indicates the absence of, or minimal symptoms, and '3' refers to the presence of severe symptoms. The scoring is done for each subscale, whereby a score between ‘0’ to ‘7’ represents a *normal* case, ‘8’ to ‘10’ is categorised as *borderline normal* and ‘11’ to ‘21’ is defined as an *abnormal* case (Zigmond & Snaith, 1983). For the purpose of this study, the subscales were used separately. The internal consistency of the subscale ‘Anxiety’ was good (α = .80). Likewise, the reliability of the subscale ‘Depression’ was good (α = .78).

Internalised Access Barrier

Finally, the questions regarding internalised access barriers to mental health care were taken from the survey distributed by NaDiRa for their study report and adjusted for the

current study. Regarding the adaption of the questions, instead of relating the internalised access barriers to health care in general, this study specified the scope of the questions to mental health care, to sustain the conciseness of the current aims. In total, there were three questions, where two were specifically related to internalised access barriers, namely "In the last 12 months, have you delayed or avoided mental health care treatment, because you believed you were not going to be taken seriously?" and "In the last 12 months, have you delayed or avoided mental health care treatment, because you believed you would receive worse treatment than others?". Both questions were dichotomous, hence they could be answered with a 'yes' or 'no'. Following these questions, participants were asked to voluntarily choose one of four given reasons for avoiding or delaying treatment. The final question indirectly assessed internalised access barriers, as it was related to the participants' perceived need for mental health care ("When was the last time you sought mental health care for counselling, examination or treatment?"). This question was a multiple-choice question, with the choices being “less than 12 months ago”, “more than 12 months ago”, “I am still waiting for an appointment”, “I have given up trying to make an appointment” and “I have no need for mental health care”. Participants were asked to voluntarily choose one of the options.

In all, the survey consisted of 34 items, including demographic questions. Last but not least, participants were able to access the survey through any device that was capable of accessing the internet with the use of a stable Wi-Fi connection.

Procedure

In order to begin the process of data collection, ethical approval was requested from the ethics committee of the Behavioural, Management and Social Sciences (BMS) Faculty at the University of Twente. Upon receiving the approval to proceed with data collection, the survey was distributed. Regarding the recruitment of the target group, two sampling methods were employed, namely convenience sampling and snowball sampling. Thus, participants were recruited through several social media platforms (e.g., Instagram), and were asked to forward the survey to others who meet the inclusion criteria. In addition to that, participants were recruited from the research platform Sona System of the University of Twente, which specialises in participant recruitment. Finally, to inform possible participants of the aim of the study as well as the inclusion criteria, a short information sheet was distributed.

At the beginning of the survey, participants were informed of the purpose of the study and the inclusion criteria. More specifically, participants received a short definition of each inclusion criterion, so they were able to determine whether it applies to them. Next, an overview of the survey followed, and participants were informed about their rights, including

the right to exit the survey at any time and that their participation was completely voluntary. At the end of the welcome sheet, participants were asked to give consent to being a participant in the study.

After that, eight questions regarding demographics were asked, including participants' age, gender, nationality, ethnicity, and country of residence. Following this, participants filled in the HADS, the Everyday Discrimination Scale and the questions regarding internalised access barriers. Before each set of questions, the participants received a short instruction, and when necessary, an explanation of some terms (e.g., mental health care). At the end, participants were debriefed and thanked for their participation. Additionally, they were reminded of the sensitivity of the topic of interest and the contact information of the researcher was left in case someone experienced psychological distress while filling out the survey. For participants recruited from the Sona System, the contact information for the student psychologists at the University of Twente was left in addition. (see Appendix A for the whole survey).

Data Analysis

To begin with, participants who did not meet the inclusion criteria, i.e., participants without a migration background and who are below the age of 18, were removed from the data set. Additionally, participants with missing responses for the subscales *of Anxiety*, *Depression* and *Experiences of Racism* were omitted from the data set. In total, 31 participants were removed from the data set. Following that, the data set was transferred to a CSV file and exported to the statistical program R Studio.

At first, the internal consistency for each (sub)scale was examined using Cronbach's alpha. This was followed by an analysis of the descriptive statistics. Here, the mean and standard deviation for each continuous variable (i.e., *Anxiety*, *Depression*, *Experiences of Racism*) were calculated. Additionally, the mean and standard deviation for the continuous variables across the perceived causes of discrimination were calculated, to determine if there are differences between the causes of discrimination. The subgroups for the perceived causes of discrimination were determined through the participants' answers to the question "What do you think is the main reason for these experiences (of racism)?". In total, there were four subgroups, namely *Ethnicity*, *Skin Colour*, *Religion* and *Other*. In order to assess whether there is a significant difference between the means of the different causes of discrimination, Welch's Analysis of Variance (ANOVA) was performed. For the variable *Internalised Access Barrier*, the outcome proportions for each question and their answer options were calculated. In addition to that, outcome proportions for potential access barriers and their causes were

calculated. This provided an insight into the distribution and frequency of the different outcomes.

At the next stage, the parametric assumptions of normality, homogeneity, and multicollinearity were examined, to determine whether parametric tests for the main analysis were appropriate. This was done by conducting the Durbin-Watson test, creating a residual plot and a scatterplot, and finally, by calculating Pearson's correlation to measure multicollinearity. As two of the four assumptions were violated, non-parametric tests were performed for the main analysis. At first, Spearman's rho rank correlation matrix was determined, to get an overall impression of the relationships between the continuous variables *Anxiety*, *Depression*, and *Experiences of Racism*. After that, Kendall's tau rank correlation was calculated to answer the first and second hypotheses. Additionally, Kendall's tau correlations were calculated for the different causes of discrimination, to assess differences between the subgroups and their respective associations between racism and symptoms of anxiety and depression.

Finally, to answer the third hypothesis, the outcome proportions for the questions "In the last 12 months, have you delayed or avoided mental health care, because you believed you were not going to be taken seriously?" and "In the last 12 months, have you delayed or avoided mental health care, because you believed you believed you would receive worse treatment than others?" were calculated. For this purpose, participants were divided into two subgroups, namely *Clinical* and *Non-Clinical*. To determine what constitutes a clinical case and a non-clinical case, the scoring from the HADS was adopted. Participants with a score between '0' to '10' were below the average, hence they were allocated to the *Non-Clinical* subgroup, while participants with a score between '11' to '21' were above the average, and were thus allocated to the *Clinical* subgroup. In this instance, participants who were *borderline normal* (according to Zigmond and Snaith (1983)) were allocated to the non-clinical group, as their scores did not constitute an *abnormal* case. In order to determine, if the outcome proportions for the two questions related to *Internalised Access Barriers* were significant, a chi-square test of independence was performed for each question. Last but not least, outcome proportions were calculated for the question "When was the last time you sought mental health care for counselling, examination or treatment?", which ultimately shows the participants' need for mental health care.

Results

Descriptive Statistics

The current study had four variables of interest, namely *Anxiety, Depression, Experiences of Racism* and *Internalised Access Barriers*. Table 2 shows the descriptive statistics for each variable individually, as well as across the perceived causes of discrimination (to view the distributions for *Internalised Access Barrier*s, see Table 3).

Table 2
Descriptive Statistics

	Anxiety	Depression	Experiences of Racism
	M (*SD*)	*M* (*SD*)	*M* (*SD*)
Sample (*N = 101*)	10.61 (2.81)	8.90 (1.68)	13.01 (6.63)
Perceived Causes of Discrimination			
Ethnicity (*n = 17*)	10.47 (3.20)	8.94 (1.48)	13.94 (7.61)
Skin Colour (*n = 44*)	10.91 (2.72)	8.82 (2.50)	13.20 (6.74)
Religion (*n = 10*)	10.70 (2.67)	9.00 (1.41)	10.80 (6.81)
Other	10.23 (2.86)	8.97 (2.16)	12.93 (5.97)

The values for *Anxiety* within the current sample ranged from ‘3’ to ‘17’, while the values for *Depression* ranged from ‘5’ to ‘16’. The mean scores for *Anxiety* and *Depression* were almost equal across the perceived causes of discrimination.

For the variable *Experiences of Racism*, the values within the sample ranged from ‘0’ to ‘35’, with ‘0’ representing an individual who never experiences discrimination in the scenarios that were outlined, and ‘35’ representing an individual who experiences discrimination regularly. Table 1 shows the distribution of the perceived causes for discrimination, with skin colour (*n=44*) and ethnicity (*n=17*) being the most quoted reasons.

A Welch’s ANOVA was performed to assess the differences between the causes of discrimination. The analysis yielded no significant difference between the subgroups Skin Colour, Ethnicity, Religion, and Other with the variable *Anxiety* ($F(3, 31.43) = 0.35$, $p = .79$), *Depression* ($F(3, 32.38) = 0.07$, $p = .97$) and *Experiences of Racism* ($F(3, 31.05) = 0.43$, $p = .73$).

In regard to *Internalised Access Barriers*, 25% of the participants within the sample stated they sought mental health care less than 12 months ago, while another 25% reported that they sought mental health care more than 12 months ago. In total, 11% have indicated

that they have either given up getting an appointment or that they are still waiting for an appointment and 39% stated that they do not need mental health care. Next to that, 24.2% of participants indicated that they have avoided mental health care because they believed they were not going to be taken seriously, while 13.1% avoided mental health care because they assumed they were going to receive worse treatment than others. The most stated reasons for these assumptions were skin colour (32.8%) and ethnicity (14.1%). Moreover, three participants reported that they have avoided mental health care due to the assumed quality of the mental health care system in their country of residence. Additionally, four participants learned about the experiences that members of their respective ethnic groups have had and decided to avoid mental health care altogether. Besides that, additional reasons for avoiding mental health care included being viewed as *weak* or *unstable*.

Main Analysis

Table 3 shows Spearman's rho (ρ) rank correlations between the variables *Anxiety*, *Depression*, and *Experiences of Racism*. There is a significant negative correlation between *Experiences of Racism* and *Anxiety*, however, the remaining correlations are not significant.

Table 3
Rank Correlation Matrix (ρ)

	Anxiety		Depression		Experiences of Racism	
	ρ	*p*	ρ	*p*	ρ	*p*
Anxiety	1.00	–	-0.09	(.35)	-0.34	(< .001)
Depression	-0.09	(.35)	1.00	–	0.08	(.45)
Experiences of Racism	-0.34	< .001	0.08	(.45)	1.00	–

Next, Kendall's tau (τ) was used to investigate the association between *Experiences of Racism* and symptoms of *Anxiety*. Contradictory to the first hypothesis, more *Experiences of Racism* were weakly associated with fewer symptoms of *Anxiety*, $\tau = -0.26$, $p < .01$. Similarly, there was a negative association between *Experiences of Racism* and *Anxiety* for participants who attributed the cause of their discrimination to skin colour ($\tau = -0.44$, $p = .03$) and ethnicity ($\tau = -0.41$, $p < .01$). For the additional causes of discrimination, no association was found.

Contrary to the second hypothesis, there was no association between the frequency of *Experiences of Racism* and symptoms of *Depression*, $\tau = 0.06$, $p = .45$. Additionally, no association between *Experiences of Racism* and *Depression* was found across the different causes of discrimination.

Table 3 shows the percentages for the subgroups *Non-Clinical* and *Clinical* regarding their internalised barriers to mental health care. The association between the subgroups *Non-Clinical* and *Clinical* with the question: "In the last 12 months, have you delayed or avoided mental health care, because you believed you were not going to be taken seriously?" was significant, χ^2 (1, 101) = 7.58, $p < .01$. Similarly, the association between the subgroups and the question: "In the last 12 months, have you delayed or avoided mental health care, because you believed you would receive worse treatment than others?" was significant, χ^2 (1, 101) = 4.97, $p = .03$.

In addition to that, Table 4 shows the need for mental health care across the two subgroups *Non-Clinical* and *Clinical*. Regarding their access level, in the subgroup *Non-Clinical*, 59.5% indicated that they have received care before, while 40.5% have not received access or sought care. Similarly, 42.6% in the subgroup *Clinical* have received care before, while 57.4% have either not received care or not sought care. Furthermore, contrary to the third hypothesis, the participants who, on average, experience above-average symptoms of anxiety and/or depression experience relatively fewer access barriers. To illustrate, while 38.6% of *Non-Clinical* participants assumed they were not going to be taken seriously, 12.7% of *Clinical* participants believed so. In the same way, while 22.7% of *Non-Clinical* participants believed they would receive worse treatment in mental health care, only 5.5% of *Clinical* participants assumed that. However, while 26.2% of *Non-Clinical* participants believed they did not need mental health care, almost half of the *Clinical* participants believed they did not need mental health care (48.1%). Thus, the third hypothesis is rejected.

Table 3

Internalised Access Barrier (%)

Subset (*N=101*)	In the last 12 months, have you delayed or avoided mental health treatment because you believed…			
	…you were not going to be taken seriously?		…you would receive worse treatment than others?	
	Yes	No	Yes	No
Non-Clinical (*n=45*)	38.6	61.4	22.7	77.3
Clinical (*n=56*)	12.7	87.3	5.5	94.5

Table 4

Need for Mental Health Care (%)

Subset (*N=101*)	Less than 12 months ago	More than 12 months ago	I am still waiting for an appointment	I have given up trying to make an appointment	I have no need for mental health care
Non-Clinical (*n=45*)	33.3	26.2	9.5	4.8	26.2
Clinical (*n=56*)	18.5	24.1	3.7	5.5	48.1

Discussion

Racism and Mental Health

The objective of the current study was to establish an association between experiences of racism and mental health and investigate the further implications it may have for racialised individuals in accessing mental health care. Moreover, the current study attempted to find similar results as was found in the study report by NaDiRa. In regard to the first hypothesis, it was expected to find a positive association between experiences of racism and anxiety. In the same way, the second hypothesis expected to find a positive correlation between racism experiences and depression. However, the results indicate that there is little to no association between anxiety and/or depression with experiences of racism. In fact, the association between racism experiences and anxiety was negative and weak, while the association between racism experiences and depression was not significant and thus non-existent.

Although these results were unexpected, certain processes may account for this pattern. First and foremost, racialised individuals may have coping mechanisms to combat the effects of racism. Griffin and Armstead (2020) identified multiple coping methods used in enduring racism and racial stress, which include problem-focused coping and emotion-focused coping. On the one hand, problem-focused coping refers to using effective, goal-oriented strategies to address a stressful situation. This may include using environmental resources to decrease the impact of racism. To illustrate, social support as well as religion and religious involvement have been shown to mitigate the psychological effects of racism (Brown, 2008; Ellison et al., 2008). On the other hand, emotion-focused coping involves responding to adversities, in this case, racial injustices, by internalising the experience, commonly guided by aggression, anxiety, distress and depression. Griffin and Armstead (2020) suggest that negative emotional coping strategies may increase the risk of developing mental health issues. Therefore, whereby problem-focused coping is effective in decreasing

the psychological effects of racism and increasing resilience, emotion-focused coping may do the opposite and increase the risk of psychological distress. In regard to the current sample, participants may have developed effective problem-solving methods to combat the psychological effects of racism.

Similarly, on an individual level, some may demonstrate more resilience than others when confronted with racial discrimination. Nandi et al. (2016) have identified two factors of resilience that combat the negative psychological effects of racism, one of which includes individual-level resilience factors. Individual-level factors refer to the ability to preserve positive psychological health when faced with negative challenges such as racial discrimination. These factors may include the sense of belongingness to one's ethnic group. Indeed, the social identity theory suggests that an individual's identity is composed of personal identity and social identity, which encompasses various group affiliations including one's ethnic group (Scheepers & Ellemers, 2019). According to Nandi et al. (2016), members of ethnic minorities who strongly identify with their own ethnic group demonstrate stronger resilience to racial discrimination. This in turn positively affects their well-being, whereby ethnic identity (i.e., sense of belongingness to one's ethnic group) positively mediates the relationship between racism experiences and psychological well-being.

In like manner, social-level factors have been identified, that decrease the psychological consequences of racism and racial discrimination. Nandi et al. (2016) describe social-level factors as resources within a community that assist in recovering and restoring well-being in the community after adversities. Taken together with the effective coping methods identified by Griffin and Armstead (2020), environmental resources and social support may positively influence the psychological consequences of racism. Thus, the sense of affiliation one may have regarding their ethnic group may mitigate the negative effects of racism on one’s mental health. In the same way, a strong social environment may assist in combating the psychological effects of racism. With regard to the current participants, individual and social-level resilience factors may be at play. On the one hand, participants may have a strong affiliation to their ethnic group, which implies a strong ethnic identity, and thus decreases the risk of psychological distress as a response to racism. On the other hand, the outcome may imply that the current participants have resourceful environments and increased social cohesion within their ethnic communities, which may also mitigate the effects of racism.

Finally, the current participants may have received psychological care in the past, which may have provided them with tools to cope with racism and racial discrimination. The

current study showed that 33% of the *Non-Clinical* subgroup, i.e., participants with below-average symptoms of anxiety and/or depression, received psychological care less than 12 months ago. According to Lakioti and Stalikas (2018), psychotherapy increases resilience which assists in managing life's stressors. Indeed, Lakioti and Stalikas (2018) found several resilience factors that are promoted through psychotherapy, including a better understanding and attitude toward the self, increased ability to cope with negative emotional experiences, and psychological empowerment. These were identified as effective methods to combat future challenges. Moreover, these skills may increase the ability to mobilise environmental resources to mitigate potential consequences of racial discrimination (Griffin & Armstead, 2020; Nandi et al., 2016). Griffin and Armstead (2020) have identified the effects of racism as racial stressors, that increase the possibility of developing anxiety and depression symptoms. Therefore, psychotherapy is effective in decreasing these consequences and providing efficient tools for combating the psychological effects of racism.

Internalised Access Barriers to Mental Health Care

According to the third hypothesis, racialised individuals with above-average symptoms of anxiety and depression ought to experience more internalised barriers when accessing mental health care. However, upon comparing the subgroups *Non-Clinical* and *Clinical* with each other, it is evident that racialised individuals with below-average symptoms of anxiety and depression experience more internalised access barriers in mental health care. Interestingly, almost half of the participants with above-average symptoms of anxiety and depression assumed they did not need mental health care, while approximately one-fourth of the participants with below-average symptoms assumed this.

Multiple scientific explanations may account for these outcomes. To begin with, the participants may not experience internalised access barriers to mental health care because they do not believe they need care to begin with. Indeed, the current study showed that almost 50% of the participants with above-average symptoms of mental illness lack help-seeking attitudes, simply because they assume they do not need mental health care. This assumption is called unmet need, which is defined as "an individual who is in need of psychiatric treatment [but] does not seek care" (Pattyn et al., 2014, p. 232). According to Pattyn et al. (2014), this assumption may be a consequence of culture-based beliefs and stigmas related to mental health and mental health care which are transmitted through the process of socialisation and internalisation. Within various ethnic minorities the common understanding of what constitutes mental illness, and hence, what requires mental health care, differs from the dominant culture (Carpenter-Song et al., 2010; Satinsky et al., 2019). These beliefs are often

internalised by members of these ethnic groups, which then guides their perception of and behaviour towards mental health. Nevertheless, as has been discussed above, ethnic minorities often cope differently with adversities, including symptoms of anxiety and depression. Griffin and Armstead (2020) show that many racialised individuals have a collection of effective coping mechanisms, most of them being community-based. Ultimately, it is important to acknowledge the effectiveness of the coping mechanisms used by ethnic groups, while simultaneously evaluating their adequacy in combating more severe symptoms of psychological distress.

Furthermore, the baseline level of anxiety may be higher for racialised individuals than for non-racialised individuals. This may be due to the normative experience of hypervigilance caused by regular expectations of racial discrimination. As 50% of the *Clinical* subgroup assumed they have no need for mental health care, a higher baseline of anxiety may account for this assumption. Godsil and Richardson (2017) suggest that expected racial discrimination can create a sense of threat for racialised individuals. This form of hypervigilance is defined as racial anxiety. A regular consequence of feeling threatened is increased attention to the source of the threat. Richards et al. (2014) suggest that anxiety is related to hypervigilance, whereby the assumption of threat leads to selective attention towards the source of threat which in turn retains the state of anxiety. Godsil and Richardson (2017) propose that racialised individuals frequently experience racial anxiety when interacting with non-racialised individuals, thus maintaining the state of hypervigilance and with that the state of anxiety. Ultimately, this implies a potentially higher baseline of anxiety for racialised individuals living in predominantly White countries due to the consistent experience of hypervigilance caused by regular encounters with racism. The prevalence of racism in these countries warrants a more normalised response to racial discrimination. Thus, rather than being the exception, racial anxiety becomes the norm for racialised individuals. This, in turn, justifies the current assumption, that they have no need for mental health care, as a higher baseline simultaneously implies a higher cut-off score.

Differently, a lack of help-seeking behaviour may be caused by both public and internalised stigma. Stigma is defined as attitudes or beliefs, mostly negative, towards certain ideas or mechanisms that influence how an individual or a collective acts towards others. In this case, mental health stigmatisation refers to the discriminatory beliefs or assumptions individuals have towards people with mental disorders (Gary, 2005). Pattyn et al. (2014) differentiate between two types of stigmas, namely perceived public stigma and anticipated self-stigma. Perceived public stigma is defined as the knowledge of publicly held stereotypes

about a specific topic (Pattyn et al., 2014). In contrast, anticipated self-stigma refers to the internalisation of these (negative) stereotypes, which may simultaneously lead to an internalisation of the devaluation and dehumanisation communicated through one's perceived public stigmas (Pattyn et al., 2014). In the current research, multiple participants mentioned how they feared being viewed as *weak* or *unstable* by others if they were to seek mental health care, which is an illustration of the internalisation of perceived public stigmas surrounding mental health care. Furthermore, the fear of potential disadvantages of appearing *weak* within the workplace, or the assumption that employers may question their ability to function at the workplace, are further deterring factors identified as treatment fearfulness (Deane & Chamberlain, 1994). Pattyn et al. (2014) propose that individuals consider various factors before executing a behaviour, including adopting the viewpoint of others concerning the behaviour and whether it is socially desirable. The negative stereotypes that surround help-seeking behaviours thus deter individuals from performing these behaviours.

In addition to that, the results show that participants were deterred from accessing mental health care, due to the perceived quality of the mental health care system and/or the treatment members of their respective ethnic groups have received. Kapadia (2023) defines this as structural stigma which refers to systematic discriminatory practices executed by public institutions. This phenomenon affirms the reality of institutional as well as structural racism in many public, governmental and health institutions. Kapadia (2023) suggests that mental health care professionals may originate the root of the psychological issues experienced by ethnic minorities, to themselves and their cultural, and/or biological specifications. This is a process of racialisation within the field of mental health care, whereby it is argued that an individual from an ethnic minority experiences mental distress due to belonging to their respective ethnic group. This is often done unconsciously but can also be a conscious process of underestimating their concerns. This then has the effect of deterring members of various ethnic minorities from seeking mental health care, as they may believe their concerns are going to be dismissed and not taken seriously, or their concerns are going to be attributed to their affiliation to their respective ethnic group (Kapadia, 2023). According to the attribution theory, this may be considered an attributional bias (Kelley & Michela, 1980). In other words, the aetiology of mental disorders within ethnic minorities is attributed to their ethnicity, which describes an internal attribution, while external factors, such as racism, are disregarded. Consequently, the cause of the mental disorder is assumed to be intrinsic, and the magnitude of external factors is neglected. Similarly, the attribution theory may account for the lack of help-seeking behaviour displayed by members of different

ethnic minorities. Kapadia (2023) suggests that several mental health care professionals, as well as researchers, ascribe the lack of help-seeking behaviours of members of ethnic minorities to personal stigmas. Although internalised and public stigmas deter ethnic minorities from seeking mental health care, these merely represent two factors of a multifaceted and complex mechanism. In fact, disregarding structural stigma when discussing possible causes for the lack of help-seeking behaviour is a detrimental error. Especially neglecting institutional racism as a potential stressor that may hinder racialised individuals from seeking mental health care, reaffirms the process of racialisation within the mental health care system.

Finally, almost one-quarter of the participants have avoided mental health care as they believed they would not be taken seriously, while over 10% avoided care because they expected to receive worse treatment than others. This outcome is similar to the findings of the study report by NaDiRa, where 10% of the racialised participants indicated that they have avoided seeking health care because they believed they would receive worse treatment and/or they would not be taken seriously. This is also in line with the findings of Memon et al. (2016) where racialised individuals avoided mental health care as they expected to be racially discriminated against by the health care staff. The process of internalising the biased and stereotypical perceptions of minority groups by members of the dominant social group is referred to as *Othering* (Dumke & Neuner, 2022). Othering has been evident in the mental health care system; here psychological health care professionals have been shown to have cultural biases against racialised individuals. These biases represent the cognitive component of the Othering process, while the behavioural execution of these biases is discrimination (DeZIM, 2023; Dumke & Neuner, 2022). Dumke and Neuner (2022) showed that psychotherapists with biased and stereotypical viewpoints towards refugee patients had fewer patients with migration backgrounds. Thus, the detrimental effect of Othering on patient treatment, and its implications regarding the utilisation of mental health care contribute to the ethnic disparities within the mental health care system.

In sum, the current findings suggest that (1) there is a proportion of participants with an unmet need for mental health care, (2) racialised individuals have a higher baseline for certain mood disorders, (3) some participants are more resilient to the effects of racism, (4) participants are deterred from accessing mental health care, which is influenced by multiple stigmas and Othering processes and (5) participants have delayed or avoided mental health care as they expected racial discrimination within the system.

Strengths and Limitations

The current study had a multi-cultural sample with an appropriate sample size. The study found evidence for the proposed concept of the dual victimisation of racialised individuals, introducing a term that provides a new viewpoint to the different racialisation processes at play. Last but not least, the current findings suggest a novel perspective to the ongoing discussion of the effects of racism on mental health and its implication on accessing mental health care for racialised individuals.

However, it is important to acknowledge the limitations of the current study. Firstly, to measure racism and experiences of racism, the construct had to be operationalised to observable concepts. Accordingly, racism was operationalised as racial discrimination. Therefore, when selecting an instrument to assess the occurrence of racism in the lives of the participants, a scale measuring racial discrimination was used. Although racism and racial discrimination are closely related concepts, whereby the former represents the cognitive component and the latter the behavioural component, racism and racial discrimination are still two distinct concepts. Consequently, this may have created a discrepancy between the intended objective of the current research and the actual outcomes of the study.

Furthermore, the current research attempted to find similar results as was found in the report conducted by NaDiRa. More specifically, this study originally aimed to replicate the NaDiRa findings. However, the current study design differed with respect to the original report. Whereas NaDiRa conducted a comparative study, in which they compared racialised individuals to non-racialised individuals, the current sample only consisted of racialised individuals. In the same way, the demographic in this study differed compared to the study report by NaDiRa. Concerning the study *Racism and its Symptoms*, the sample of racialised individuals was limited to Blacks, Asians, and Muslims. On the other hand, the current study included more ethnicities, which ultimately means, more variety in the experiences of racism. Lastly, while the NaDiRa study report was a representative study, the current study was not representative. Ultimately, these factors made a replication of the NaDiRa study unfeasible. Consequently, these discrepancies may account for the disparities in the outcomes.

Last but not least, in the current sample, there were differences in the perceived causes of racial discrimination, as well as perceived causes of access barriers, showing the heterogeneity of experiences of racism. It is crucial to obtain an accurate account of the experiences of racism, to draw precise conclusions on the relationship between racism and mental health. Relatedly, if comparisons were to be made between the perceived causes of discrimination, representative sample sizes are needed. The current study however lacked

representative subsamples, thus the comparisons between the causes of discrimination should be regarded with caution.

Recommendations

Finally, future research is needed regarding the different racialisation processes within varying contexts. Indeed, future research should identify the types of racism that are most commonly experienced by racialised groups. These results may then be used to detect which form of racism is most harmful to the mental health of racialised individuals. Furthermore, future research should further investigate the effective coping methods used to combat the psychological consequences of racism. Moreover, within that framework, the effects of a strong ethnic identity and group affiliation should be further investigated. Especially in the Western European context, more research into the efficacy of coping mechanisms used to mitigate the effects of racism is necessary, given that most studies are conducted in the United States. A follow-up study may then examine whether these coping methods are effective in diminishing the symptoms of depression and anxiety. These may consequently be considered a form of therapeutic intervention, which differs from traditional Western mental health care, yet shows similar success rates. In regard to practical recommendations, a more diversity-sensitive and anti-racist approach to mental health care is needed, which addresses the needs of racialised individuals, and simultaneously reduces the cultural bias of mental health care professionals. Rather than focusing the majority of resources on decreasing personal stigma, the focus should be redirected to diminishing structural stigma and institutional racism within the mental health care system.

Conclusion

In conclusion, the current study has provided a new perspective on the relationship between racism and mental health. The findings suggest that there is a negative association between racism and symptoms of mental illness. Nevertheless, it is crucial to acknowledge that the average levels of anxiety and depression across the different causes of discrimination were concerningly high. Surprisingly, participants with above-average levels of anxiety and depression symptoms did not believe they needed mental health care. On the other hand, those who did show help-seeking attitudes reported a delay or refusal to access mental health care, as they feared racial discrimination within this system. Therefore, the findings show disparities in internalised barriers to mental health care between racialised individuals with varying levels of anxiety and depression. Moreover, the current research, along with other studies, suggests that several deterring factors are internalised by racialised individuals. Next to that, half of the participants with above-average symptoms of depression and anxiety, do

not perceive a need for mental health care, which can have detrimental effects on their psychological well-being. Indeed, the current study stresses the need for diversity-sensitive mental health care services to decrease the deterring factors to mental health. Finally, it is important to address the consequences of structural stigma on the underutilisation of mental health care services. Ultimately, reconstructing the current mental health care system to resolve the barriers experienced by racialised individuals may account for the underutilisation of mental health care services.

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Appendix A

Welcome Message and Consent Form

Welcome to my bachelor's thesis, thank you for participating! You are invited to take part in the current research study titled "Racism and Mental Health – A Cycle of Victimisation". This study is conducted by Priscilla Benneh from the Faculty of Behavioural, Management and Social Sciences (BMS) at the University of Twente. The study aims to investigate the potential effects of racism on mental health and its implications regarding access to mental health care providers. The study will take approximately 20 minutes to complete, and the data is going to be used to investigate the aim outlined above. Additionally, you can choose whether you want to execute the study in English or German (see the right upper corner). In order to take part in the current study, you must have a migration background and be either a 1st generation or 2nd generation immigrant. A 1st generation immigrant is defined as an individual who was born in a country and immigrated to a different country, while a 2nd generation immigrant refers to an individual who was born in a specific country, but whose parents were born in a different country. If this does not apply to you, I kindly ask you to exit the study.

Your participation in this study is completely voluntary and you can withdraw from it at any time. Please try to answer the questions as accurately and truthfully as possible, however, you are not obligated to answer the questions. At the beginning, you will be asked to provide some demographic information. After that, you are going to fill out the survey regarding racism, mental health and access to mental health care.

The present research has been reviewed and approved by the BMS Ethics Committee, and there appear to be no known risks associated with the participation of this study. However, as this is a sensitive topic, the possibility of psychological discomfort and/or distress exists. If you feel uncomfortable when answering the questions, feel free to exit the study. Next to that, as the current survey is an online study, the risk of a breach is possible. Nevertheless, your answers are going to be treated confidentially and anonymously. The obtained data will not be used for any other purpose besides research. If you have any further questions, feel free to contact me or my supervisor.

Contact details for further information or questions:

Priscilla Benneh: p.benneh@student.utwente.nl

Yudit Namer (supervisor): y.namer@utwente.nl

In case you have any concerns about your rights as a participant, you can contact the Ethics Committee of the Faculty of Behavioural, Management, and Social Sciences of the University of Twente: ethicscommittee-bms@utwente.nl.

If you click on 'I consent', you accept to being a participant in this current research.

To begin with, we are going to collect some demographic information.

How old are you?

_____

What gender do you identify with?

- Male
- Female
- Non-binary/third gender
- Prefer not to say

What is your ethnicity? (Note: Ethnicity refers to the membership of a group with a shared cultural, traditional, historical, linguistic and ancestral identity)

_____

What is your nationality? (Note: Nationality refers to the membership of a specific country, either through being born there or through obtaining legal citizenship)

_____

What country are you currently residing in?

- Germany
- Netherlands
- United Kingdom
- Other: _____

Did you migrate yourself to the country where you are a long-term resident/citizen?

- Yes
- No

Did one or both of your parents migrate to the country where you are a long-term resident/citizen?

- Yes
- No

Tick the box beneath the reply that is closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate answer is best.

I feel tense or 'wound up':

- Most of the time
- A lot of the time
- From time to time, occasionally
- Not at all

I get a sort of frightened feeling as if something awful is about to happen:

- Very definitely and quite badly (3)
- Yes, but not too badly (2)
- A little, but it doesn't worry me (1)
- Not at all (0)

Worrying thoughts go through my mind:

- A great deal of the time (3)
- A lot of time (2)
- From time to time, but not too often (1)
- Only occasionally (0)

I can sit at ease and feel relaxed:

- Definitely (0)
- Usually (1)
- Not often (2)
- Not at all (3)

I get a sort of frightened feeling like 'butterflies' in the stomach:

- Not at all (0)
- Occasionally (1)
- Quite often (2)

- Very often (3)

I feel restless as I have to be on the move:

- Very much indeed (3)
- Quite a lot (2)
- Not very much (1)
- Not at all (0)

I get sudden feelings of panic:

- Very often indeed (3)
- Quite often (2)
- Not very often (1)
- Not at all

I still enjoy the things I used to enjoy:

- Definitely as much (0)
- Not quite so much (1)
- Only a little (2)
- Hardly at all (3)

I can laugh and see the funny side of things:

- As much as I always could (0)
- Not quite so much now (1)
- Definitely not so much now (2)
- Not at all (3)

I feel cheerful:

- Not at all (3)
- Not often (2)
- Sometimes (1)
- Most of the time (0)

I feel as if I am slowed down:

- Nearly all the time (3)
- Very often (2)
- Sometimes (1)
- Not at all (0)

I have lost interest in my appearance:

- Definitely (3)
- I don't take as much care as I should (2)
- I may not take quite as much care (1)
- I take just as much care as ever (0)

I look forward with enjoyment to things:

- As much as I ever did (0)
- Rather less than I used to (1)
- Definitely less than I used to (2)
- Hardly at all (3)

I can enjoy a good book or radio or TV program:

- Often (0)
- Sometimes (1)
- Not often (2)
- Very seldom (3)

In your day-to-day life, how often do any of the following things happen to you?

- You are treated with less courtesy than other people are (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- You are treated with less respect than other people are (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- You receive poorer service than other people at restaurants or stores (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- People act as if they think you are not smart (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- People act as if they are afraid of you (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- People act as if they think you are dishonest (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- People act as if they are better than you are (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- You are called names or insulted (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)
- You are threatened or harassed (almost every day, at least once a week, a few times a month, a few times a year, less than once a year, never)

- None of these

What do you think is the main reason for these experiences? (choose a few)

- Your ethnicity
- Your skin colour
- Your religion
- Your German/English/Dutch skills
- Your name
- A different reason, namely: _____

The next questions refer to your access to mental health care. This includes psychological counselling, psycho-social counselling, systemic counselling, emotional counselling, spiritual counselling, psychotherapy, and psychiatry.

In the last 12 months, have you delayed or avoided mental health treatment, because you believed you were not going to be taken seriously?

- Yes
- No

In the last 12 months, have you delayed or avoided mental health treatment, because you believed you would receive worse treatment than others?

- Yes
- No

Why did you believe you were not going to be taken seriously or treated worse than others?

- Because of my skin colour
- Because of my religion
- Because of my German/Dutch/English skills
- Different reason, namely: _____

When was the last time you sought mental health care for counselling, examination or treatment?

- Less than 12 months ago
- More than 12 months ago
- I am still waiting for an appointment
- I have given up trying to make an appointment
- I have no need for mental health care

Thank you for your participation! Your response has been recorded.

In case any of the questions triggered psychological discomfort, feel free to contact me (p.benneh@student.utwente.nl). If you are a student at the University of Twente, you may also contact the student psychologists (sacc@utwente.nl).

Appendix B

Artificial Intelligence Statement

"During the preparation of this work, the author(s) used Grammarly.com for spelling and grammar checks. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the work."