Examining The Relationship Between Internalized Racism and Mental Health, and The Moderating Effect of Cultural Orientation

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Abstract

Internalized racism (IR), where individuals internalize prejudice and beliefs about their ethnic group, is considered one of the subtle types of racism with different facets. The consequences can be enormous, once these beliefs are internalized. IR can lead to a negative impact on mental health such as psychological distress or depressive symptoms. Based on Berry's model of acculturation, the importance of keeping one's own ethnic culture is indispensable for mental health. In this cross-sectional study, the relationship between internalized racism and mental health (MH) was examined with the moderating effect of cultural orientation (CO) toward one's ethnic group. Through experience sampling methods, 65 participants of various ethnicities, mainly residing in Europe, were evaluated through social media platforms. To measure internalized racism, the subscale Devaluation of One's Own Group (DOG) of the Appropriated Racial Oppression Scale (AROS) was applied. Further, the Mental Health Continuum Short Form (MHC-SF) was used to assess an individual's mental health. Lastly, to assess cultural orientation, the Stephenson Multigroup Acculturation Scale (SMAS) was utilized. Pearson's correlation test revealed no significant relationship between IR and MH for the total sample. Nonetheless, a negative effect of IR on mental health among ethnically white participants (EWP) was found. Similar results were found in the multiple regression analysis, where only a negative effect between IR and two subscales of mental health, namely psychological and emotional well-being for EWP. These results suggest that the perception and experience of IR vary among the population and need to be tailored for further investigations.

Keywords: internalized racism, cultural orientation, mental health, cross-sectional study, Berry's model of acculturation

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Examining The Relationship Between Internalized Racism and Mental Health, and The Moderating Effect of Cultural Orientation

In past years, psychologists have emphasized on research concerning internalized racism. While the direct effect of racism has been researched, the indirect effect functioning on internalizing levels has been largely overlooked (David, Schroeder & Fernandes, 2019). Internalized racism is only one of the four types of racism besides structural, institutional, and interpersonal racism (Speight, 2007). Structural racism involves racism that is deeply established in law, policies or attitudes, leading to an unfair treatment towards ethnically non-white individuals. Further, institutional racism refers to unfair practices like discriminatory treatment towards a specific ethnic group within an organization. Interpersonal racism occurs when prejudice and discrimination of an individual's influences the treatment and interaction towards another individual. In comparison to these three types of racism, internalized racism operates within an individual. The term internalized racism (IR) can be conceptualized as one form of racism in which individuals internalize prejudice and beliefs about themselves or their ethnic group that are maintained by mainstream society (James, 2020; Pyke, 2010). The act of internalization can take place on a conscious as well as unconscious level and involves the belief in a racial hierarchy where whiteness is continuously placed above other racialization (Huber & Johnson, 2006).

Racialization describes the process of categorization, classifying differentiating and attributing specific characteristics to individuals based on physical appearance. Thus, the term racialization does not only refer to 'race' as such but is more important in the context of unequal power relations (Bernard, 2015). In contrary, the term ethnicity refers to cultural values, characteristics and traits that are shared among individuals of a group (Baker, 2024)

Researchers attempted to analyze the mechanism behind IR , where force and visible suppression are not necessarily present. Instead, it is a process wherein the dominant group manufactures reality through the formation of beliefs or 'knowledge', which is disseminated through society (Foucault, 1977; Pyke, 1996). The dissemination can take place through media representation, language, or everyday interactions. Consequently, by framing these beliefs as a benefit for society, the marginalized groups are persuaded to accept the ideas to reduce conflict. This process is referred to as Foucault's conception of discourse as knowledge and Power (Foucault,1977).

The consequences of IR operate as subtly but as impactful as the process of conception of

discourse (David, Schroeder & Fernandez, 2019; Speight, 2007). The adoption of prejudiced beliefs is associated with adverse health issues. The consequences of experiencing IR are linked to negative symptoms such as lower self-esteem and higher levels of physiological distress (James, 2022; Pyke 2010). A meta-analysis found an association between racism and poor mental health, whereas depression was found to be the most frequently reported outcome (Paradies et al., 2015). Further consequences on mental well-being due to racism have been found in numerous studies, including depressive symptoms, anxiety, or insomnia (Moody et al., 2023).

Mental health is not solely the absence of a mental illness. It describes a state of mental well-being where individuals can overcome stress and reach their full potential (Marquant et al., 20219). Mental health can be divided into three components, namely social, psychological, and emotional well-being (Rickwood et al., 2019). These components influence people's thinking, feelings, and relations to others. Further, mental health exists in a spectrum, meaning that the state of every individual varies over time. The variation can be caused by factors such as life events, biological factors, and environmental factors. Next to the neg ative impact on mental health, racism can affect an individual's physical health as well. For instance, racism is linked with a higher risk of hypertension (Brondolo et al., 2011). Hypertension can be triggered by stress that an individual experiences through racism.

Moreover, in order to cause internal stress within marginalized groups, direct interaction between individuals of different racial backgrounds is not needed. Merely the awareness of stereotypes is sufficient to create a mentally harmful condition (Speight, 2007). For example, a quantitative experimental study conducted by Steele & Aronson (1995) found that African Americans who are aware of the intellectual prejudice towards their own race, portraying them as less intelligent than whites, tend to do worse on the given intellectual tests. The displayed behavior is referred to as a “stereotype threat” and can have an overall negative impact on performance. In the long run, academic life could be negatively impacted, which can have implications for social mobility (Steele & Aronson, 1995). Considering this, the World Health Organization (WHO) reports that those who are affected by inequality or poverty are at a higher risk of developing a mental disorder (Charlson et al., 2019).

Accordingly, the occurrence of internalized racism is not limited to white-dominated societies. The phenomenon of embracing ‘whiteness’, such as the practice of straightening one's hair or using skin-lightening products, can be seen around the world, where white dominance is

not prevalent. For instance, one of the most successful skin-lightening products ‘Glow and Lovely’ (formerly ‘Fair and Lovely’), was introduced by Hindustan Unilever (Hindustan Unilever, n.d.). Through commercials and media, the idealization of light skin reinforces and propagandizes racial stereotypes and exemplifies cultural racism. The term ‘cultural racism’ can be conceptualized as the belief and promotion of racial stereotypes of one group, to be superior to those of another (Rodat, 2017). The advertised skin-lightening product reinforces the cultural dominance of whiteness and emphasizes how racial hierarchy impacts the beauty standard.

Although ‘whiteness’ is perceived as inferior, internalizing racism can also occur among white ethnicities. Nonetheless, racism against white individuals differs from non-whites. Certain privileges come with being ‘white’. Considering the conceptualization of IR, namely the acceptance of prejudice towards one’s own ethnic group. racism against white population must be accordingly positively afflicted, meaning that a stronger negative relationship between IR and mental health is assumed among nonwhite individuals.

In the context of the relationship between internalized racism and mental health, moderator variables may play a significant role (Brondolo, 2011; Williams & Mohammed, 2013). One such moderating factor is cultural orientation. This identification can be operationalized through assessing aspects such as language use, the practice of cultural tradition, social relationships with individuals of the culture, or through the importance placed on cultural values.

To gain a better understanding of the importance of cultural orientation, it's crucial to understand how individuals deal with new cultures. Berry’s model of acculturation states that when an individual is faced with a new culture, a decision between assimilation, marginalization, separation, and integration is made (Berry, 2017). Assimilation describes the process of fully adapting to the new culture while disconnecting from one’s original culture. Contrary, separation describes the avoidance of the new culture while only practicing one's ethnic culture. Integration on the other hand can be described as a unity of both, the practice of one’s ethnic culture while also adopting the new culture. Lastly, marginalization can be defined as the denial of the ethnic and new culture (Berry, 2017).

Cultural orientation can impact mental health as well. To illustrate, the ‘healthy immigrant effect’ states that immigrants tend to have better mental health conditions upon arrival, however, there tends to be a change over time (Ferrara, Grindel & Brunori, 2024). Longer-established immigrants may experience a decline in mental health that is comparable to or worse than that of

native-born individuals. This pattern aligns with the unhealthy assimilation hypothesis, which states that as immigrants spend more time in the country with a new culture, the assimilation into that culture may lead to a decline in mental health. According to the hypothesis, the decline is caused by unhealthy behaviors, as they assimilate to the new culture accompanied by stressors related to acculturation and discrimination (Ferrara, Grindel & Brunori, 2024).

Considering these challenges, the maintenance of one's own ethnic culture becomes essential regarding mental health. The practice and involvement towards one ethnic culture refers to ethnic societal immersion (Koch, 2014). As Berry's Acculturation Model (2017) states the best possible health outcome for individuals is integration, highlighting the importance of one's ethnic country practices. This is also supported by Green, King & Ajrouch (2024) who report a link between the connection of one's own ethnicity and mental health benefits (Green, King & Ajrouch, 2024).

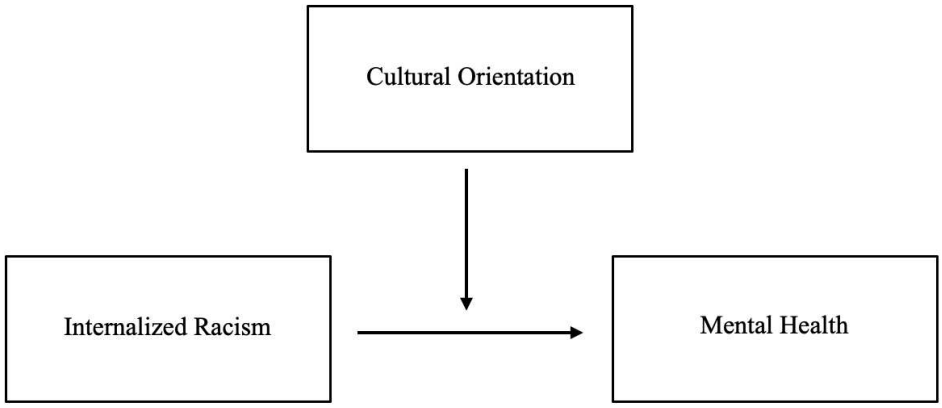
Thus, despite the investigations into the relationship between internalized racism and mental health, it appears to be crucial to explore cultural orientation as a moderating factor that may influence this relationship. By investigating the individual's cultural orientation, the aim of this study lies in gaining a deeper insight into the relationship between IR and mental health. This approach is based on the theoretical framework of Berry's acculturation model (2017), indicating that assimilation, a lack of one's ethnic identity, impacts mental health negatively. Through a cross-sectional study design.

The current study aims to answer the following research question: *To what extent is internalized racism related to mental health and how is this relationship moderated by cultural orientation towards one's ethnic culture?* The following hypotheses have been formulated:

- Hypothesis 1: Internalized racism has a negative relationship with mental health.
- Hypothesis 2: A higher level of cultural orientation towards one's ethnicity, negatively moderates the relationship between internalized racism and mental health, such that for those with a lower level of cultural orientation the relationship is more strongly negative.
- Hypothesis 3: There is a difference in the relationship between internalized racism and mental health as well as in the moderating relationship between ethnically white participants and participants of other ethnicities

Figure 1

Schematic Presentation of the Relationship Between Internalized Racism, Mental Health, and Cultural Orientation as a Moderator



Methods

Design

The current study was performed by a Bachelor student at the University of Twente and ethically approved by the Ethics Committee of the Faculty of Behavioral Sciences (reference number: 2343533). Moreover, the study was conducted online, allowing a non-obtrusive process for the participants. Through a cross-sectional study design, the relationship between Internalized racism and mental health was investigated with a possible moderating effect of cultural orientation. This choice was made because the cross-sectional study method is inexpensive, allowing a large pool of samples, and increasing representativeness. Moreover, the method allows an assessment of multiple variables at one point in time.

The extent of devaluing one's own group was treated as the independent variable and mental health as the dependent variable. Native country practices were treated as a moderating effect.

Participants

For the recruitment, a convenience sampling process was applied. The process took place on the platforms Instagram, Reddit, and through the SONA-System. The SONA-System is a subject pool at the University of Twente, where students were rewarded with 0.25 credits for their participation. The remaining participants were not compensated with any type of reward.

The inclusion criteria consisted of four requirements: First, a minimum age of 18 years is required. Second, because the study was conducted in English, competence in the English language was needed. Third, a technological device such as a laptop or smartphone was necessary since the study was conducted online. The last criterion was the participant's informed consent (see Appendix A). Participants who did not agree to the informed consent or did not finish all questionnaires were excluded. After excluding unsuitable participants, the sample size was reduced from 100 to 65 (N = 65).

Table 1

Sociodemographic Characteristics of Participants

Sample Characteristics	*n*	*%*
Gender		
Female	45	69.2
Male	18	28.7
Binary	1	1.5
Prefer Not to Say	1	1.5
Nationality		
Dutch	2	3.1
German	51	78.5
Indian	3	4.6
Congolese	1	1.5
Azerbaijan	1	1.5
Italian	1	1.5
Somali	1	1.5
Turkish	1	1.5
American	1	1.5
Not Disclosed	3	4.6
Ethnic/ Racial Background		
White	31	47.7
Black	12	18.5
Hispanic/ Latinx	4	6.2
Middle Eastern	9	13.8

Asian	8	12.3
Migration Status		
Citizen	48	73.8
Foreign Student	9	13.8
Foreign Resident	6	9.2
Foreign Worker	1	1.5
Asylum Seeker/ Refugee	0	0
Other	1	1.5

Note. $N = 65$. Participants were on average 24.3 years old ($SD_{age} = 4.1$). Percentages were rounded to one decimal.

Materials

Internalized Racism

For measuring participants' level of internalized racism, the subscale devaluation of one's own group (DOG) of the Appropriated Racial Oppression Scale (AROS) was applied (Stephenson, 2000). The total questionnaire consists of four subscales: devaluation of one's own group, adaptation of white standards, emotional response, and patterns of thinking. Given the aim of this study, only the first subscale was included, consisting of eight items. Participants were given statements to which they responded by using a 7-Likert scale ranging from 1 ("strongly agree") to 7 ("strongly disagree"). The subscale devaluation of one's own group (DOG) included statements such as "Whenever I think a lot about being a member of my racial group, I feel depressed" or "Because of my race, I feel useless at times". The highest achievable score for DOG is 49 indicating higher levels of internalized racism, whereas the lowest level of 7 indicates lower levels of internalized racism. In the current study, the internal consistency of the subscale was high ($\alpha = .86$).

Mental Health

Participants were assessed on their mental well-being using the Mental Health Continuum Short Form (MHC-SF). The self-report survey, consisting of 14 questions, included three subscales. The subscales include the key aspects of mental health, namely *social* ("During the past month, how often did you feel that the way our society works makes sense to you?"), *psychological* ("During the past month, how often did you feel that your life has a sense of direction or meaning

to it?"), and *emotional* well-being ("During the past month, how often did you feel happy?"). Participants were able to give their responses on a 6-point Likert scale, with 0 representing "never" and 5 representing "every day". Participants can achieve an overall minimum score of 0 and a maximum score of 70.

The subscale scores range from 0-15, 0-25, and 0-30 for emotional, social, and psychological well-being, respectively. Reporting a score ≥ 1 of 3 for emotional signs and ≥ 6 of 11 for social and psychological signs combined, can be defined as flourishing mental health. Subsequently, higher scores indicate a greater level of positive well-being. Moreover, the scale has high reliability ($\alpha = 0.89$), indicating adequate internal consistency and accuracy of the tool (Keyes, 2002; Bassi et. al., 2021). In the current study, the internal consistency was high ($\alpha = 0.89$).

Cultural Orientation

To measure to what extent the participants engage in their native country's practices, a subscale of the Stephenson Multigroup Acculturation Scale (SMAS) was used (Stephenson, 2000). The 32-item scale includes two sub-scales, namely "ethnic society immersion" (ESI) and "dominant society immersion" (DSI). Hereby, a difference is made between a native country or language and the country of residence. The participants' country of residence refers to the place where they currently reside, whereas their country of origin is the country where their family originally came from (see Appendix E). Given the aim of the testing, the focus will be on measuring cultural orientation towards one's heritage group, which is why only the ESI scale was utilized. The subscale includes 17 items about different aspects of life, such as language or political knowledge ("I am informed about the current affairs of my native country" or "I know how to speak my native language").

Participants were able to agree with statements using a Likert-scale from 1 ("False") to 4 ("True"). For the subscale, participants were able to reach the highest score of 68, indicating a positive link between their ethnic country versus the country that they reside. Conversely a lower score indicates a less positive relationship. The scale indicated good internal consistency reliability scores for both subscales (ESI: $\alpha = .94$, DSI: $\alpha = .75$). In the current study, the internal consistency was high as well ($\alpha = .88$).

Procedure

Participants were either invited to take part in the study through the distribution of the link on different platforms or the SONA-system. First, the participants were presented with informed

consent, which included all necessary instructions. After giving consent, participants were led to the next slide, where they were asked to fill out demographic information. Subsequently, respondents were forwarded through the questionnaires in the following order: DOG, NCP, and MH. The order of the questionnaires was randomly selected. Before every questionnaire, potentially unclear terms were elaborated upon (see Appendices C, D and E). An example of an unclear term is the differentiation between 'Native Country' and 'Country of Origin' (see Appendix E). Lastly, upon completing the questionnaires, participants were thanked for their time. At the end, participants were again provided with the link for further support if needed, as well as the researcher's contact details for any additional concerns. In total, the duration to complete the questionnaires took approximately seven minutes.

The data collection took place over 23 days. Although a period of 14 days was scheduled, the date was extended to nine days to enable a larger sample size. Subsequently, participant recruitment started on April 10, 2024, and lasted until May 1, 2024. The data collection process was solely conducted by the researcher without collaboration.

Demographic Questionnaire

The demographic questionnaire collected sociodemographic data on age, sex, race/ethnicity, nationality, and residing status (see Appendix B). To publish the surveys, the platform Qualtrics was selected (https://www.qualtrics.com/). Qualtrics is an online survey tool that allows researchers to publish their studies without requiring extensive knowledge of coding.

The survey included informed consent (see Appendix A), demographics (see Appendix B), and three questionnaires, namely the Appropriated Racial Oppression Scale, the Mental Health Continuum Short Form, and the Stephenson Multigroup Acculturation Scale (Appendices C, D, and E).

The informed consent instructed the participant about the process of the study, stated the risks and benefits, maintained confidentiality, and informed them about their rights to withdraw at any given moment. Since participants are asked about sensitive information, such as their experience with racism, informed consent offers a link for emotional support (www.helpguide.org). This was done at the end of the surveys as well (see Appendix F).

Data Analysis

For the statistical analysis, the software R Studio (Version 2024.04.0+735) was used. After importing the dataset from Qualtrics to R, the data was cleaned. This includes the exclusion of

participants who did not agree with the informed consent or did not finish all surveys, removing unnecessary columns and rows from the data frame, renaming columns for a better overview, coding categorical variables into integer variables, and coding the Likert-scale for MHC from 1 to 6 into 0 to 5. Furthermore, total, and mean scores and standard deviations for each scale and subscale were computed for each participant and included as a variable in the dataset. For an overview, see Table 2.

Hypothesis Testing I and III

The statistical analysis was conducted using Pearson's correlation test between internalized racism and (the subscales of) mental health. Moreover, to test the third hypothesis, the correlations were tested for the whole sample, for ethnically White participants, and for participants of other ethnicities (namely Black, Hispanic/ Latinx, Middle Eastern, and Asian), resulting in a total of 12 correlation tests.

Hypothesis Testing II and III

For the second hypothesis, whether a higher level of cultural orientation positively moderates the relationship between internalized racism and mental health, a moderation analysis was conducted. All assumptions for the MRA were tested and found to not be violated. Here, DOG was treated as the independent variable, total MH and the MH subscale scores as the dependent variable with, and ESI as the moderator variable. Again, to test for the third hypothesis, the moderation analysis was conducted for the whole sample, for ethnically White participants, and for participants of other ethnicities, resulting in 12 moderation analyses in total. Moreover, a significance level of .05 ($\alpha = .05$) was chosen.

Results

Table 2

Overview of Means and Standard Deviations for Each (Sub-)Scale for each Group

Scale´	Total Sample		White		Black		Hispanic/ Latinx		Middle Eastern		Asian	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
MHC-SF Total Score	43	11.8	44.8	12.3	37.8	6.4	47.3	14.4	48.5	11	36	13.4

MHC-SF Subscale: Emotional Well-Being	10.1	2.9	10.4	3.3	9.7	1.7	9.3	4	10.4	3.1	8.9	2.8
MHC-SF Subscale: Social Well-Being	12	5.5	13.2	5.2	8.8	4.2	15.7	5.9	13.8	5.9	9.8	5.7
MHC-SF Subscale: Psychological Well-Being	20.9	5.2	21.2	5.2	19.3	3.8	22.3	5	24.4	3.7	17.4	6.3
DOG	17.1	7.5	17.5	6.3	15.4	8.1	16.7	11	17.8	9.9	17.4	9.4
ESI	50.9	9.4	53.6	9	45.7	9.5	56.3	9	48.5	9.5	47.6	9.1

Note. MHC-SF = Mental Health Continuum Short Form; DOG = Devaluation of One's Own Group; ESI = Ethnic Society Immersion.

Hypothesis Testing I and III

An overview of the results of Pearson's correlation analysis can be seen in Table 3, 4 and 5. For the total sample as well as for the participants of other ethnicities, the results were statistically insignificant (see Tables 3 and 5). However, the results for the ethnically White sample were all statistically significant, indicating a negative correlation between internalized racism (DOG) and mental health (MH) and each of the subscale (see Table 4).

Table 3

Results of Pearson's Correlation For Total Sample

Scale		95% CI	
	DOG	*LL*	*UL*
1. MHC Total	-.12	-.35	.13
2. MHC-SF Subscale: Emotional Well-Being	-.20	-.43	.04
3. MHC-SF Subscale: Social Well-Being	-.04	-.28	.21
4. MHC-SF Subscale: Psychological Well-Being	-.11	-.34	.14

Note. MHC-SF = Mental Health Continuum Short Form; DOG = Devaluation of One's Own Group; CI = confidence interval; LL = lower limit; UL = upper limit.

Table 4

Results of Pearson's Correlation For Ethnically White Participants

Scale		95% CI	
	DOG	*LL*	*UL*
1. MHC Total	**-.44**	-.68	.11
2. MHC-SF Subscale: Emotional Well-Being	**-.40**	-.65	.06
3. MHC-SF Subscale: Social Well-Being	**-.36**	-.63	.02
4. MHC-SF Subscale: Psychological Well-Being	**-.42**	-.67	.09

Note. Correlations in bold are significant with $p < .05$; MHC-SF = Mental Health Continuum Short Form; DOG = Devaluation of One's Own Group; CI = confidence interval; LL = lower limit; UL = upper limit.

Table 5

Results of Pearson's Correlation For Participants of Other Ethnicities

Scale		95% CI	
	DOG	*LL*	*UL*
1. MHC Total	.11	-.24	.44
2. MHC-SF Subscale: Emotional Well-Being	-.06	-.39	.29
3. MHC-SF Subscale: Social Well-Being	.16	-.20	.48
4. MHC-SF Subscale: Psychological Well-Being	.10	-.24	.43

Note. MHC-SF = Mental Health Continuum Short Form; DOG = Devaluation of One's Own Group; CI = confidence interval; LL = lower limit; UL = upper limit.

Hypothesis Testing II and III

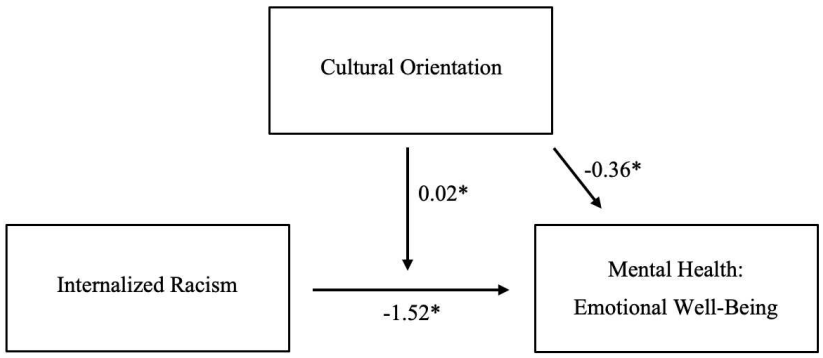
Statistically significant coefficients of the MRA were found for two models: For the ethnically White participants and the emotional well-being subscale of the MHC-SF, as well as for the psychological well-being subscale. For a schematic presentation of the moderation relationships, see Figures 2 and 3.

For the first model, with the ethnically white sample and the emotional well-being subscale, a significant negative main effect between IR and emotional well-being was found (b = -1.52, t = -3.06, p = .005) as well as for cultural orientation and emotional well-being (b = -0.36, t = -2.18, p = .038). A significant positive but small interaction effect by cultural orientation on IR and emotional well-being was found (b = 0.02, t = -2.69, p = .012).

For the second model, with the ethnically White sample and the psychological well-being subscale, again significant negative main effect between IR and psychological well-being was found (b = -2.02, t = -2.45, p = .020). The effect between cultural orientation and psychological well-being was not significant (b = -0.48, t = -1.76, p = .090). Again, a small positive but significant interaction effect by cultural orientation on IR and psychological well-being was found (b = 0.03, t = -2.06, p = .049). All other models were statistically insignificant.

Figure 2

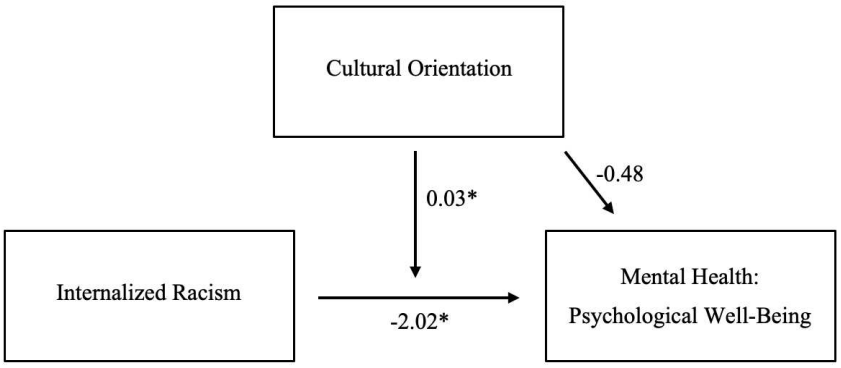
Regression Coefficients for the Relationship Between Internalized Racism and Mental Health (Emotional Well-Being Subscale) With Cultural Orientation as a Mediator For Ethnically White Participants



Note. *$p < .05$

Figure 3

Regression Coefficients for the Relationship Between Internalized Racism and Mental Health (Psychological Well-Being Subscale) With Cultural Orientation as a Mediator For Ethnically White Participants



Note. *$p < .05$

Discussion

This paper aimed at investigating the relationship between internalized racism and mental health, while analyzing a possible moderating effect of cultural orientation on the relationship. For the overall sample, there was no significant relationship found between internalized racism and mental health, including the different subscales. However, a significant relationship between IR and mental health including all subscales, was only found among ethnically white participants. The different outcomes can be caused by several factors. One factor could be the rising change in the perception of racial identity among whites (Gallagher, 2019). There appears to be a shift from ethnicity to racialization, meaning that the focus is drawn towards being categorized as white rather than the ethnic background (Crowley, 2019; McDermott & Samson, 2005). Although, white individuals are seen as the superior race, rising awareness about white privilege might evoke feelings of shame within white individuals (Grzanka, Frantell & Fassinger, 2020). White privilege refers to a societal set of advantages for individuals who are perceived as white, especially in a context where the white dominant race holds institutional power (Kendall, 2012). This can be highlighted by the results of this study, where ethnically white individuals score higher on devaluing one's own ethnic group.

Another factor in the results might be that non-white participants might have developed a higher resilience to racism. Resilience describes the ability to recover and adapt from stressful events (Troy et al., 2023). In terms of the role of resilience, a similar study analyzed the relationship between racism-related stress and psychological resilience among non-white individuals. The participants showed a better ability to cope with racism-related stress as their psychological resilience increased (Byers et al., 2021). This assumption aligns with the Minority Stress Theory Model (MSTM). According to the MSTM, one consequence of identity-based stressors such as discrimination is to internalize them (Meyer, 2003). The model argues that minoritized people tend to internalize these behaviors when they lack the coping mechanisms to deal with them.

The results of this study can be another indicator of the different perceptions of culture among ethnic groups. As a shift from ethnicity to racialization can occur, culture and cultural orientation can be perceived differently among groups since racialization is dynamic where the shift is dependent on the race (Chan, 2021). In addition to this, many existing instruments, assessing cultural orientation are tailored to specific ethnic groups. The majority of scales focus

on Asian, Latinx, or African populations (Klonoff & Landrine, 2000; Kwan & Sodowsky, 1997; Marin & Gamba, 1996). Since the experience of cultural orientation can vary in different populations, the scale utilized may limit its applicability among the current sample.

In light of this, the result of this study may have been influenced by the fact that solely group-focused behavior (devaluation of one's own group) on internalized racism was measured. In 2021, a similar study took group- and self-focused IR into account (James, 2021). The difference between the two forms is that group-focused IR refers to how individuals feel about their ethnic group as a whole, whereas self-focused IR describes how people view themselves as a result of belonging to their ethnic group. The study found that both self-focused and group-focused IR independently predict symptoms of anxiety and depression (James, 2021). In fact, studies found that self-focused IR had a stronger effect on mental health than group-focused IR (James, 2021). Considering that the measures of this study for IR align only with behavior that is group-focused such as negative comparison, it underscores the importance of including self-focused IR in investigations (James, 2022). Self-focused IR includes behavior like self-doubt, low self-esteem, or negative self-talk (James, 2022).

Limitations

Although this paper offers valuable insights into the complex interplay of internalized racism, mental health, and cultural orientation, there are limitations that need to be acknowledged, which may impact the results.

There are a few limitations to this study that need to be acknowledged. First, the cross-sectional study design may be a limiting factor in the investigation. Since it is a one-time measure, it may be challenging to draw causal relationships or to observe possible changes (Setia, 2009). Second, and the lack of a monocultural sample (80% Germans) reduce the reliability of this study. This might be due to the ongoing discussions about integration in Germany and their willingness to participate in studies that tackle societal concerns (Mahadevan, 2024). Third, the use of devaluation of one's own group is the only indicator for IR. As IR is a complex construct, this study may not accurately capture all its components. By excluding self-focused IR, crucial emotions such as self-hatred could be overlooked, which could have a significant impact on mental health. Additionally, the reliability is harmed through the limited sample size. Especially, through the further reduction by dividing the sample to run a comparison between the non-whites and whites. Furthermore, the utilization of subscales displays another possible limitation of this

investigation. Moreover, by solely using scattered behaviors for internalized racism and cultural orientation, a limitation might be presented. This is since the subscales have not been validated independently by the original paper or in this study.

Future Implications

To ensure the reliability and validity of findings on IR and its influence on mental health, scale applicability plays a major role. Thus, future research should work towards developing ethically inclusive measures with the aim of understanding different experiences of IR and its impact on mental health. Here, next to the distinction between white and non-white individuals, the attempt to investigate in differences among non-white ethnicities should be taken.

Moreover, there is a need for further research on the role of moderating variables. Although the moderating effect of cultural orientation was weak in this study, there remains a need for further research.

Additionally, considering the Foucauldian concept of hegemony, where the dominant group spreads their beliefs as ‘knowledge’, the practice and participation of one's ethnic group could counteract these beliefs. To counteract the risk of racialization, researchers should consider examining multiple aspects of internalized racism, without limiting the behavior to group-focused behaviors.

Lastly, given the high prevalence of white participants in this study, further research should aim for an approximately similar sample size between white and non-white individuals to enable a comparison between both groups. This comparison could provide better insight into differences between populations.

Conclusion

This paper aimed to explore the relationship between internalized racism and mental health with a moderation effect of cultural orientation (CO). The findings of this paper showed that no negative association between internalized racism and mental health was found among the total sample. Nonetheless, an association between internalized racism and mental health was found for the ethnically white sample. This association was also present between internalized racism and all subscales of mental health. Similarly, a moderating effect of cultural orientation was found among ethnically white people as well. Here, the effect was only significant for both subscales of mental health, namely emotional well-being, and psychological well-being, whereas no significant correlation was found for the total sample. It was indicated that differences in the perception of IR

among populations might have affected the outcome. Further implications are targeted measures, including the measurement of various behaviors. This paper offered an approach to comprehending the complexity of IR. Further, the importance of discussing this subtle form of racism is driven by this investigation. By highlighting the interaction between IR and its impact on mental health, this study aims to address the systematic roots of racial inequality.

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Appendix A
Informed Consent

Dear participant, we value your participation in our research on the relationship between cultural orientation, internalized racism, and its effect on mental health. Please take the time to carefully read the information below.

STUDY BACKGROUND

Your participation will contribute to the understanding of the complex mechanisms of internalized racism and its impact on mental health. This insight can guide interventions to provide help and support diverse minorities suffering from the consequences of internalized racism and related mental health issues.

WHAT ARE YOU BEING ASKED TO DO?

If you decide to take part in this study, you will be asked to fill out demographic data and complete three different questionnaires about your mental well-being, cultural orientation and internalized racism.

WHAT ARE THE RISKS AND BENEFITS OF TAKING PART?

In the context of this study, the primary risk may involve potential emotional stress when dealing with sensitive topics such as racism or mental health. To reduce the potential risk, you will be provided with the researcher's contact details for any questions or concerns. Moreover, you will be provided with a website offering support and tips for coping with emotional distress. Additionally, as a University of Twente student studying psychology or communication science, you may be eligible to receive compensation in the form of SONA credits. Finally, your participation helps us investigate the complex mechanisms of internalized racism.

YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION

You are under no obligation to take part in this study. Furthermore, you are free to withdraw from the study at any time without providing a reason. You can withdraw from the study even after it has been completed. Your personal data will be deleted upon request and will not be utilized for additional analysis.

This study has been approved by the Ethics Committee of the University of Twente. Please do not hesitate to contact the researcher before, during or after your involvement if you have any questions or concerns.

Researcher: Aylin Kaya: a.kaya@student.utwente.nl

Supervisor: Yudit Namer: y.namer@utwente.nl

Hereby I confirm that I am 18 years or older and have entirely read and understood the information above and that I am willing to take part in this study. I voluntarily agree to participate in this study and provide my agreement for my data to be processed by checking the box 'Yes' below:

- Yes, I agree
- No, I do not agree to

Appendix B
Demographic Questionnaire

Age

[ ]

Gender

- Female
- Male
- Non-binary
- Prefer not to say
- Other

  [ ]

Nationality

- German
- Dutch
- Other

  [ ]

Ethnicity/Race

- White
- Black
- Hispanic or Latino
- Middle Eastern

- Asian
- Other (specify)

What is your current migration status in the country where you reside?

- Citizen
- Foreign Student
- Foreign resident (Individuals who reside in the country but are not citizens, including long-term residents with visas or residency permits)
- Foreign worker (temporary)
- Asylum seeker/refugee
- Other

Before proceeding with the questions, please note that discussing topics related to racism may evoke strong emotions. If you find yourself in need of support or resources at any point, we recommend visiting www.helpguide.org for guidance and assistance.

Appendix C

Appropriated Racial Oppression Scale (AROS) – Factor 3: Devaluation of Own Group

Please rate your level of agreement with the following statements on a scale, ranging from 'Strongly Disagree' to 'Strongly Agree'

1. Because of my race, I feel useless at times

- (1) Strongly Disagree
- (2) Disagree
- (3) Somewhat Disagree
- (4) Neutral
- (5) Somewhat Agree
- (6) Agree
- (7) Strongly Agree

2. I wish I were not a member of my race

- (1) Strongly Disagree
- (2) Disagree
- (3) Somewhat Disagree
- (4) Neutral
- (5) Somewhat Agree
- (6) Agree
- (7) Strongly Agree

3. Whenever I think a lot about being a member of my racial group, I feel depressed

- (1) Strongly Disagree

- (2) Disagree

- (3) Somewhat Disagree

- (4) Neutral

- (5) Somewhat Agree

- (6) Agree

- (7) Strongly Agree

4. Whites are better at a lot of things than people of my race

- (1) Strongly Disagree

- (2) Disagree

- (3) Somewhat Disagree

- (4) Neutral

- (5) Somewhat Agree

- (6) Agree

- (7) Strongly Agree

5. People of my race don't have much to be proud of

- (1) Strongly Disagree

- (2) Disagree

- (3) Somewhat Disagree

- (4) Neutral

- (5) Somewhat Agree

- (6) Agree

- (7) Strongly Agree

6. It is a compliment to be told "You don't act like a member of your race"

- (1) Strongly Disagree
- (2) Disagree
- (3) Somewhat Disagree
- (4) Neutral
- (5) Somewhat Agree
- (6) Agree
- (7) Strongly Agree

7. When I look in the mirror, sometimes I do not feel good about what I see because of my race

- (1) Strongly Disagree
- (2) Disagree
- (3) Somewhat Disagree
- (4) Neutral
- (5) Somewhat Agree
- (6) Agree
- (7) Strongly Agree

Appendix D

Mental Health Continuum – Short Form (MHC-SF)

Please answer following questions

During the past month, how often did you feel..

1. Happy

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

2. Interested in life

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

3. Satisfied with life

- (1) Never
- (2) Once or Twice

- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

4. That you had something important to contribute to society

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

5. that you belonged to a community (like a social group, or your neighborhood

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

6. that our society is a good place, or is becoming a better place, for all people

- (1) Never
- (2) Once or Twice

- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

7. that people are basically good

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

8. that the way our society works makes sense to you

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

9. that you liked most parts of your personality

- (1) Never

- (2) Once or Twice

- (3) About once a week

- (4)About 2 or 3 times a week

- (5) Almost every day

- (6) Every day

10. good at managing the responsibilities of your daily life

- (1) Never

- (2) Once or Twice

- (3) About once a week

- (4)About 2 or 3 times a week

- (5) Almost every day

- (6) Every day

11. that you had warm and trusting relationship with others

- (1) Never

- (2) Once or Twice

- (3) About once a week

- (4)About 2 or 3 times a week

- (5) Almost every day

- (6) Every day

12. that you had experiences that challenged you to grow and become a better person

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

13. confident to think or express your own ideas or opinion

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

14. that your life has a sense of direction or meaning to it

- (1) Never
- (2) Once or Twice
- (3) About once a week
- (4)About 2 or 3 times a week
- (5) Almost every day
- (6) Every day

Appendix E

Stephenson Multigroup Acculturation Scale (SMAS) – Factor 1: Native country practices/ Ethnic Society Immersion

Below are a number of statements that evaluate changes that occur when people interact with others of different cultures or ethnic groups. For questions that refer to "COUNTRY OF ORIGIN" or "NATIVE COUNTRY", please refer to the country from which your family originally came. For questions referring to "NATIVE LANGUAGE", please refer to the language spoken where your family originally came from.

Has your family migrated multiple times? Then please consider the country where you have spent the most time or had the most significant cultural influence.

Do you have two native languages? Then please select the language that is primary or most influential within your family context.

Is your native country the same as the country you live in? Then please consider that country for all the questions.

I speak my native language with my friends and acquaintances from my country of origin

-False

-Partly False

-Partly True

-True

I have never learned to speak the language of my native country

-False
-Partly False
-Partly True
-True

I eat traditional foods from my native culture

-False
-Partly False
-Partly True
-True

I feel comfortable speaking my native language

-False

-Partly False

-Partly True

-True

I am informed about current affairs in my native country

-False

-Partly False

-Partly True

-True

I know how to read and write in my native language

-False

-Partly False

-Partly True

-True

I attend social functions with native people of the country that I live in

-False

-Partly False

-Partly True

-True

I speak my native language at home

-False

-Partly False

-Partly True

-True

I regularly read magazines of my ethnic group

-False

-Partly False

-Partly True

-True

I know how to speak my native language.

-False

-Partly False

-Partly True

-True

I am familiar with the history of my native country

-False

-Partly False

-Partly True

-True

I like to listen to music of my ethnic group

-False

-Partly False

-Partly True

-True

I like to speak my native language

-False

-Partly False

-Partly True

-True

With my partner or spouse, I speak my native language

-False

-Partly False

-Partly True

-True

When I pray, I use my native language

-False

-Partly False

-Partly True

-True

I think in my native language

-False

-Partly False

-Partly True

-True

I stay in close contact with family members and relatives in my native country

-False

-Partly False

-Partly True

-True

Appendix F
Help Guide

We thank you for your participation in this survey.

Your response has been recorded.

If you find yourself in need of support or resources after answering these questions, we recommend visiting www.helpguide.org for additional guidance and assistance.