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## Stigma related to depression: a comparison between african american and white young adults

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STIGMA RELATED TO DEPRESSION: A COMPARISON BETWEEN  
AFRICAN AMERICAN AND WHITE YOUNG ADULTS

by

AMIRICA NICHOLSON

A thesis submitted in partial fulfillment of the requirements  
for the Honors in the Major Program in Psychology  
in the College of Sciences  
and in The Burnett Honors College  
at the University of Central Florida  
Orlando, Florida

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Thesis Chair: Dr. Charles Negy

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## **ABSTRACT**

This study examined the effects of gender, ethnicity, social support, and acculturation on depression-stigma in college communities; specifically targeting the racial groups of African Americans and Whites. Undergraduates of various ages and class standings were given surveys within their demographics pertaining to: acculturation, social support, stigma, and depression. The above factors were compared to ethnicity. The results supported that African Americans have a higher level of depression-stigma overall, especially those who have been enculturated into their traditional culture; none of the additional hypotheses were supported by the research.

## **DEDICATION**

God. I can do all things through the source that strengthens me. This research thesis would not have been possible if it were not for the foundational support that I received from my faith in God. My research journey has been an experience of learning, humility, and triumphs. I have concluded this project wiser, more self-assured, and more confident in my abilities than when I first began.

My Mother. The support of my mother has played an intricate role in the completion of my research. Her listening ear and words of affirmation encouraged me to stay steadfast in my goals.

Friends and Mentors. To the special individuals who have been with me from the beginning to the end of this research excursion. I am appreciative for every word of constructive criticism, advice, and kindness that I have received pertaining to my work and state of being.

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## **INTRODUCTION**

Depression is a mental illness that causes mood to decline and is categorized as a cognitive disorder. The etiology of depression has been traced to encounters with traumatic or adverse life events in past research findings (Kleim, Ehlers & Glucksman, 2012). Furthermore, one framework associated with depression is the learned helplessness model (Abramson et al., 1978). According to Peterson and colleagues (Peterson et al., 1982) learned helplessness refers to the development of depression due to attributing uncontrollable, aversive events to internal, stable, and/or global factors. An event that is perceived as being caused by the sufferer is labeled as an internal attribution, as opposed to an external attribution associated with the actual situation; as a result any subsequent form of depression caused by that specific incident may lead to a loss in self-esteem. In addition, if an event is connected with a stable attribution (a situation, act, or location that cannot be changed), instead of an unstable attribution (a situation, act, or location that is viewed as flexible and possible to change) the depressive symptoms are presumed to be long-lasting. Also, events that are associated with a variety of situations (global attributions), instead of circumscribed incidents (specific attributions), are more likely to cause depression that has pervasive effects (Peterson et al., 1982). There has been an adequate amount of research on depression; however more insight is needed into the additional causes of this mental illness.

Depression is one of the most common mental disorders (Blease, 2012), and is a leading cause of impairment in the developed world (Mulder, 2008). According to the World Health Organization over 121 million people internationally suffer from depression (2012). In the United States, 18.8 million adults are diagnosed with depression every year, with lifetime



prevalence rates of 21.3% for women and 12.7% for men (Kessler et al., 1994a). Treatment through interpersonal psychotherapy and pharmacotherapy has generally proven to be effective for depression in adults (Levenson et al., 2012).

Additional variables can have a role in how depression is experienced or how it is reacted to by others. A brief examination of a few of these variables is provided below; these specific variables will be included in this study to determine their correlation with depression-stigma.

Stigma is a social construct that invokes social rejection, devaluation, and/or discrimination (Brown et al., 2010). Goffman defined stigma as an “attribute that is deeply discrediting” and reduces the bearer “from a whole and usual person to a tainted, discounted one” (as cited in Link & Phelan, 2001, p. 364). Through stigmatization, a culturally dominant group holds negative attitudes, stereotypes, and belief systems toward the “out” or minority group. This may result in the non-dominant group receiving disproportionately poor interpersonal or economic outcomes relative to the dominant group due to discrimination (Crocker & Major, 1989). A study conducted by Markowitz examined the effects of stigma on the psychological well-being and life satisfaction rates of mentally impaired individuals. He discovered that the mentally-ill are more likely to be unemployed, have a lower income, have lower self-esteem, and have fewer support groups (Falk, 2001).

Depression-stigma is separated into the two constructs of public-stigma and self-stigma. Public-stigma encompasses the negative attitudes towards depression held by the general public/non-sufferers; while self-stigma describes the internalized negative feelings towards depression held by actual sufferers (Kanter, Rusch, & Brondino, 2008). Goldstein and Rosselli

(2003) conducted a review to evaluate how the general public reacted to the causes of depression. The etiology models used in the experiment were: biological, psychological, and environmental. The biological model yielded results associated with increased empowerment which is the public perspective that sufferers could overcome depression, a preference for psychotherapy, and a reduction of stigma. The psychological model yielded results associated with an increased belief that sufferers could help themselves, and an increased level of stigma. The environmental model results were inconclusive, and were associated with a mixture of positive and negative beliefs concerning depression (Goldstein, & Rosseli, 2003). In comparison to other disabilities, depression has elicited an increased amount of implicit and explicit negative automatic attitudes and stereotypes (Monteith & Pettit, 2011). Stigmatization is problematic for sufferers of all mental illnesses because it causes avoidance of treatment (Corrigan, 2004), and encourages social distance by non-sufferers (Lauber et al., 2004).

Research examining which gender has greater depression-stigma has been inconclusive (Griffiths, Christensen & Jorm, 2008). However, according to the National Institute of Health, depression is more common among women. The potential causes of this gender difference may be hormones, life-cycle constructs, child care, and psychosocial. Women and men also have different experiences with depression. Women are more likely to feel sadness, worthlessness, and excessive guilt. In contrast, men are more likely to be irritable, tired, apathetic, and have difficulty sleeping (National Institute of Mental Health, 2011).

The ramifications of race may also play a role in depression-stigma. Brown et al. (2010) expressed that in the United States, stigmatization has not only been attached to mental illnesses

such as depression but also to factors such as race, culture, religion, and physical disabilities. For example, research shows that many African Americans display a higher level of stigmatizing attitudes towards mental illness, and are more likely to avoid or end treatment prematurely, than Whites (Rusch et al., 2008). Moreover, in the area of medical treatment for depression, African Americans are less likely to receive specialized medical treatment for depression; instead they are more likely to be treated in primary care facilities including cases involving major depression (Cooper, Corrigan, & Watson, 2003). Little to no research exists pertaining to the cross-relation between ethnicity, attitude, and seeking treatment for mental illness (Conner et al., 2010).

Acculturation refers to the extent of the process of which ethnic minority groups adopt the cultural traditions, values, belief-systems, and practices of a more dominant society. Acculturation has a major impact on the perspectives, cultural influences, and customs of ethnicity groups (Landrine & Klonoff, 1994). Moreover, past research has found a positive correlation between acculturation into the majority White society, and favorable attitudes towards receiving psychological help (Rojas-Vilches, Negy & Reig-Ferrer, 2011). Furthermore, minorities' acculturation is more likely to occur if they have attended a university that has a predominately white student body (Kimbrough, Molock & Walton, 1996). Aside from acculturation the level of social support an individual perceives as having could also affect depression-stigma levels.

Social support refers to the amount of social acceptance received by individuals and the level of satisfaction acquired from it (Grainge, Brugha, & Spiers, 2000). The social networks that individuals affiliate themselves with are vital for encouragement and security, and include

groups such as: family, friends, and confidants. A sense of belonging is an important predictor of mental health (McLaren, Jude, & McLachlan, 2008). Moreover, the level of importance that is assigned to perceived and received social support fluctuates depending on the quantity of life stressors an individual may be experiencing. For example, if an individual is undergoing times of emotional stress or a traumatic life occurrence, social support will be most valuable. This is important due to the positive effects sufficient social support has on overall health (Montada, Filipp, & Lerner, 1992). High levels of social support play a vital role in positive mental health and may be negatively correlated with depression (Hewitt, Turrel, & Giskes, 2012).

#### Purpose of Study

Research suggests that stigma is a primary concern for depression sufferers. Although past studies have examined stigma associated with depression, few have attempted to identify variables that predict stigma associated with depression held by non-sufferers (i.e. public-stigma) (Griffiths, Christensen, & Jorm, 2008). The objective of this study was to investigate how the variables of gender, ethnicity, acculturation, and social support correlate with depression-stigma among college students.

Generally, stigma can have negative effects on social opportunities and on self-perception, and this may translate as an expectation to be devalued or rejected. The role of stigma pertaining to mental health is particularly problematic for African Americans because of a “double stigma” in regards to race and mental illness (Gary, 2005). Three hypotheses were tested for this study, they included: (1) On average, African Americans would express a higher level of negative attitudes toward depression sufferers, more so than Whites. (2) Irrespective of race,

participants who have either experienced depression or have family who have experienced depression would have less negative attitudes toward those who suffer from depression. And (3) Among African Americans, the more enculturated they are towards traditional African American culture, the more negative attitudes they would express related to depression, and those who suffer from depression. Negative attitudes related to depression included perceived stigma attached to depression sufferers, the belief that those who suffer from depression are dangerous, have poor social skills, and that depression is not treatable.

## METHODS

This study included 106 undergraduate students. Fifty-three self-identified as African American (40 women, 13 men), and 53 non-Hispanic Whites (38 women, 15 men). Due to the low ratio of females to males, the factor of gender was not examined for this study. All participants were students at the University of Central Florida. The average age of the African American participants was 22.81 ( $SD = 3.91$ ). The average age of the White participants was 22.64 ( $SD = 4.27$ ). All participants were treated in accordance with the ethical standards of the American Psychological Association.

### Materials

#### *Demographic Questionnaire*

All participants completed a demographic questionnaire, which indicated age, gender, ethnicity, class standing, and personal/family history of depression.

#### *The Revised African American Acculturation Scale (AAAS)*

The Revised African American Acculturation Scale measures the degree to which African Americans are enculturated into traditional African American society versus their acculturation into White Society. It contains eight subscales that assesses: religious beliefs, family structure, socialization, traditional foods, item preferences, interracial attitudes, superstitions, and health beliefs and practices. Each subscale contains items to which participants respond using a yes or no format (Landrine & Klonoff, 1994). Higher scores reflect more enculturation toward traditional African American culture. Based on the present sample of African Americans, this scale obtained an overall reliability estimate (Cronbach alpha) of .85.

### *Multidimensional Scale of Perceived Social Support*

The Multidimensional Scale of Perceived Social Support is a self-report measure that addresses the subjective assessment of social support adequacy (Zimet, Dahlem, Zimet, & Farley, 1988). The scale contains twelve item ratings based on a seven point Likert-type scale with response options ranging from very strongly disagree (1) to very strongly agree (7) (Zimet, Powell, Farley, Werkman, & Berkoff, 1990). Higher scores reflect higher levels of perceived social support. Based on the present sample of participants, this scale obtained an overall reliability estimate (Cronbach alpha) of .83 for African Americans and .95 for Whites.

### *Stigma Scale for Receiving Psychological Help (SSRPH)-modified*

The Stigma Scale for Receiving Psychological Help assesses to what degree receiving psychological help is stigmatized by an individual. It includes five items that target specific viewpoints and situations regarding psychological help. Each item is responded to using a 5-point Likert-type scale, with response options ranging from 1 (Strongly disagree) to 5 (Strongly agree) (Komiya, Good, & Sherrod, 2000). For this study, the scale was modified to assess stigma attached to those who suffer depression as opposed to the general term of mental illness. Higher scores reflect more perceived stigma attached toward those who suffer depression. Based on the present sample of participants, this scale obtained a reliability estimate (Cronbach alpha) of .83 for African Americans and .79 for Whites.

### *Beliefs Toward Mental Illness Scale-modified*

The Beliefs Toward Mental Illness Scale measures the internal beliefs that individuals associate with mental illness. It requires respondents to indicate their attitudes towards those with a mental illness in terms of dangerousness, poor interpersonal and social skills, and incurability.

Items are responded to using a 5 point Likert-type scale, with response options ranging from 1 (strongly disagree) to 5 (strongly agree) (Hirai, & Clum, 2000). This scale was modified by replacing the phrase “mental illness” with “depression” in order to make the scale applicable to this study. Thus, items assessed respondents’ views that those who suffer from depression are dangerous, have poor social skills, and whether or not they believed depression was treatable or curable. Higher scores reflected negative views about depression or those who suffer from depression. Based on the present sample of participants, the reliability estimates (Cronbach alpha) were obtained for the following subscales: Dangerousness: .76 for African Americans, .65 for Whites. Poor social skills: .68 for African Americans, .82 for Whites. Curability: .89 for African Americans, .87 for Whites. It is noted here that two of the subcales (Dangerousness and Poor social skills) had marginally acceptable reliability estimates for Whites and African Americans, respectively, against traditional psychometric standards.

### Procedures

Participants of this study were recruited from two courses offered within the Psychology Department at the University of Central Florida. The courses were Cross-Cultural Psychology and Sexual Behavior. Both courses generally include a diverse range of students in terms of ethnicity, age, gender, etc. Participation in this study was completely voluntary and upon completion all participants received extra-credit points from their course instructor. All participant information and responses were kept confidential. Upon approval of the university’s IRB department, surveys were passed out to all consenting students. Participants were then asked to complete each survey component to the best of their abilities. The contents of the survey packets included: a demographic questionnaire, The Revised African-American Acculturation



Scale, The Multidimensional Scale of Perceived Social Support, The Stigma Scale for Receiving Psychological Help-modified, and The Beliefs Towards Mental Illness Scale-modified. Once participants had completed the survey packet, names were recorded on a separate sheet of paper aside from the surveys, for the purpose of the students receiving extra-credit.

## RESULTS

Data from all participants who self-identified as African American ( $n = 53$ ) were included for data analytic purposes. To include data from an equal number of Whites, 53 questionnaires from over 200 participants who self-identified as White were randomly selected, and their data was included for analytic purposes.

Prior to testing the hypotheses, preliminary analyses were conducted to rule out potential covariates that may need to be controlled for in subsequent analyses. Consequently, a multiple analysis of variance (MANOVA) was performed on the data. The independent variable (IV) was ethnicity (African American vs. White). The dependent variables (DVs) were age, class standing, perceived social support, depression status (yes/no), and family history of depression (yes/no). Using Wilks' Lambda, ethnicity was not found to be associated with a significant effect on the DVs ( $F [5, 100] = .36, p > .05$ , partial eta squared = .02). None of the univariate tests achieved statistical significance (all  $ps > .05$ ).

To test the initial hypothesis that, on average, African Americans would perceive depression and those who are depressed less favorably than Whites, a MANOVA was performed. The IV was ethnicity. The DVs were stigma, perceived dangerousness, poor social skills, and incurability. As predicted, ethnicity was associated with a significant effect on the DVs ( $F [4, 101] = 5.64, p < .001$ , partial eta squared = .18). Univariate tests indicated African Americans, on average, perceived there to be significantly more stigma attached to those who suffer depression than Whites ( $M_s = 3.17$  and  $2.53$  [ $SD_s = 1.03$  and  $.85$ ], respectively ( $F [1, 104] = 12.37, p < .01$ , partial eta squared = .11). African Americans also perceived those who suffer from depression to be dangerous ( $M = 2.71$  [ $SD = .86$ ]), have poor social skills ( $M = 2.66$  [ $SD =$

.95]), and to be incurable ( $M = 3.27$  [ $SD = .91$ ]) significantly more so than Whites ( $M_s = 2.17$ , 2.00, and 2.87 [ $SD_s = .63$ , .60, and .85] respectively ( $F_s$  [1, 104] = 13.59, 18.56, and 5.32,  $p_s < .001$ , .001, and .05, partial eta squared = .12, .15, and .05, respectively). Table 1 shows the means and standard deviations on these study variables as a function of ethnicity.

In order to test the second hypothesis, that participants who have experienced depression ( $n = 25$  for African Americans;  $n = 26$  for Whites) or who have family members who have suffered from depression ( $n = 27$  for African Americans;  $n = 31$  for Whites) would differ in their attitudes about depression, including depression-related stigma, compared to participants who report not having suffered from depression ( $n = 28$  for African Americans;  $n = 27$  for Whites) nor having family members with depression ( $n = 26$  for African Americans;  $n = 22$  for Whites), a MANOVA was performed for each ethnic group separately. The IVs were individual history of depression status (yes/no) and family history of depression status (yes/no). The DVs were stigma, dangerousness, poor social skills, and incurability. The data did not support this hypothesis for either group. For African Americans, the IVs were not significantly associated with an effect on the DVs ( $F_s$  [4, 46] = .72 and .24,  $p_s > .05$ , partial eta squared = .06 and .02, respectively). None of the univariate tests achieved significance (all  $p_s > .05$ ). Likewise, for Whites, the IVs were not significantly associated with an effect on the DVs ( $F_s$  [4, 46] = .98 and .32,  $p_s > .05$ , partial eta squared = .08 and .03, respectively). None of the univariate tests achieved significance (all  $p_s > .05$ ). Tables 2 and 3 shows the means and standard deviations on the study variables as a function of individual and family history of depression for African Americans and Whites, respectively.

In reference to the third hypothesis, using data from African Americans only, zero-order correlations were performed to assess for relations between enculturation toward African American culture and scores on stigma, dangerousness, poor social skills, and incurability. Although none of the correlations achieved statistical significance (thus, not supporting the hypothesis), the direction of the correlations was consistent with the hypothesis in that the more African Americans were enculturated toward African American culture, the more stigma they perceived attached to those suffering from depression, and the more they believed those who suffer from depression have poor social skills, and that depression is incurable (see Table 4).

Finally, although not part of any formal hypothesis, it deserves noting that among African Americans, the more stigma participants perceived to be attached to those who suffer from depression, the more they believed depression sufferers were dangerous ( $r = .53, p < .001$ ), have poor social skills ( $r = .67, p < .001$ ), and to be untreatable ( $r = .29, p < .05$ ).

## **DISCUSSION**

It was predicted that, on average, African Americans would hold more negative attitudes toward depression and those who suffer from depression, in comparison to Whites. The data supported this hypothesis. African Americans indicated that they perceived stigma attached to those who suffer from depression significantly more than Whites. African Americans, on average, also expressed that they believed those who suffer from depression are dangerous and have poor social skills significantly more than did Whites. African Americans also held the belief that depression is untreatable significantly more than did Whites. There are multiple possible explanations for why African Americans hold such unfavorable views of depression and those afflicted by it. Previous research has found that African Americans tend to stigmatize mental illness in general more so than the general population (e.g., Rusch et al., 2008). There also is evidence that African Americans tend to resist seeking professional assistance for psychological challenges, including symptoms of depression (e.g., Cooper, Corrigan, & Watson, 2003). Moreover, there is evidence suggesting that people of lower socio-economic status (SES) backgrounds hold more negative views toward mental illness and therapy (Rojas-Vilches, Negy, & Reig-Ferrer, 2011). Although the present sample of African Americans—in light of their college student status—likely will achieve middle- or upper-SES life styles subsequent to graduation, it is possible that as a group, they are more likely to be first-generation university students compared to their White counterparts. Thus, to an unknown degree—given that SES was not assessed about participants—this sample of African Americans may share their parents' biased attitudes toward mental illnesses and professional treatment.

It also was hypothesized that participants—irrespective of race—who had either experienced depression themselves or have family members who have suffered from depression,

would hold less pejorative views toward depression and those who suffer from it. This hypothesis was made based more on logic than previous research. Namely, it should be expected that those with firsthand experiences of depression—either themselves or their family members—would most likely have more empathy for those with depression and consequently have less negatively biased attitudes toward the illness. However, the data did not support this hypothesis. Neither for African Americans nor for Whites was there a significant difference in attitudes toward depression and depression sufferers as a function of personal experience with depression. In the absence of additional information, it is difficult to know with certainty the explanation for this counterintuitive finding. Perhaps if additional details about the severity or duration of individuals' experiences with depression were to have been assessed, including their ages when they were depressed, whether they had obtained professional treatment, and so on, such variables may have been controlled for, thus elucidating the observed lack of group-mean differences.

The third hypothesis was that the more African Americans were enculturated toward traditional African American culture, the more pejorative their views would be toward depression and those who suffer from depression. The data did not support this hypothesis, at least not from a statistical significance standpoint. The correlations between enculturation and the primary study variables (stigma, dangerousness, poor social skills, and incurability) did not achieve statistical significance. It bears noting, however, that the correlations were in the expected directions (e.g., the more enculturated African Americans were, the more stigma they perceived toward those who suffer depression, etc.). Possibly with a larger sample size, the correlation coefficients may have achieved statistical significance. Likewise, having had a

broader range of variable scores, which might have been obtained by data from a community sample rather than from college students, might have caused the coefficients to be statistically significant. Future studies with either large sample sizes or data from participants from the larger non-university community should be conducted to determine if the observed correlations between enculturation and depression variables would be more pronounced.

Although not a formal focus of the present study, the data revealed strong correlations between African Americans' perceived stigma attached to those who suffer depression and pejorative views about depression. Specifically, the more stigma African Americans believed there was attached to those who suffer depression, the more they expressed negative views towards depression and those who suffer depression. These findings, to some degree, suggest that African Americans who believe stigma exists due to suffering depression may actually contribute to such stigma by holding such pejorative views of those who experience depression. Future research should be conducted to examine ways to reduce African Americans' negative attitudes toward mental illness, depression, and those who experience the general condition of mental illness.

This study had various shortcomings that must be acknowledged. The participants were university students and predominantly represent emerging adulthood. Consequently, it is difficult to know if these findings generalize to samples within the larger community who probably would vary more among myriad socio-politico-economic lines. Also, this study has a relatively small sample size, even for a study based on college students. As indicated, this artifact may have contributed to some of the statistically insignificant findings or even the absence of some findings (e.g., differences between those who have suffered depression versus those who have

not). Moreover, the large imbalance between women and men precluded any analysis based on gender. Further, socioeconomic status was not assessed among participants, particularly in relation to their families' socioeconomic statuses. This shortcoming precluded my ability to determine if some of the discrepant findings between African Americans and Whites could have been accounted for by group-mean differences in socioeconomic status. Finally, the study did not shed any light on why African Americans, on average, held relatively more negatively biased attitudes toward depression and depression sufferers compared to Whites. As indicated, future studies should consider examining an array of potential causal variables that might explain findings such as those yielded by this study (e.g., SES, misinformation about mental illnesses and psychotherapy, religious beliefs that adversely affects attitudes about mental illness, science, etc.).



## **APPENDIX**

Table 1 Means and Standard Deviations of Study Variables as a Function of Ethnicity

---

		ETHNICITY	
		African Americans	Whites
		( <i>n</i> = 53)	( <i>n</i> = 53)
STUDY VARIABLES			
Stigma	M ( <i>SD</i> )	3.17 ( <i>1.02</i> )	2.52 ( <i>.85</i> )**
Dangerousness		2.71 ( <i>.86</i> )	2.17 ( <i>.63</i> ****)
Poor Social Skills		2.66 ( <i>.95</i> )	2.00 ( <i>.60</i> ****)
Incurability		3.27 ( <i>.91</i> )	2.87 ( <i>.85</i> *)

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Note: \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*\*  $p < .001$ .

Table 2 Means and Standard Deviations of Study Variables as a Function of History of Individual and Family Depression for African Americans

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		HISTORY OF DEPRESSION			
		Individually		Family	
		Yes ( <i>n</i> = 25)	No ( <i>n</i> = 28)	Yes ( <i>n</i> = 27)	No ( <i>n</i> = 26)
<b>STUDY VARIABLES</b>					
Stigma	M ( <i>SD</i> )	3.10 (.94)	3.23 (1.10)	3.14 (1.09)	3.20 (.97)
Dangerousness		2.49 (.73)	2.90 (.92)	2.64 (.92)	2.71 (.86)
Poor Social Skills		2.50 (.93)	2.81(.95)	2.60 (1.09)	2.73 (.78)
Incurability		3.21 (.88)	3.33 (.95)	3.36 (.97)	3.17 (.86)

---

Table 3 Means and Standard Deviations of Study Variables as a Function of History of Individual and Family Depression for Whites

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		HISTORY OF DEPRESSION			
		Individually		Family	
		Yes ( <i>n</i> = 26)	No ( <i>n</i> = 27)	Yes ( <i>n</i> = 31)	No ( <i>n</i> = 22)
<b>STUDY VARIABLES</b>					
Stigma	M ( <i>SD</i> )	2.65 (.94)	2.40 (.76)	2.51 (.90)	2.55 (.80)
Dangerousness		2.21 (.68)	2.13 (.60)	2.16 (.67)	2.17 (.59)
Poor Social Skills		2.03 (.60)	1.98 (.64)	2.04 (.62)	1.95 (.58)
Incurability		3.06 (.95)	2.70 (.72)	2.91 (.90)	2.83 (.79)

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Table 4 Zero-order Correlations between Enculturation and Study Variables for African Americans<sup>a</sup>

VARIABLE	Enculturation	Stigma	Dangerousness	Poor Social Skills	Incurability
Enculturation	--	.14	-.04	.17	.24
Stigma	.14	--	.53***	.66***	.29*
Dangerousness	-.04	.53***	--	.67***	.34**
Poor Social Skills	.17	.66***	.67***	--	.36**
Incurability	.24	.29*	.34**	.36**	--

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Note: <sup>a</sup>  $n = 53$ . \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

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