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The Impact of Acculturation and Labeling on African Americans' Stigmatization of Mental Illness

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THE IMPACT OF ACCULTURATION AND LABELING ON AFRICAN
AMERICANS' STIGMATIZATION OF MENTAL ILLNESS

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DISSERTATION

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ABSTRACT OF DISSERTATION

THE IMPACT OF ACCULTURATION AND LABELING ON AFRICAN
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Although African Americans endorse more stigma towards those with mental illnesses than European Americans and are quite susceptible to stigma's detrimental effects on help-seeking for mental health problems, stigma has not been adequately studied for African Americans. Given that stigma is a key barrier to obtaining help for mental health problems, it is imperative that we gain a more nuanced understanding of stigma. This study used experimental design and vignettes to examine the influence of acculturation and labeling on African Americans' stigmatization of depression, social phobia, alcohol dependence, and schizophrenia. Results indicated that schizophrenia was generally the most stigmatized disorder and social phobia was least stigmatized. Having a label predicted increased desire for social distance from vignette subjects with depressive symptoms only. Additionally, acculturation predicted stigmatization of depression and social phobia.

KEYWORDS: Stigma, Mental Illness, African Americans,
                      Acculturation, Labeling

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The poster above the desk in my apartment reads, "We owe it to our ancestors and to the sacrifices they made to continue to achieve higher goals while maintaining our identity." The poster serves as a constant reminder that there were those who came before me who did not have any academic opportunities, but paved the way so that I could have the privilege of obtaining a Ph.D. I am thankful for and forever indebted to my ancestors for that. I would also like to acknowledge the many African American psychologists, such as Dr. Francis Cecil Sumner (the first African American to obtain a Ph.D. in psychology) and Drs. Inez Beverly Prosser and Ruth Winifred Howard (the first African American women to earn psychology Ph.D.s) and many after them who laid the foundation for future African American psychologists and psychology research that is pertinent to African Americans.

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helped me maintain a sense of balance in my life, keeping me grounded and giving me opportunities where I did not have to think about school. Without all of these bonds, my sanity may have been compromised during this process.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter 1: Introduction

Mental illness stigma, the devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses, is "the most formidable obstacle to future progress in the arena of mental illness and health," according to the Surgeon General's report on mental health (Hinshaw, 2007; U.S. Department of Health and Human Services [DHHS], 1999, p. 3). Much of that report, in addition to over forty years of research, was dedicated to identifying the mechanisms and effects of mental illness stigma. Mental illness stigma is of dire concern because of its many detrimental effects on stigmatized individuals. Perhaps most troubling is that the mental health of those with mental illnesses is further negatively impacted by stigma. People with mental illnesses may internalize society's stigmatizing notions such as the belief that people with mental illnesses are dangerous and undesirable to be around, diminishing their sense of worth and self-esteem and compounding their mental health problems, making recovery even more difficult (Corrigan, 2004; Link et al., 2001; Shah & Beinecke, 2009).

The negative social impact of stigma has also been well documented (e.g., Corrigan, 2004; DHHS, 1999; Martin, Pescosolido, & Tuch, 2000; Wahl, 1999). The majority of Americans are unwilling to have people with a mental illness marry into their family (68%), work closely with them (58%), or spend an evening socializing with them (56%; Martin et al., 2000). Also, individuals with mental illnesses often encounter fewer opportunities and reduced access to resources because of discriminatory practices by employers who tend to avoid giving jobs to them and proprietors who are less inclined to rent housing to them, thus depriving those with mental illnesses of the chance to fully participate in society in ways that others can (Corrigan, 2004; DHHS, 1999; Wahl, 1999).

1

There is evidence that African Americans may stigmatize people with mental illnesses more than European Americans. Whaley (1997) used a nationally-collected sample of 1,468 American Indian, Asian/Pacific Islander, African American, Latino, and European American participants to determine ethnic/racial differences in perceptions of dangerousness of those with mental illness, one stigmatizing belief about people with mental illnesses. Contact with those with a mental illness was also examined as a moderator of ethnic/racial differences in perceptions of dangerousness. African Americans (as well as Asians/Pacific Islanders and Latinos) perceived those with mental illness as significantly more dangerous than did European Americans. For European Americans, more contact was associated with less dangerous perceptions, but for African Americans, more contact was associated with more dangerous perceptions. This points to an important distinction, especially since increasing contact with people with mental illnesses is one of the most common strategies for decreasing mental illness stigma (Corrigan & Wassel, 2008). Whaley's (1997) study supports the importance of further examining mental illness stigma and interventions to reduce stigma among African Americans.

A more recent study by Anglin, Link, and Phelan (2006) supports some of Whaley's (1997) findings. Anglin and colleagues (2006) used a nationally representative sample of 81 African Americans and 590 European Americans to examine racial differences in the public's stigmatizing attitudes toward people with schizophrenia and depression. Even when controlling for age, income, education, political views and religion, the researchers found that African Americans were more likely than European Americans to hold the stigmatizing belief that those with mental illnesses were

dangerous. Despite their beliefs, African Americans were less likely to blame individuals with mental illnesses for violent acts and less likely to believe that those with mental illnesses should be punished for violent acts (Anglin, Link, & Phelan, 2006). At baseline for their anti-stigma intervention study, Rao, Feinglass, and Corrigan (2007) also found that African Americans perceived people with mental illnesses as more dangerous and expressed wanting more segregation from those with mental illnesses than European Americans did. Taken together, findings from Whaley's (1997), Anglin, Link, and Phelan's (2006), and Rao, Feinglass, and Corrigan's (2007) studies provide strong support for the notion that stigmatizing attitudes differ for African Americans.

Especially for African Americans, stigma serves as a barrier to seeking help for mental health problems (Alvidrez, Snowden, & Kaiser, 2008; Corrigan, 2004; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009). Qualitative studies by Mishra, Lucksted, Gioia, Barnet, and Baquet (2009) and Alvidrez, Snowden, and Kaiser (2008) indicate that, for African Americans, stigma is a major barrier to obtaining information about mental health problems to aid in recognizing the existence of mental health problems. Alvidrez et al. (2008) found that 32% of study participants recognized that they had mental health problems, but because of stigma, they initially failed to recognize the need to seek help. Ayalon and Alvidrez (2007) and Alvidrez and colleagues (2008) examined stigma and mental health help-seeking among African Americans and found that perceived stigma was a commonly endorsed barrier to using mental health services. In fact, 62% of participants in one study stated that they or someone they knew was reluctant to seek professional help despite knowing that they needed it (Alvidrez et al., 2008).

Given African Americans' higher endorsement of mental illness stigma (as compared to European Americans) and the well-documented detrimental impact of stigma on African Americans' mental health help-seeking, it is imperative that mental illness stigma is better understood for African Americans. Sue (1999) has suggested that the racial differences found in many studies are not actually due to the demographic constructs of race or ethnicity. Rather, a more plausible explanation is that differences in cultural values, socialization, and/or cultural conceptualizations of mental illness influence differences in stigma (Rao, Feinglass, & Corrigan, 2007). Therefore, to improve our understanding of African Americans' stigmatization of people with mental illnesses, in this study I examine how stigma may be impacted by acculturation (an ethnocultural variable) and labeling, a variable whose relationship with mental illness stigma has been extensively researched. To provide further background information on the study's variables and build support for the contribution of the study, I first thoroughly define stigma and discuss the factors that are believed to make individuals susceptible to stigma. Next, I review and critique the literature on mental illness stigma and labeling, mental illness stigma and African Americans, and mental illness stigma and acculturation. I also discuss how the study can improve upon the current body of research in each of those areas. Last, I summarize the purpose and describe the objectives, hypotheses, and implications of the study.

Mental Illness Stigma

The word stigma is derived from a Greek term that refers to marks or signs that were cut or burned into people's bodies to indicate that there was something immoral, unusual, or bad about them and they should be avoided (Goffman, 1963). Thus, stigma is

an attribute that discredits an individual, makes the person different from others, and essentially reduces the person's status from a "whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). Pescosolido and colleagues (2008) defined stigma as "a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and 'less than'" (p. 431). Stigma has also been thought of as an attribute that associates a person with unfavorable stereotypes (Jones et al., 1984) and subsequent discrimination (Link & Phelan, 1999), and as a combination of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). Perhaps the most thorough definition describes stigma as a pervasive and global "devaluation of certain individuals on the basis of some characteristic they possess, related to membership in a group that is disfavored, devalued, or disgraced by the general society" (Hinshaw, 2007, p. 23). Thus, applied specifically to mental illness, stigma refers to the social judgment, degradation, or devaluation of individuals because they have mental illnesses. Researchers use the term "public stigma" to describe the general public's social judgment, degradation, or devaluation of people with mental illnesses (Corrigan & Kleinlein, 2005). When considering stigma, public stigma is typically the type of stigma that is discussed. However, a distinction should be made between public stigma and "self stigma," which occurs when a person with a mental illness internalizes society's negative judgments, degradation and devaluation regarding mental illness (Corrigan, 2004; Corrigan, 2007; Corrigan & Wassel, 2008).

Operationalizing stigma. Public mental illness stigma is most commonly operationalized as social distance, people's willingness to avoid or interact with a person with mental illness in various social situations (Feldman & Crandall, 2007; Link, Yang,

Phelan, & Collins, 2004). However, the validity of social distance in encompassing the entire construct of mental illness stigma is debatable (Feldman & Crandall, 2007). There is evidence that self-report social distance measures are associated with behavioral social avoidance (Crandall & Warner, 2005). However, social distance scales measure behaviors that could result from underlying stereotypes and judgments, but they do not directly measure those underlying beliefs. Therefore, it is possible that some people may devalue or negatively judge people with mental illnesses but not endorse a strong desire to distance themselves from people with mental illnesses. Further, social desirability bias may lead to underreporting of social distance (Link et al., 2004).

Attributional measures better gauge the underlying cognitions and emotions one may have towards people with mental illnesses (Link at al., 2004). Such measures are based on attributional theory, which holds that perceived responsibility for a person's condition and perceived controllability of the condition predict negative emotional reactions, stereotyping, and discrimination (Link et al., 2004). Like social distance measures, attributional measures may suffer from social desirability bias; however, they likely capture a concept that is closer to the core of stigma. Therefore, in this study, I used a social distance measure so that I can compare the study's results to those of previous studies on mental illness stigma. In addition, I used an attributional measure to better assess the cognitive and emotional components of mental illness stigma.

Attributes associated with mental illness stigma. It is important to understand the attributes of mental illnesses that make people with mental illnesses more vulnerable to negative cognitive, emotional, and behavioral responses such as being socially judged, degraded, devalued, or isolated by the general public. Researchers have identified many

characteristics that may make people with mental illnesses more susceptible to stigmatization. Jones and colleagues (1984) have grouped most of these characteristics into six "dimensions" to describe attributes that make a person prone to stigmatization: concealability, course, disruptiveness, peril, aesthetics, and origin. Although Jones and colleagues (1984) did not apply their dimensions to mental illness stigma, others have (e.g., Feldman & Crandall, 2007 and Hinshaw, 2007).

In an effort to better understand the underlying structure of mental illness stigma, Feldman and Crandall (2007) recently conducted a study to determine the extent to which 17 attributes, including five of Jones and colleagues' (1984) six dimensions, contribute to the stigmatization of 40 mental illnesses. There were 270 participants, each of whom read two different vignettes describing a person with a mental illness. The vignettes described the person's gender, age, symptoms, diagnosis, definition of the disorder, likely causes, treatment the person has undergone, immediate outcome, and long-term prognosis. For each vignette, participants were asked to complete a measure of social distance and use 7-point semantic differential scales to rate the 17 attributes [dangerousness of the person (Jones et al.'s peril), fault for having the disorder, avoidability of the disorder, how in touch with reality the person is, rarity of the disorder, social disruptiveness of the disorder (disruptiveness), treatability of the disorder with medication or therapy (treatability), how problematic the disorder is at work, how embarrassing the disorder is to have, whether the symptoms are sexual, whether the disorder is acute or chronic (course), how much control the person has over him/herself, severity of the disorder, whether one sex or both have the disorder, whether the disorder is potentially concealable vs. publicly visible (concealability), heritability of the disorder (origin)].

Results indicated that participants desired greatest social distance from those diagnosed with antisocial personality disorder, pedophilia, and factitious disorder. Personal responsibility, dangerousness (peril), and rarity were the only attributes that were significant predictors of social distance, and they accounted for about 60% of the variance in social distance. Thus, they desired greater social distance from people who they believed to be responsible for their disorder, who they perceived as dangerous, and whose disorder they viewed as uncommon. While extremely informative and the only known study to date to examine attributes of stigma, Feldman and Crandall's (2007) sample consisted of 85% European Americans and analyses were not stratified by ethnicity, making it impossible to know if the results were consistent for participants of other ethnic backgrounds. Further, their vignettes contained a great deal of information that may have, in and of itself, contributed to increased desire for social distance. For instance, the vignettes all contained mental illness labels, which studies have been found to be associated with social distance (Jorm & Oh, 2009).

Mental illness stigma and labeling. Labels such as "mentally ill," "schizophrenia," and "depressed" have been proposed as contributing to people with mental illnesses' susceptibility to public stigma. Labeling theory suggests that public stigma occurs because of the "heavy weight of moral condemnation" (Scheff, 1984, p. 30) that labels carry. According to the theory, labeling leads to the arousal of negative emotions. This emotional response is most often fear and/or anger, and is stronger than what is rationally necessary, leading to stigmatizing responses like increased social distance from people with mental illnesses (Scheff, 1984).

The relationship between labeling and mental illness stigma has been researched and debated extensively, yielding paradoxical findings and opposing viewpoints (see Link, Cullen, Frank, & Wozniak, 1987 for a complete review). According to Cormack and Furnham (1998), the public generally views people with mental illnesses negatively, but do not always identify symptom sets that professionals would consider mental illnesses as such and therefore stigmatize more when labels are present. Many studies have discredited this with findings that suggest it is a person's behavior that, above and beyond any labels, causes the public to stigmatize him or her (Bord, 1971; Kirk, 1974). Methodological flaws in studies by researchers on both sides of the debate have contributed to the difficulty in gaining a clear understanding of the effect labeling has on the stigmatization of people with mental illnesses.

Kirk (1974) investigated labeling and stigmatization of those with mental illnesses using a sample of 864 college students. The experiment had a 3x3x4 (behavior/symptoms x label x labeler) factorial design, resulting in 36 conditions. Each participant was presented with a vignette from one of the 36 study conditions. Vignettes described a man who either had severe psychiatric symptoms (paranoid), moderate symptoms (depressed and anxious), or was normal (good job, easy to get along with, engaged). At the end of the vignette, a labeler (the man himself, family, some people, or psychiatrist) provided a label (mentally ill, wicked, or under stress) to interpret the man's behavior. After reading the vignettes, participants were asked to indicate the extent to which they would be willing to engage in various interactions with the man in the vignette and their desire for social distance from the man in the vignette. Results indicated that the severity of the symptoms was the only predictor of social rejection, meaning that participants were more

9

socially rejecting of those whose symptoms were described as more severe. There were no effects for the labels or labelers, nor were there any interactions. The study is limited because the design is confusing. Several of the conditions do not make sense. For example, it is unclear what responses participants gave when presented with a vignette describing a normal man who a psychiatrist has said is wicked. When presented with several sentences describing behavior that drastically contrasts with one sentence containing a label, it is not surprising that participants would respond more to the behavior than the label or the person conferring the label.

Farina (e.g., Farina, Felner, & Boudreau, 1973; Farina & Hagelauer, 1975) has conducted several studies yielding results that also indicate that behavior, as opposed to a mental illness label, results in greater stigmatization. Farina, Felner, and Boudreau (1973) conducted three studies, one with 48 female department store employees, one with 48 male hospital employees, and one with 44 female hospital employees. Participants in all three studies were asked to evaluate a same-gender confederate who was being interviewed for a position at their place of employment. Prior to the interview, each employee was either told that the confederate was a "mental patient" or an "ordinary job applicant." The confederates were not aware of whether each employee had been told they were mental patients or ordinary applicants. During half of the interviews, confederates acted normal (calm and relaxed), and during the other half, they acted tense (very little eye contact, wringing hands, swinging lower leg). Following the interviews, employees were asked whether the confederate should be hired and how they would get along with the confederate. For both of the female samples, there were no differences in how much employees thought they would get along with the confederate. There were also

no differences in employees' hiring recommendations for employees for whom the confederate was labeled as a mental patient versus those for whom she was labeled as an ordinary applicant. Farina and Hagelauer (1975) conducted a study similar to the first part of Farina, Felner, and Boudreau's (1973), but with 60 female employees and a male job applicant confederate and got the same results. Male employees, on the other hand, in Farina, Felner, and Boudreau's (1973) study indicated that they would not get along with or want to hire the confederate when he acted nervous, nor would they get along with or want to hire the confederate when he was labeled as a mental patient. No interactions were significant.

Loman and Larkin (1976) conducted a study with 204 college students who viewed videotapes of an actress posing as a student in an academic counseling session. The study had a 2 (behavioral symptoms) x 2 (label) x 3 (explanation of behavior) factorial design. In the tapes, the actress either gave common explanations for her poor grades (mild behavioral symptoms) or displayed more severe symptoms (paranoia: stating teachers were failing her for no reason). In both tapes, the actress questioned whether the counselor cared about her. Half the tapes had an introduction in which the actress was said to have had previous academic problems, but was a normal college student, while the other half had an introduction in which she was described as having had previous academic problems and a previous psychiatric diagnosis that included paranoid tendencies. At the end, the actress either provided no explanation for her comments about the counselor, explained it as due to pressure from her relationships with her boyfriend and her parents, or explained it as a result of not being in complete control of herself and possibly in need of psychiatric help. Stigma was assessed by asking

participants to complete social distance and social competence (likelihood of future success and ability to deal with others effectively) ratings of the actress following the video. Results indicated main effects for behavior and label in a predicting social distance, such that paranoia and mental illness label were associated with a stronger desire for social distance from the actress. Mental illness label was also associated with a greater perception of the actress as socially incompetent. There were no interactions, nor were there any effects for behavioral explanation.

Socall and Holtgraves (1992) found results similar to Loman and Larkin (1976) in their vignette study. Socall and Holtgraves examined 206 participants' stigma using vignettes that labeled a person as having anxiety, depression, or schizophrenia, or labeled the identically-behaving person in analogous vignettes as physically ill (food allergy, medication side effects, or brain tumor, respectively). The anxiety/food allergy condition was considered to be low severity, the depression/medication side effects condition was considered moderate severity, and the schizophrenia/brain tumor condition was high severity. After reading the vignettes, participants were asked to respond to questions about willingness to interact with (i.e., social distance from) the man in the vignette and beliefs about his predictability (e.g., dangerousness, likelihood of committing a crime, degree he is controlled by emotions) and outcomes (e.g., on welfare, a failure, never employed). Results indicated that participants desired more social distance from vignette subjects described as having a mental illness and viewed them as less predictable and less likely to have positive outcomes as compared to the identically behaving vignette subjects described as having a physical disorder. Also, there were main effects for symptom severity such that regardless of mentally ill or physically ill label, participants

12

perceived the man in the vignette as less predictable and less likely to have positive outcomes as symptoms increased in severity. No interaction effects were found.

Unlike in the previously discussed studies, moderation effects were found in Link, Cullen, Frank, and Wozniak's (1987) study. They examined stigma as measured by social distance and perceived dangerousness using six different vignettes. Vignettes varied on behavior (no objectionable behavior, mild – frustrated/anxious, or severe – threatening/angry) and label (previous mental hospitalization or previous hospitalization for back problems). The 152 participants were asked to read the assigned vignette and respond to questions about desire for social distance from the man in the vignette and perceived dangerousness of the mean in the vignette. Results indicated a main effect for severity of behavior in predicting social distance, such that participants desired greater social distance from the man described as having more severe behavior. However, there was also an interaction between label (mental hospitalization vs. back pain hospitalization) and perceived dangerousness in predicting social distance. This suggests that people who perceived the man in the vignette to be dangerous desire significantly more social distance when he was labeled as having a previous mental hospitalization than when he was labeled as having a previous back pain hospitalization.

All the previously reviewed studies have used explicit measures of stigma, which rely heavily on self-report. More recently, Graves, Cassisi, and Penn (2005) conducted a study examining mental illness stigma and physiological response to labeling in 35 African American college students. Participants were given 30 seconds to imagine interacting in a given situation with a same-sex person who was either described as having schizophrenia or described as leading a normal life while brow muscle activity,

heart rate, and skin conductance were measured. Subjective Units of Distress Scale ratings were taken following the exercise. Results indicated that participants rated imagining interactions with those labeled with schizophrenia as more stressful than interactions with those described as normal. Also, those who imagined interacting with a person with schizophrenia had more brow muscle activity (a proxy for negative affect) and lower heart rate (associated with aversive situations). Increased brow muscle activity during imagery involving a person labeled as schizophrenic also predicted greater general desire for social distance from those with mental illnesses.

Studies on mental illness stigma and labeling have had many methodological flaws, as Socall and Holtgraves (1992) pointed out. Several studies compared a person in a vignette with a mental illness label to a person in a vignette with the same behavior but no label or a normal label. Normal and no label conditions fail to adequately explain the behaviors in the vignettes and may make the vignette less believable (Socall & Holtgraves, 1992). Another criticism of vignette studies is that they confound labels and behaviors when informal or underlying labels such as "afraid of people" are used (Loman & Larkin, 1976). Instead, describing the behavior that occurs (e.g., "makes excuses to leave social situations") eliminates subtle labels. The studies reviewed used a wide variety of labels (e.g., previous mental hospitalization, mental patient, paranoid, depression). Socall and Holtgraves (1992) suggest specifying the mental illness label by using the name of a disorder, rather than broad terms like "mentally ill" to minimize individual differences in the meaning attributed to the label that are unaccounted for in the study.

Another limitation of the labeling and mental illness stigma literature is that it has rarely been studied in African Americans. Graves and colleagues' (2005) study is the only known study to examine labeling and mental illness stigma in African Americans. The other studies reviewed either did not include African American participants, or they conducted no analyses comparing them to other racial groups, making it impossible to know what the relationship between labeling and stigma is for African Americans. Given the racial differences that have been found in mental illness stigma, it is important to conduct research on the effects of labeling on mental illness stigma in African Americans.

Mental illness stigma among African Americans. As previously mentioned, cross-racial studies examining mental illness stigma have consistently indicated that African Americans stigmatize mental illness more than European Americans (Anglin, Link, & Phelan, 2006; Rao, Feinglass, & Corrigan, 2007; Whaley, 1997). Few studies have examined stigma specifically among African Americans. Those that do are mostly qualitative. For example, Cruz, Pincus, Harman, Reynolds, and Post (2008) conducted a qualitative study examining barriers to seeking mental health care among 43 African American participants in therapy for depression. Participants were asked why they thought African Americans with psychological problems utilize mental health services at half the rate of European Americans with similar problems. Stigma was the most frequent response given by participants. This study suggests that even African Americans who are in therapy see stigma as a problem.

In another qualitative study, Alvidrez, Snowden, and Kaiser (2008) interviewed 34 African American participants who were receiving mental health treatment. About

three-fourths (76%) of participants reported that stigma had initially prevented them from seeking mental health treatment. For many, stigma was a hindrance to recognizing or admitting that they had a mental health problem. Many also feared being socially rejected, judged, ridiculed, or the subject of gossip. The majority of participants (68%) reported actually experiencing some form of stigmatization (social rejection, social judgment, self-stigma, discrimination, or differential treatment) as a result of receiving mental health treatment.

Mishra and colleagues (2009) conducted focus groups with 42 African American adults who were not receiving mental health services. The focus groups began with a discussion of what mental health is, and included views on specific mental illnesses, mental health professionals and services, and other beliefs about mental health care. Results indicated that fear of stigma and racism were the primary barriers to seeking mental health services or information about mental illnesses or available services. Participants pointed to several underlying factors that contribute to stigma, including the stereotype that mental illness is contagious and chronic, and the belief that those with mental illnesses are dangerous, unpredictable and hopeless, the belief that a mental illness is a personal weakness, curse or sin, and the belief that seeking professional mental health care will result in labeling and forced treatment. Also, historical and current racism were factors contributing to stigma. Participants related general experiences of racism to a desire to reduce vulnerability by not discussing problems with outsiders.

Research on mental illness stigma in African Americans indicates that stigma is more prevalent among African Americans than it is among European Americans (Anglin, Link, & Phelan, 2006; Rao, Feinglass, & Corrigan, 2007; Whaley, 1997). Stigma also

serves as a barrier to seeking help for mental health problems for African Americans. These studies have, however, assumed that African Americans are a largely monolithic group, an incorrect but often-made assumption. It is important to consider within-group differences in African Americans' stigmatization of mental illness stigma. One way of doing this is by examining cultural variables such as acculturation, which has been found to be a differentiating variable for African Americans in predicting other outcomes [e.g. alcohol use (Abdullah & Brown, 2012; Klonoff & Landrine, 1999), psychological distress (Pillay, 2005), disordered eating behaviors (Abrams, Allen & Gray, 1993), high-risk sexual behavior (Snowden & Hines, 1998)].

Mental illness stigma and acculturation. Acculturation is the process by which sociocultural and psychological changes, including changes in attitudes, lifestyles, and values, occur following intercultural interactions (Berry, Phinney, Sam, & Vedder, 2006). As applied in the US, acculturation typically refers to the degree to which an ethnic minority individual identifies with the attitudes, lifestyles, and values of Eurocentric US culture (Lee, 1997). Although it applies to all ethnic minority groups in the US, acculturation has been investigated more as a variable of interest for Asians and Latinos in the US than it has for African Americans. One possible reason for the neglect to include African Americans is that some view African American culture as indistinguishable from US culture (Pillay, 2005). However, by viewing African Americans as simply American, unique cultural factors are discounted or ignored in research. This contributes to a lack of understanding of the differences between African Americans and other ethnic groups, and an even greater scarcity of knowledge relating to differences that exist among African Americans.

Historically, acculturation has been conceptualized as a unidimensional construct. The unidimensional model places acculturation on a continuum from complete immersion in the dominant culture to complete immersion in one's own culture. The assumption of this model is that as people become more assimilated, or immersed in the dominant culture, they identify less with their culture of origin. The major limitation of the unidimensional acculturation model is that it confounds identification with the dominant culture with the distinct dimension of identification with one's own culture (Cabassa, 2003). For this reason, some researchers have begun to reconceptualize acculturation as a bidimensional construct (e.g., Berry, Kim, Power, Young, & Bujaki, 1989; Obasi & Leong, 2010). The bidimensional model places identification with the dominant culture on one continuum and identification with one's own culture on a separate, orthogonal continuum (Cabassa, 2003). Thus, people are not forced into immersion in one culture or the other; they could be immersed in both or neither, which likely allows for a more accurate representation of the complexity of the construct (Cabassa, 2003; Obasi & Leong, 2010).

Berry and colleagues (1989) identified four acculturation strategies based on the bidimensional model. Crossing identification with the dominant culture and identification with one's culture of origin yields four acculturation strategies: assimilation, separation, integration, and marginalization. Obasi and Leong (2010) have applied this model to African Americans, crossing the extent to which a person maintains African ethnocultural heritage and the extent to which a person participates in Eurocentric US culture. The resulting acculturation strategies are assimilationist (adopting Eurocentric US cultural thoughts and ideals while rejecting African culture), traditionalist (remaining true to

African thoughts and ideals and rejecting Eurocentric US culture), integrationist (merging the two cultural ideals together), and marginalist (rejecting both cultural ideals; Obasi & Leong, 2010).

Very few studies have examined the relationship between acculturation or cultural values and mental illness stigma or mental health treatment stigma. Wallace and Constantine (2005) investigated the effect of Africentric cultural values (communalism, unity, harmony, spirituality, and authenticity) on perceived mental health treatment stigma, mental health help-seeking attitudes, and self-concealment (nondisclosure of personal information) in 251 African American college students. Findings were similar for men and women and indicated that increased Africentric cultural values were associated with increased perceived mental health treatment stigma and increased self-concealment. Wallace and Constantine's (2005) study is the only known published study of acculturation and stigma among African Americans. However, this study is limited in that just one dimension of acculturation, maintenance of African ethnocultural values, was measured. Although understandable given the context of the study, it is unfortunate that the instrument used to measure mental health treatment stigma, the Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, Good, & Sherrod, 2000), assesses only general awareness of stigma associated with receiving psychological services. Thus, the SSRPH measures the extent to which an individual *is aware of* mental health treatment stigma as opposed to the extent to which an individual stigmatizes mental health treatment.

The other studies investigating acculturation and stigma have used Asian American participants. Kumar and Nevid (2010) conducted a study with 118 Asian

Indians in the US investigating the effects of acculturation and adherence to Asian cultural values on beliefs about medical vs. psychological etiology of depression and schizophrenia for case vignettes, treatment recommendations for the cases, and stigma associated with treatment. Although other effects were found, none of the study variables significantly impacted stigma. However, stigma was measured using a single item that measured one specific aspect of mental illness stigma, "If [the person in the case vignette] were a member of my family, I would be embarrassed if people knew he was treated by a psychologist or psychiatrist."

Two other studies indicated that Asian cultural values were positively correlated with perceived mental health treatment stigma (Miville & Constantine, 2007; Shea & Yeh, 2008). Miville and Constantine (2007) examined perceived mental health treatment stigma as a mediator of the relationship between adherence to Asian cultural values and intent to seek counseling among 201 Asian American college women. Results indicated that greater Asian cultural values were associated with greater perceived counseling stigma and Asian cultural values and perceived stigma were negatively correlated with intent to seek counseling. The results supported perceived stigma as a weak, partial mediator, indicating that greater endorsement of Asian cultural values was associated with increased perceived stigma, which in turn negatively influenced intent to seek counseling. Shea and Yeh (2008) explored the impact of Asian cultural values, perceived public stigma, and attitudes toward seeking professional psychological help in 219 Asian American college students. Like Miville and Constantine (2007), they found that Asian cultural values were positively correlated with stigma; however, Shea and Yeh's results indicated that stigma did not mediate the relationship between Asian cultural values and

20

help seeking attitudes. Miville and Constantine's (2007) and Shea and Yeh's (2008) studies are limited in the same way as Wallace and Constantine's (2005) study because of their use of the SSRPH as the sole determinant of stigma.

Acculturation and cultural values have more often been studied as predictors of a construct related to mental health treatment stigma, attitudes toward seeking mental health treatment. Results of such studies may be informative in considering the possible relationship between acculturation and mental illness and treatment stigma. Similar to the studies on acculturation and mental illness and treatment stigma, most studies that have examined acculturation and attitudes toward mental health treatment have also done so using Asian American samples. These studies indicate that an orientation towards Eurocentric US culture is associated with positive attitudes toward seeking mental health treatment (Atkinson & Gim, 1989; Tata & Leong, 1994; Zhang & Dixon, 2003) and an orientation toward traditional Asian values is associated with more negative attitudes toward seeking mental health treatment (Kim, 2007; Kim & Omizo, 2003).

The studies that have examined the relationship between acculturation and attitudes toward seeking mental health treatment in African Americans have yielded less consistent results. Wallace and Constantine (2005) found no relationship between Africentric cultural values and attitudes toward seeking mental health treatment in African American college students. Similarly, in a study of African American male college students, Duncan (2003) found no relationship between African self-consciousness (positive Black identity and pro-Black attitudes, beliefs, priorities, practice, etc.) and attitudes toward seeking mental health treatment. Wallace and Constantine (2005) and Duncan (2003) focused solely on one dimension of acculturation

(i.e., maintenance of African ethnocultural values). However, Obasi and Leong (2009) measured acculturation bidimensionally and found a positive correlation between maintaining traditional African beliefs and willingness to tolerate the stigma associated with mental health treatment and a negative correlation between participating in the society of another ethnocultural group and willingness to tolerate the stigma associated with mental health treatment. There was also a negative relationship between participating in the society of another ethnocultural group and openness to disclosing problems to others. Thus, more traditional African orientation was associated with being less ashamed to seek psychological help, while more Eurocentric orientation was associated with being more ashamed to seek psychological help and less willing to share personal matters with others. These results are a stark contrast to the studies involving Asian Americans, which essentially showed an opposite pattern, providing more evidence for the necessity of studying ethnic minority groups like African Americans separately, as opposed to grouping everyone together.

Purpose of the Study

Although African Americans endorse more stigma towards those with mental illnesses than European Americans and are quite susceptible to stigma's detrimental effects on help-seeking for mental health problems, stigma has not been adequately studied for African Americans. We know little about why between-group differences exist (i.e., why African Americans tend to stigmatize mental illness more than European Americans) and even less about the nature and existence of within-group differences (i.e., whether some African Americans tend to stigmatize mental illness more than other African Americans). Although labeling has long been studied and has gained inconsistent

support as a predictor of mental illness stigma for European Americans, its effects for African Americans have been examined in just one known study to date, making it impossible to know whether labeling is salient for African Americans. Without a more thorough understanding of mental illness stigma and its predictors for African Americans, we are not in a position to develop quality anti-stigma interventions geared towards African Americans, as they will be based on assumptions that do not necessarily generalize to African Americans. Learning more about what predicts mental illness stigma among African Americans will help us to understand more about what can help prevent it or buffer its effects. In an effort to learn more about what predicts mental illness stigma for African Americans, the purpose of this study was to investigate the effects of type of disorder, labeling and acculturation on stigma. The following hypotheses were tested:

- Schizophrenia will be stigmatized more than other disorders, and social phobia will be stigmatized less than other disorders.

- Having a diagnostic label will elicit more stigma than using an alternative explanation for symptoms.

  o This relationship will not differ based on acculturation

- There will be differences in stigma based on acculturation such that those who are higher in their identification with African ethnocultural beliefs and behaviors will have more stigmatizing attitudes toward people with mental illness overall, and those who are higher in their identification with Eurocentric culture will stigmatize people with mental illness less.

Chapter 2: Method

Participants

The online survey was completed by 152 people. Due to endorsement of a race other than Black/African American, 13 participants were excluded. Another 33 participants were excluded due to excessive missing data, yielding an overall sample of 106. Of the 106 remaining participants, 59 had been randomly assigned to the labeling condition and 47 had been assigned to the alternative explanation condition.

Participants were African American adults who were recruited at Lexington's Roots and Heritage Festival, through the Uniformed Services University Center for Health Disparities' Community Research Outreach Network Registry, and through emails to African American organizations. Most of the participants were women (71.9%). Participants ranged in age from 18 to 88 years ($M = 42.82$, $SD = 16.882$). The majority of participants (61.9%) had a Bachelor's degree or higher, and 54.1% reported an income of $50,000 or more. Sample characteristics are depicted in Table 2.1.

Measures

Acculturation. To assess acculturation, the 45-item Measurement of Acculturation Strategies for People of African Descent (MASPAD; Appendix A; Obasi & Leong, 2010) was used. This is a bidimensional acculturation instrument designed specifically for people of African descent living in the United States. To date, it is the only instrument that measures African American acculturation bidimensionally. The measure contains two orthogonal subscales, Dimension 1 (D1; 22 items) and Dimension 2 (D2; 23 items). The items on each subscale assess beliefs and behaviors to determine the extent to which a person maintains values and engages in activities consistent with

African culture (D1) and Eurocentric US culture (D2). Participants rated their endorsement of African American acculturation strategies on a six-point continuum ranging from "strongly disagree" (1) to "strongly agree" (6). High scores on D1 reflect an interest in maintaining the heritage of one's own ethnocultural group through behaviors and beliefs (e.g., "I was socialized to treat my elders with respect," and "I actively support Black-owned businesses"). High scores on D2 reflect an interest in and/or preference for engaging in the behaviors and adopting the beliefs of the dominant Eurocentric US culture (e.g., "I do not feel connected to my African heritage," and "I am comfortable putting on the mask in order to fit in"). In the standardization sample, internal consistencies for these scales were α = .80 to .87 for D1 and α = .75 to .81 for D2. For the labeling condition in this sample, the internal consistency was α = 0.864 for D1 and α = 0.762 for D2. For the alternative explanation condition, the internal consistency was α = 0.87 for D1 and α = 0.781 for D2.

Scores for the D1 and D2 subscales were created by averaging each participant's responses to the items on each subscale. Since there are 22 items on D1, the sum of the items on that subscale for each participant were divided by 22 to get an average D1 subscale score. Similarly, there are 23 items on the D2 subscale, so the sum of the items on that subscale for each participant was divided by 23 to get an average D2 subscale score.

Social desirability. Given that self-report stigma measures are subject to social desirability effects (Link & Cullen, 1983; Stier & Hinshaw, 2007), a measure of social desirability was included to measure and control for those effects. Version 6 of the Balanced Inventory of Desirable Responding (BIDR; Appendix B; Paulhaus, 1991) is a

40-item measure of socially desirable response bias. The inventory consists of two subscales: Self-Deception Enhancement (SDE) and Impression Management (IM). The SDE subscale measures unintentionally positively biased responding and consists of items such as "I never regret my decisions" and "I don't care to know what other people really think of me." The IM subscale measures the extent to which a person intentionally attempts to portray himself or herself in a favorable way by responding in ways that distort his or her self-image. The IM subscale includes items such as "I never swear" and "I always obey laws, even if I'm unlikely to get caught." Participants rated their agreement with each item on a 7-point Likert scale ranging from 1 (Not True) to 7 (Very True). A review of published studies utilizing the BIDR indicated that the average reliability was $\alpha = 0.69$ for the SDE subscale, $\alpha = 0.76$ for the IM subscale, and $\alpha = 0.80$ for the overall measure (Li & Bagger, 2007). In the present study, the SDE subscale had a reliability of $\alpha = 0.681$, the IM subscale reliability was $\alpha = 0.805$, and the reliability for the overall measure was $\alpha = 0.788$. Although the BIDR can be scored dichotomously, some researchers have suggested using the overall BIDR score because it has been found to be more reliable than the separate IM and SDE subscales (Li & Bagger, 2007). After reverse scoring the appropriate 20 items, an overall social desirability score was obtained by summing each participant's ratings for each item.

Vignettes. I developed vignettes (Appendix C) for the current study to describe four different symptom sets. There are two vignettes for each set of symptoms, making a total of eight different vignettes. For each symptom set, one vignette explains the symptoms as a mental illness (e.g., major depressive disorder), while the other vignette is identical except that it describes the symptoms as a result of some other problem (e.g.,

work-related stress). The other symptom sets are described as social phobia/inability to relax, alcohol dependence/coping with marital problems, and paranoid schizophrenia/insomnia. Each participant will be given four vignettes. The four vignettes each participant receives will have a mental illness explanation or all four will have an alternative explanation.

To arrive at the study's vignettes (Appendix C), I used a combination of Star's (1955) vignettes (which have been used in many other similar studies), the vignettes Socall and Holtgraves (1992) developed for their study (described previously), and diagnostic criteria from the DSM-IV-TR for major depressive disorder, social phobia, alcohol dependence, and paranoid schizophrenia (American Psychiatric Association, 2000). Star's (1955) vignettes have been criticized for confounding label and behavior (Loman & Larkin, 1976). Star's (1955) vignettes also include a lot of demographic information about the person in the vignette (e.g., education level and race). Since those variables could impact participants' stigmatization, I did not want to include the extra demographic information. Socall and Holtgraves' (1992) vignettes do not confound label and behavior, but they include a lot of extraneous information, which was used so that they could easily explain symptoms as a result of a physical illness or a mental illness (e.g., "A friend who was with James took him to the doctor's office. There he was treated for *acute anxiety/food allergy* and referred to a *mental/local* health center for outpatient *psychological/nutritional* treatment"). I wanted to include enough information so that either the mental illness explanation or the alternative explanation would be plausible. I also was careful to describe the behaviors associated with symptoms and to exclude any other information outside of those behaviors and the designated psychiatric labels that

27

could also lead to stigmatization. Also, the person described in each vignette is an African American male since the roles of race and gender in the extent to which a person is stigmatized are not part of the study's research questions.

Mental illness stigma. To examine mental illness stigma, participants were asked to complete the Social Distance Scale (Appendix D; Link, Cullen, Frank, & Wozniak, 1987) and Attribution Questionnaire-20 (Appendix E; Brown, 2008) after reading each vignette. Each measure is described below.

Social Distance Scale. Link, Cullen, Frank, and Wozniak's (1987) Social Distance Scale (Appendix D) is a measure designed to be used with a vignette. Items ask respondents to indicate the extent to which they would be willing to engage in various social interactions with the person described in the vignette. The Social Distance Scale consists of 7 items which are scored on a 4-point continuum (0 = definitely willing, 3 = definitely unwilling). The measure includes questions such as, "How would you feel about renting a room in your home to someone like [man in vignette]?" and "How would you feel about recommending someone like [man in vignette] for a job working for a friend of yours?" A total social distance score is determined by averaging responses to the seven items. Higher scores indicate greater desire for social distance. Penn and colleagues (1994) found the Social Distance Scale to be significantly moderately correlated in the expected direction with other stigma measures (Dangerousness Scale, Affect Scale). Link and colleagues (1987) found that the internal consistency for the Social Distance Scale was α = 0.92. For the labeling condition, the internal consistency was α = 0.983 for depression, α = 0.977 for social phobia, α = 0.99 for alcohol dependence, and α = 0.995 for schizophrenia. For the alternative explanation condition,

the internal consistency was $\alpha = 0.983$ for depression, $\alpha = 0.983$ for social phobia, $\alpha = 0.993$ for alcohol dependence, and $\alpha = 0.995$ for schizophrenia.

Attribution Questionnaire-20. The Attribution Questionnaire-20 (AQ-20; Appendix E) was developed by Brown (2008) as a modified version of Corrigan, Markowitz, Watson, Rowan, and Kubiak's (2003) original Attribution Questionnaire. Brown determined that only 20 of the original 27 items were reliable and valid based on a factor analysis. The AQ-20 is designed to be used with a vignette that describes a person with a mental illness and prompts respondents to use a 9-point continuum (1 = not at all, 9 = very much) to indicate their agreement with different attitudes and beliefs about the person described in the vignette. The AQ-20 consists of four factors: Fear/Dangerousness, Help/Interact, Forcing Treatment, and Negative Emotions.

The Fear/Dangerousness factor consists of seven items (e.g., "I would feel threatened by [man in vignette]") that assess feelings of fear about people with mental illnesses. Internal consistency for the Fear/Dangerousness factor was $\alpha = 0.93$ in the standardization sample. In this study, Fear/Dangerousness internal consistencies for the labeling condition were $\alpha = 0.95$ for depression, $\alpha = 0.973$ for social phobia, $\alpha = 0.979$ for alcohol dependence, and $\alpha = 0.984$ for schizophrenia. For the alternative explanation condition, internal consistencies were $\alpha = 0.951$ for depression, $\alpha = 0.963$ for social phobia, $\alpha = 0.947$ for alcohol dependence, and $\alpha = 0.952$ for schizophrenia.

The Help/Interact factor consists of six items (e.g., "I would be willing to talk to [man in vignette] about his problems") that assess willingness to help and interact socially with people with mental illnesses. Items on this factor were reversed scored. The internal consistencies for the Help/Interact factor for the labeling condition were $\alpha =$

0.913 for depression, α = 0.916 for social phobia, α = 0.941 for alcohol dependence, and α = 0.96 for schizophrenia. For the alternative explanation condition, internal consistencies were α = 0.858 for depression, α = 0.932 for social phobia, α = 0.868 for alcohol dependence, and α = 0.828 for schizophrenia.

Forcing Treatment is a factor measuring the desire to force those with mental illnesses into treatment. The Forcing Treatment factor has four items (e.g., "How much do you agree that [man in vignette] should be forced into treatment with his doctor even if he does not want to go?") and had an internal consistency of α = 0.79 in the standardization sample. Internal consistencies for the labeling condition in this study were α = 0.877 for depression, α = 0.894 for social phobia, α = 0.908 for alcohol dependence, and α = 0.954 for schizophrenia. For the alternative explanation condition, internal consistencies were α = 0.84 for depression, α = 0.882 for social phobia, α = 0.87 for alcohol dependence, and α = 0.866 for schizophrenia.

The Negative Emotions factor consists of three items (e.g., "I would feel aggravated by [man in vignette]") and assesses feeling negative emotions toward those with mental illnesses. The internal consistency for that factor was α = 0.81 in Brown's (2008) study. In this study, the internal consistencies for the labeling condition were α = 0.908 for depression, α = 0.952 for social phobia, α = 0.973 for alcohol dependence, and α = 0.937 for schizophrenia. For the alternative explanation condition, internal consistencies were α = 0.817 for depression, α = 0.908 for social phobia, α = 0.885 for alcohol dependence, and α = 0.88 for schizophrenia.

In a factor analysis, Brown (2008) found that each of the four factors correlated significantly and in the expected direction with three other stigma measures, the Social

Distance Scale, Dangerousness Scale, and Affect Scale. In this study, a total AQ score was determined by reverse-scoring the Help/Interact items and averaging ratings on each of the 20 items for each participant. Brown (2008) found that the internal consistency for the total AQ measure was $\alpha = 0.81$. In this sample, the internal consistency for the total measure was $\alpha = 0.993$ for both the labeling condition and the alternative explanation condition.

   Manipulation check. Prior to beginning the study, independent ratings from three advanced therapists in the University of Kentucky's clinical psychology program who were unfamiliar with the study were obtained to determine whether each vignette accurately depicted the disorder's symptom set. To do this, raters were provided with the vignettes (eliminating the italicized sentences) and asked whether, based on the information given, the man described in the vignette has a mental illness, and if so which mental illness he has. All three raters correctly identified the mental illness depicted in each of the vignettes. Independent ratings of the believability of the alternative explanations of the symptom sets were obtained from three African American undergraduate students. To do this, I provided the three raters with the vignettes using the alternative explanations. Raters were asked to read each vignette and indicate on a 4-point scale the believability of the explanations of why the man in each vignette was experiencing the symptom set. All three raters rated the alternative explanations for the vignettes describing a person with depression, social phobia, and alcohol dependence symptoms as Very Believable. For the vignette describing a person with schizophrenia symptoms, one rater rated the alternative explanation as Pretty Hard to Believe, and the other two rated it as Pretty Believable. Since the vignettes they read did not contain a

diagnostic label, raters were asked if any other reasons for the symptoms the vignette subject was experiencing came to mind. One rater indicated that depression could be another explanation for the vignette describing a man with depressive symptoms. One rater stated "mental illness" and another rater stated "schizophrenia or bipolar" as possible explanations for the vignette that described the man with schizophrenia symptoms. Last, raters were asked if anything seemed out of place in the vignettes, and if so, to describe what was out of place and why. None of the raters indicated anything that seemed out of place.

Each study participant was also asked to complete manipulation check items (Appendix F). Participants in the labeling condition were asked to rate on a 4-point continuum (1 = not believable at all, 4 = very believable) the believability that the man in each vignette was experiencing the symptom set because of the mental illness he was described as having in the vignette. They were also asked to describe what they thought was going on with the man in each vignette, to rate on a 4-point continuum (1 = not likely at all, 4 = very likely) the extent to which they thought his symptom set was due to something else, and to indicate (yes, no, or not sure) whether they consider the mental illness label ascribed to the man in each of the vignettes to be a mental illness. Participants who were in the alternative explanation condition were asked to rate on a 4-point continuum (1 = not believable at all, 4 = very believable) the believability that the man in each vignette was experiencing the symptom set because of the explanation given in the vignette (i.e., stress at work, inability to relax, coping with marital problems, insomnia). They were also asked to describe what they thought was going on with the man in each vignette and to rate on a 4-point continuum (1 = not likely at all, 4 = very

likely) how likely it is that each man's symptoms were due to a mental illness, and if likely, what mental illness they thought he might have.

Procedures

Study participants were recruited by tabling at Lexington's Roots and Heritage Festival, through the Uniformed Services University Center for Health Disparities' Community Research Outreach Network Registry, and by sending emails to chapters of predominantly African American organizations to request their members' participation. The study was done online using Qualtrics. The online format allowed participants to be randomly assigned to either the alternative explanation condition or labeling condition. Upon completion of the survey, participants were redirected to a separate survey thanking them for their participation in the study and asking them to enter in their name, address, phone number, and email address to be entered into a drawing for a gift card. Since the main survey and the participants' contact information were two separate surveys, participants' answers to the main survey's questions were saved in a separate file from their contact information, and participants' answers were not tied to their names or any other identifying information.

Table 2.1: Sample Characteristics

	Mean	*SD*
Gender		
Female (%)	26.60	-
Male (%)	71.90	-
Age	42.82	16.88
Education	6.60	1.48
Income	6.87	3.24
D1	4.22	0.62
D2	3.02	0.56
Depression AQ	2.77	1.11
Social Phobia AQ	2.11	1.12
Alcohol Dependence AQ	4.19	1.45
Schizophrenia AQ	4.91	1.62
Depression SDS	2.61	0.54
Social Phobia SDS	2.11	0.63
Alcohol Dependence SDS	3.29	0.53
Schizophrenia SDS	3.49	0.53

Chapter 3: Results

This study involved testing three main hypotheses: (1) participants would indicate the most desire for social distance and negative attributions towards the vignette subject with schizophrenia symptoms and the least desire for social distance and negative attributions towards the vignette subject with social phobia symptoms, (2) having a diagnostic label would elicit more desire for social distance and more negative attributions than using an alternative explanation for symptoms, and (3) there would be differences in desire for social distance and negative attributions based on acculturation such that those who are higher in their identification with African ethnocultural beliefs and behaviors would have more stigmatizing attitudes toward people with mental illness overall and those who are higher in their identification with Eurocentric beliefs and behaviors would stigmatize people with mental illness less.

Since all the participants completed the same stigma measures [Social Distance Scale (SDS) and Attribution Questionnaire (AQ)] for each of the symptom sets (depression, social phobia, alcoholism, and schizophrenia), eight stigma variables (depression SDS, depression AQ, social phobia SDS, social phobia AQ, alcohol dependence SDS, alcohol dependence AQ, schizophrenia SDS, and schizophrenia AQ) were calculated for each participant. The Social Distance Scale and Attribution Questionnaire variables are interval scale variables. The acculturation variables, desire to hold beliefs and engage in behaviors consistent with African culture (D1) and desire to hold beliefs and engage in behaviors consistent with Eurocentric culture (D2), are also interval scale variables.

Manipulation Check

For each vignette, participants were asked to rate the believability of the alternative explanations and diagnostic labels for the symptoms the vignette subject (Mike, Chris, James, or Will) was experiencing. For the depression symptom set, 89.8% of participants in the alternative explanation condition found the explanation that Mike was experiencing symptoms "because of the enormous amount of stress he is under at work" to be pretty believable or very believable, and 65.3% thought that Mike's symptoms were not likely at all or probably not due to a mental illness. Of the participants in the labeling condition, 87.1% found the major depressive disorder diagnostic label to be pretty believable or very believable. Still, 67.9% of participants in the labeling condition thought it was probable or very likely that Mike's symptoms were due to something else. Although the majority of participants in the labeling condition (66.7%) considered major depressive disorder to be a mental illness, 25.9% indicated that they were not sure if it is a mental illness or not, and 7.4% indicated that they do not consider major depressive disorder to be a mental illness.

For the social phobia symptom set, 91.5% of those in the alternative explanation condition found the explanation that Chris's symptoms were "a result of his inability to loosen up and relax his nerves" to be pretty believable or very believable. Of those in the alternative explanation condition, 57.5% thought that Chris's symptoms were not likely at all or probably not due to a mental illness. Of those in the labeling condition, 92.6% found the social phobia diagnostic label to be pretty believable or very believable. Most of the participants in the labeling condition (52.9%) thought that it was probable or very likely that Chris's symptoms were due to something else. About 46.3% of those in the

labeling condition considered social phobia to be a mental illness, while 29.6% did not consider social phobia to be a mental illness, and 24.1% were not sure.

For the alcohol dependence symptom set, 95.8% of those in the alternative explanation condition found the explanation that James's drinking was "an effort to cope with the problems he is having with his wife" to be pretty believable or very believable. Of those in the alternative explanation condition, 54.2% thought that James's symptoms were not likely at all or probably not due to a mental illness. Of those in the labeling condition, 94.4% found the alcohol dependence diagnostic label to be pretty believable or very believable. Most of the participants in the labeling condition (53.7%) thought that James's symptoms were probably not or not likely at all to be due to something else. The majority (53.7%) considered alcohol dependence to be a mental illness, while 29.6% did not consider alcohol dependence to be a mental illness, and 16.7% were unsure.

For the schizophrenia symptom set, 62.6% of those in the alternative explanation condition found the explanation that Will's behavior was "due to serious sleep deprivation" to be pretty believable or very believable. Of those in the alternative explanation condition, only 34% thought that Will's symptoms were not likely at all or probably not due to a mental illness. Of those in the labeling condition, 94.6% found the schizophrenia label to be pretty believable or very believable, and 70.3% thought that Will's symptoms were probably not or not likely at all to be due to something else. An overwhelming majority (92.7%) of those in the labeling condition considered schizophrenia to be a mental illness, while 3.6% did not consider schizophrenia to be a mental illness, and 3.6% were unsure.

Preliminary Analyses

The bivariate correlations among all the study variables were examined (Table 3.1). The D2 acculturation variable (desire to adopt Eurocentric beliefs and behaviors), was positively correlated with AQ scores for the depression, social phobia, and alcohol dependence symptom sets and SDS scores for the social phobia and alcohol dependence symptom sets. The condition variable (labeling vs. alternative explanation) was negatively correlated with social distance scores for the depression symptom set, indicating that the labeling condition is associated with greater social distance from vignette subjects displaying depressive symptoms. AQ scores for the depression, social phobia, alcohol dependence, and schizophrenia symptom sets were all positively correlated with each other. The AQ score for each symptom set was also positively correlated with its respective SDS score. In addition, the AQ score for the depression symptom set was positively correlated with the SDS scores for the social phobia and alcohol dependence symptom sets, and the AQ score for the schizophrenia symptom set was positively correlated with the SDS score for the alcohol dependence symptom set. SDS scores for the depression symptom set were positively correlated with the SDS scores for the social phobia, alcohol dependence, and schizophrenia symptom sets. The SDS score for alcohol dependence was also positively correlated with that of the schizophrenia symptom set. The social desirability measure was not correlated with any study variables; therefore, it was not used as a covariate in any analyses.

Hypothesis 1

Four one-way repeated measures analyses of variance (ANOVAs) were used to test the hypothesis that participants would indicate the most desire for social distance and

negative attributions towards the vignette subject with schizophrenia symptoms and the least desire for social distance and negative attributions towards the vignette subject with social phobia symptoms. The first ANOVA compared the mean AQ scores for each symptom set (depression, social phobia, alcohol dependence, and schizophrenia) for participants in the labeling condition. The data used in this ANOVA violated the assumption of sphericity, so a Greenhouse-Geisser correction was used. With the correction, results of the ANOVA indicated a significant main effect, $F(1.92, 63.35) = 85.972$, $p<0.01$. Post-hoc analyses were conducted with a Bonferroni correction to determine which groups differed from each other. Results indicated that AQ scores differed significantly for all of the symptom sets, with participants endorsing the most negative attributions towards the schizophrenia symptom set ($M = 5.444$), followed by alcohol dependence ($M = 4.401$), depression ($M = 2.963$), and social phobia ($M = 1.919$). The second ANOVA also examined differences in AQ scores based on symptom set, but was conducted with participants in the alternative explanation condition. Results of this ANOVA indicated significant differences in negative attributions based on symptom set, $F(3, 72) = 39.506$, $p < 0.01$. The Bonferroni-corrected post-hoc pairwise analyses indicated significant differences in AQ scores between all of the pairs except for the schizophrenia and alcohol dependence symptom sets. The AQ scores for the schizophrenia ($M = 4.738$) and alcohol dependence ($M = 4.346$) symptom sets did not differ significantly from each other ($p = 1$), and were higher than the AQ score for depression ($M = 2.770$). The AQ scores for the social phobia symptom set was significantly lower than the other AQ scores ($M = 2.122$). Figure 3.1 depicts the differences in AQ scores among the symptom sets for each condition.

The third ANOVA was conducted with participants in the labeling condition and compared mean SDS scores among the symptom sets. The data used in this ANOVA violated the sphericity assumption, so a Greenhouse-Geisser correction was used. With the correction, results of the ANOVA indicated a significant main effect, $F(2.309, 135) = 79.127$, $p < 0.01$. Bonferroni-corrected post-hoc analyses showed that the amount of social distance participants desired from the vignette subject with the alcohol dependence label did not differ significantly from the vignette subject with the schizophrenia label ($p = 0.143$). There were significant differences between all of the other pairs. The social distance desired from the vignette subject with the schizophrenia label and the alcohol label were highest ($M = 3.512$ and $M = 3.332$, respectively). Significantly less social distance was desired from the vignette subject with the depression label ($M = 2.730$), and even less social distance was desired from the vignette subject with the social phobia label ($M = 2.012$). The fourth ANOVA examined differences in social distance based on symptom set for participants in the alternative explanation condition. The data used in this ANOVA also violated the sphericity assumption, and a Greenhouse-Geisser correction was used. With the correction, there was a significant main effect, $F(2.468, 111.054) = 82.086$, $p < 0.01$. Post-hoc Bonferroni-corrected analyses indicated significant differences in the SDS scores for all the symptom sets. Participants desired the most social distance from the vignette subject with the schizophrenia symptom set ($M = 3.419$), followed by alcohol dependence ($M = 3.223$), depression ($M = 2.482$), and social phobia ($M = 2.136$). Figure 3.2 shows the differences in social distance scores among the symptoms sets for each condition.

The results of the four ANOVAs conducted support Hypothesis 1. Participants in both the labeling and alternative explanation conditions desired the least social distance from and had fewer negative attributions about the vignette subjects with social phobia symptoms. Participants in both conditions desired the most social distance from and had more negative attributions about the vignette subject with schizophrenia symptoms, although in some cases participants desired just as much social distance from and had just as many negative attributions about the vignette subject with symptoms of alcohol dependence.

Hypothesis 2 and Hypothesis 3

Eight separate hierarchical regressions, each with a different stigma variable (depression SDS, depression AQ, social phobia SDS, social phobia AQ, alcohol dependence SDS, alcohol dependence AQ, schizophrenia SDS, and schizophrenia AQ) as the dependent variable, were used to test Hypothesis 2 and Hypothesis 3. In the first step of each regression, condition (alternative explanation vs. labeling), acculturation Dimension 1, and acculturation Dimension 2 were entered. The second step consisted of the two-way interaction terms (condition x Dimension 1, condition x Dimension 2, and Dimension 1 x Dimension 2), and the three-way (condition x Dimension 1 x Dimension 2) interaction term was entered in the third step. Each step of the regressions with depression AQ, social phobia AQ, and social phobia SDS as the dependent variables was significant. Step 1 of the regression with depression SDS as the dependent variable was also significant. Table 3.2 shows the results of the hierarchical regressions.

To test the hypothesis that having a diagnostic label would elicit more desire for social distance and negative attributions than using an alternative explanation for

symptoms regardless of acculturation (Hypothesis 2), the standardized beta weights (β) for condition (labeling vs. alternative explanation) and the two-way (condition x D1 and condition x D2) interactions were examined in each regression that had a significant first step F to determine if any beta weights were significant. None of the two-way condition x D1 or condition x D2 beta weights was significant. One significant beta weight for condition was present, and that was in the regression with social distance for the depression symptom set as the dependent variable (β = -0.292, p = 0.009). This indicates that having a vignette subject with a diagnostic label of major depressive disorder predicted greater desire for social distance than having a vignette subject whose symptoms were attributed to stress at work. Thus, the hypothesis was partially supported because having a diagnostic label elicited more desire for social distance than the alternative explanation for depressive symptoms regardless of acculturation. However, having a diagnostic label did not elicit any more negative attributions than the alternative explanation for depressive symptoms. Additionally, there were no differences in social distance or negative attributions between the labeling and alternative explanation groups for the social phobia, alcohol dependence, or schizophrenia symptom sets.

To test the hypothesis that there would be differences in desire for social distance and negative attributions based on acculturation, the standardized beta weights for D1 and D2 were examined in each regression that had a significant first step F. D1 did not predict social distance or negative attributions. Higher D2 predicted more negative attributions towards the vignette subjects with the depression symptom set (β = 0.407, p = 0.001), negative attributions towards the vignette subjects with the social phobia symptom set (β = 0.46, p = 0.0001), and increased social distance from the vignette

subjects with the social phobia symptom set ($\beta = 0.346$, $p = 0.003$). Hypothesis 3 was not supported. Identification with African ethnocultural beliefs and behaviors (D1) did not predict social distance or negative attributions at all, and identification with Eurocentric culture (D2) predicted negative attributions about those with symptoms of depression and social phobia and social distance from those with symptoms of social phobia in the opposite direction of what was expected. Instead of higher identification with Eurocentric culture predicting less stigma as hypothesized, it actually predicted greater stigma for depression and social phobia.

Exploratory Analyses

Although they were not included in the hypotheses, the second and third steps of each regression were examined to determine if any of the interactions predicted negative attributions or social distance. Although the second and third step *F*-statistics were significant for three of the regressions, there was only one significant interaction beta weight. The D1xD2 interaction was a significant predictor of negative attributions towards the vignette subjects with the depression symptom set ($\beta = 0.25$, $p = 0.034$). Regression was used to probe the interaction at 1 standard deviation above and below the mean for D1 and D2. Results of the regressions showed that when D1 was high, negative attributions towards the vignette subject with depression symptoms increased as D2 increased ($\beta = 0.566$, $p = <0.001$). In other words, integrationists, those who were high on D1 and high on D2, had significantly more negative attributions towards the vignette subject with depression symptoms than traditionalists (those high on D1 and low on D2). Figure 3.3 depicts the interaction between D1 and D2 in predicting negative attributions about people with depression.

Table 3.1: Bivariate Correlations

	Condition	Dep AQ	Social Phobia AQ	Alcohol Dependence AQ	Schiz AQ	Dep SDS	Social Phobia SDS	Alcohol Dependence SDS	Schiz SDS	D1	D2
BIDR	-0.026	0.126	-0.019	0.012	0.090	-0.081	0.039	0.035	0.084	0.034	-0.089
Condition		-0.032	-0.017	-0.019	-0.173	**-0.221**	0.077	-0.045	-0.060	0.032	-0.064
Dep AQ			**0.608***	**0.511***	**0.368***	**0.539***	**0.323***	**0.265**	-0.013	0.005	**0.346***
Social Phobia AQ				**0.348***	**0.282**	0.165	**0.672***	0.170	-0.103	0.025	**0.457***
Alcohol Dependence AQ					**0.610***	**0.282**	0.113	**0.603***	0.129	-0.091	**0.236**
Schiz AQ						**0.317***	0.034	**0.399***	**0.469***	-0.091	0.088
Dep SDS							**0.214**	**0.353***	**0.252**	0.074	0.206
Social Phobia SDS								0.165	-0.058	-0.015	**0.347***
Alcohol Dependence SDS									**0.599***	-0.082	**0.229**
Schiz SDS										0.067	-0.111
D1											-0.065

Note. $p < 0.05$ is in boldface. *$p < 0.01$. BIDR = Balanced Inventory of Desired Responding. AQ = Attribution Questionnaire. SDS = Social Distance Scale.   Dep = Depression. Schiz = Schizophrenia. D1 = Dimension 1, identification with traditional African ethnocultural beliefs and behaviors. D2 = Dimension 2, identification with Eurocentric ethnocultural beliefs and behaviors.

Table 3.2: Hierarchical Regressions

	R^2	F	df	B	SE B	β	ΔR^2	ΔF
DV: Depression AQ								
Step 1	0.168	4.108*	3, 64	-	-	-	0.168	4.108*
Condition	-	-	-	-0.000	0.254	0.000	-	-
D1	-	-	-	-0.073	0.202	-0.042	-	-
D2	-	-	-	0.817**	0.235	0.407	-	-
Step 2	0.309	4.332**	6, 64	-	-	-	0.141	3.959*
Condition x D1	-	-	-	0.635	0.390	0.239	-	-
Condition x D2	-	-	-	0.659	0.444	0.241	-	-
D1 x D2	-	-	-	0.607*	0.280	0.250	-	-
Step 3	0.310	3.663**	7, 64	-	-	-	0.001	0.065
Condition x D1 x D2	-	-	-	0.150	0.589	0.049	-	-
DV: Social Phobia AQ								
Step 1	0.457	5.544**	3, 66	-	-	-	0.209	5.544**
Condition	-	-	-	0.152	0.274	0.063	-	-
D1	-	-	-	-0.059	0.234	-0.029	-	-
D2	-	-	-	0.933**	0.229	0.460	-	-
Step 2	0.555	4.451**	6, 66	-	-	-	0.099	2.866*
Condition x D1	-	-	-	0.417	0.455	0.136	-	-
Condition x D2	-	-	-	0.689	0.446	0.227	-	-
D1 x D2	-	-	-	0.615	0.315	0.220	-	-
Step 3	0.555	3.756**	7, 66	-	-	-	0.000	0.021
Condition x D1 x D2	-	-	-	-0.097	0.668	-0.028	-	-

Note. AQ = Attribution Questionnaire-20. D1 = Dimension 1, identification with traditional African ethnocultural beliefs and behaviors. D2 = Dimension 2, identification with Eurocentric ethnocultural beliefs and behaviors.
*p < 0.05. **p < 0.01.

Table 3.2: Hierarchical Regressions (continued)

	R^2	F	df	B	SE B	β	ΔR^2	ΔF
DV: Alcohol AQ								
Step 1	0.082	1.877	3, 66	-	-	-	0.082	1.877
Condition	-	-	-	0.131	0.367	0.044	-	-
D1	-	-	-	-0.257	0.301	-0.104	-	-
D2	-	-	-	0.701*	0.320	0.264	-	-
Step 2	0.121	1.379	6, 66	-	-	-	0.039	0.890
Condition x D1	-	-	-	0.161	0.644	0.043	-	-
Condition x D2	-	-	-	1.032	0.659	0.267	-	-
D1 x D2	-	-	-	0.043	0.460	0.013	-	-
Step 3	0.123	1.187	7, 66	-	-	-	0.002	0.155
Condition x D1 x D2	-	-	-	-0.387	0.983	-0.089	-	-
DV: Schizophrenia AQ								
Step 1	0.064	1.444	3, 66	-	-	-	0.064	1.444
Condition	-	-	-	-0.475	0.414	-0.141	-	-
D1	-	-	-	-0.479	0.335	-0.175	-	-
D2	-	-	-	0.258	0.352	0.090	-	-
Step 2	0.133	1.539	6, 66	-	-	-	0.069	1.594
Condition x D1	-	-	-	0.164	0.679	0.041	-	-
Condition x D2	-	-	-	0.743	0.701	0.180	-	-
D1 x D2	-	-	-	0.800	0.487	0.208	-	-
Step 3	0.136	1.325	7, 66	-	-	-	0.002	0.167
Condition x D1 x D2	-	-	-	-0.428	1.045	-0.091	-	-

Note. AQ = Attribution Questionnaire-20. D1 = Dimension 1, identification with traditional African ethnocultural beliefs and behaviors. D2 = Dimension 2, identification with Eurocentric ethnocultural beliefs and behaviors.
*$p < 0.05$. **$p < 0.01$.

Table 3.2: Hierarchical Regressions (continued)

	R^2	F	df	B	SE B	β	ΔR^2	ΔF
DV: Depression SDS								
Step 1	0.137	3.864*	3, 76	-	-	-	0.137	3.864*
Condition	-	-	-	-0.316**	0.118	-0.292	-	-
D1	-	-	-	0.007	0.097	0.008	-	-
D2	-	-	-	0.199	0.101	0.216	-	-
Step 2	0.143	1.948	6, 76	-	-	-	0.006	3.959
Condition x D1	-	-	-	0.123	0.206	0.090	-	-
Condition x D2	-	-	-	0.012	0.209	0.008	-	-
D1 x D2	-	-	-	0.032	0.148	0.026	-	-
Step 3	0.169	2.009	7, 76	-	-	-	0.026	0.065
Condition x D1 x D2	-	-	-	0.442	0.299	0.271	-	-
DV: Social Phobia SDS								
Step 1	0.136	3.731*	3, 74	-	-	-	0.136	3.731*
Condition	-	-	-	0.181	0.137	0.146	-	-
D1	-	-	-	0.006	0.115	0.006	-	-
D2	-	-	-	0.363**	0.116	0.346	-	-
Step 2	0.169	2.305*	6, 74	-	-	-	0.033	0.895
Condition x D1	-	-	-	0.277	0.241	0.184	-	-
Condition x D2	-	-	-	0.248	0.236	0.157	-	-
D1 x D2	-	-	-	0.054	0.168	0.039	-	-
Step 3	0.190	2.252*	7, 74	-	-	-	0.021	1.788
Condition x D1 x D2	-	-	-	0.463	0.347	0.254	-	-

Note. AQ = Attribution Questionnaire-20. D1 = Dimension 1, identification with traditional African ethnocultural beliefs and behaviors. D2 = Dimension 2, identification with Eurocentric ethnocultural beliefs and behaviors.
*$p < 0.05$. **$p < 0.01$.

Table 3.2: Hierarchical Regressions (continued)

	R^2	F	df	B	SE B	β	ΔR^2	ΔF
DV: Alcohol SDS								
Step 1	0.085	2.187	3, 74	-	-	-	0.085	2.187
Condition	-	-	-	-0.101	0.082	-0.097	-	-
D1	-	-	-	-0.090	0.118	-0.105	-	-
D2	-	-	-	0.217*	0.098	0.239	-	-
Step 2	0.093	1.164	6, 74	-	-	-	0.009	0.214
Condition x D1	-	-	-	-0.128	0.207	-0.102	-	-
Condition x D2	-	-	-	0.083	0.212	0.063	-	-
D1 x D2	-	-	-	0.059	0.147	0.050	-	-
Step 3	0.095	1.004	7, 74	-	-	-	0.002	0.128
Condition x D1 x D2	-	-	-	-0.110	0.307	-0.072	-	-
DV: Schizophrenia SDS								
Step 1	0.038	0.900	3, 71	-	-	-	0.038	0.900
Condition	-	-	-	-0.185	0.120	-0.184	-	-
D1	-	-	-	-0.002	0.100	-0.002	-	-
D2	-	-	-	-0.066	0.103	-0.076	-	-
Step 2	0.049	0.556	6, 71	-	-	-	0.011	0.242
Condition x D1	-	-	-	-0.140	0.217	-0.109	-	-
Condition x D2	-	-	-	0.060	0.212	0.047	-	-
D1 x D2	-	-	-	0.095	0.150	0.084	-	-
Step 3	0.049	0.476	7, 71	-	-	-	0.001	0.042
Condition x D1 x D2	-	-	-	-0.063	0.310	-0.043	-	-

Note. AQ = Attribution Questionnaire-20. D1 = Dimension 1, identification with traditional African ethnocultural beliefs and behaviors. D2 = Dimension 2, identification with Eurocentric ethnocultural beliefs and behaviors.
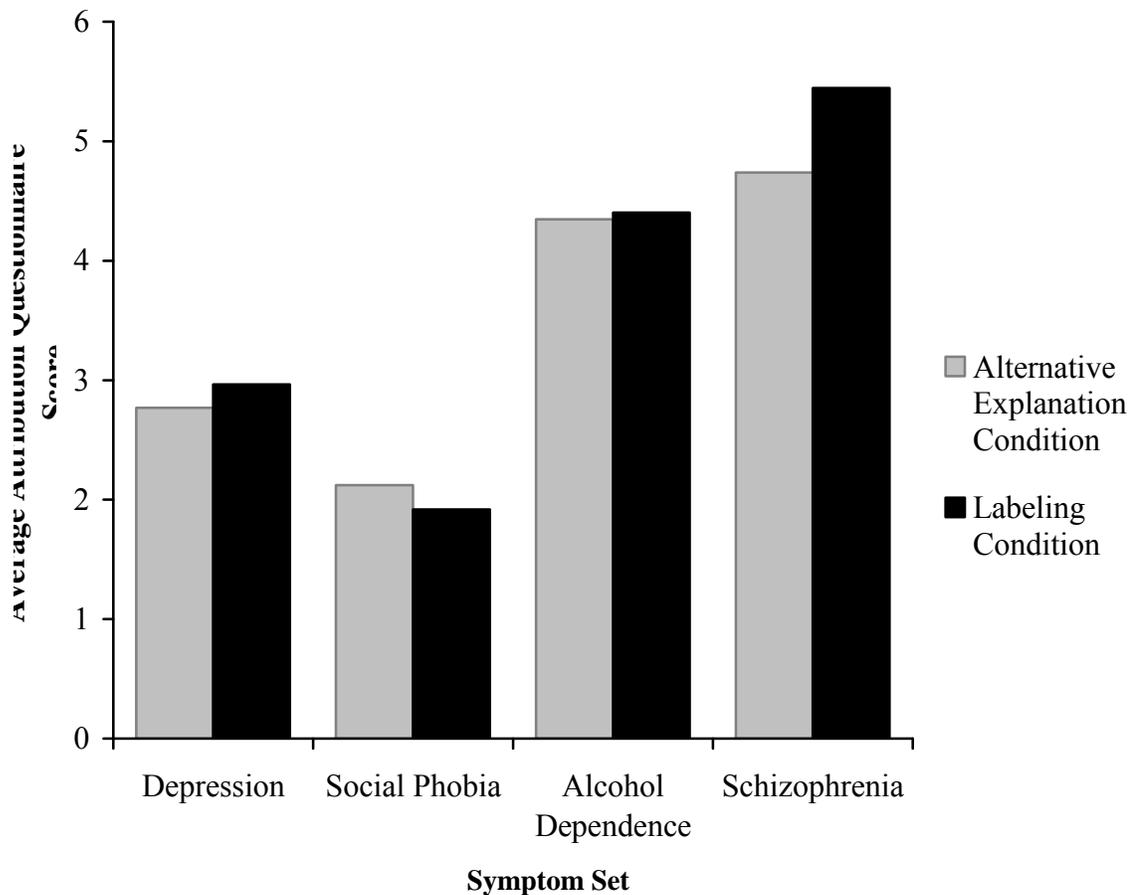*$p < 0.05$. **$p < 0.01$.

Figure 3.1: Average Attribution Questionnaire (AQ) Score by Symptom Set for Each

Condition

In the alternative explanation condition, AQ scores for the alcohol dependence symptom

set did not differ significantly from AQ scores for the schizophrenia symptom set. All

other pairs were significantly different from each other. The AQ scores for each symptom

set were significantly different from each other for participants in the labeling condition.

Figure 3.2: Average Social Distance Scale (SDS) Score by Symptom Set for Each
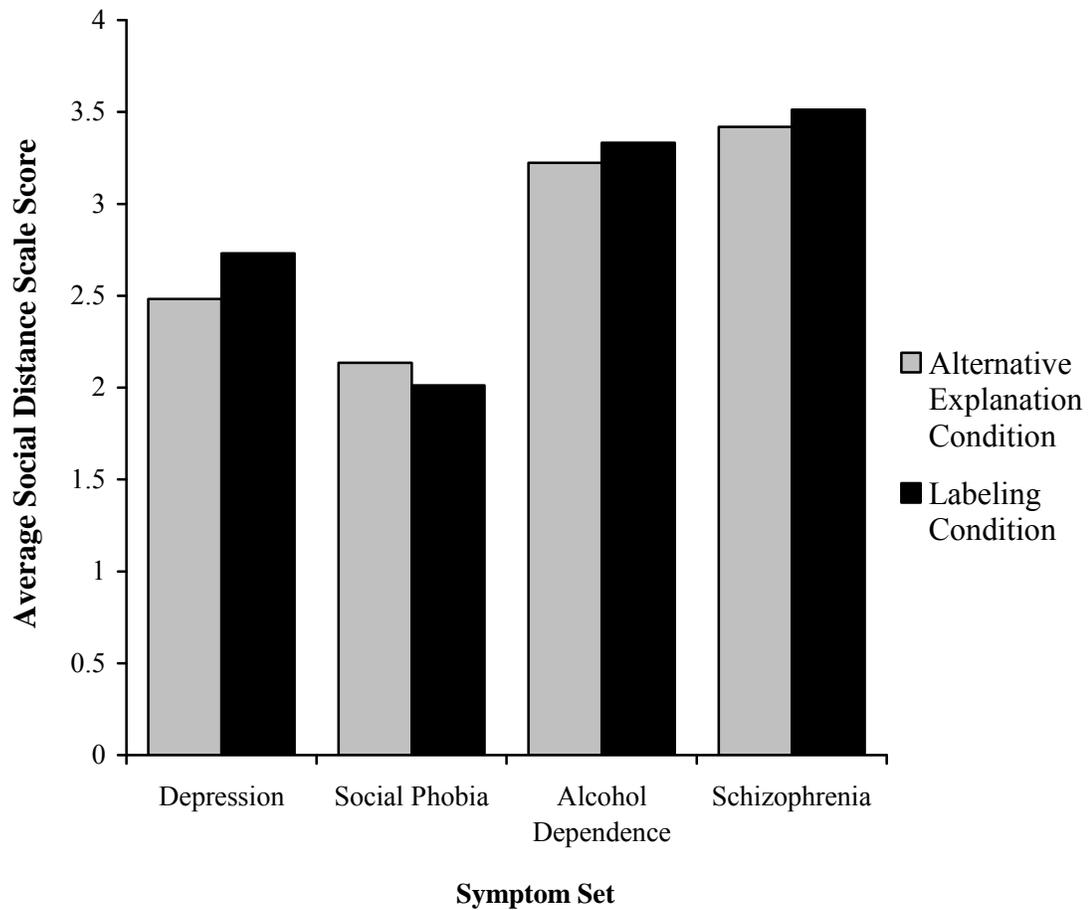
Condition

The SDS scores for each symptom set were significantly different from each other for

participants in the alternative explanation condition. In the labeling condition, SDS scores

for the alcohol dependence label did not differ significantly from SDS scores for the

schizophrenia label. All other pairs were significantly different from each other.

Figure 3.3: Dimension 1 by Dimension 2 Interaction in Predicting Attribution

Questionnaire (AQ) Scores for the Depression Symptom Set
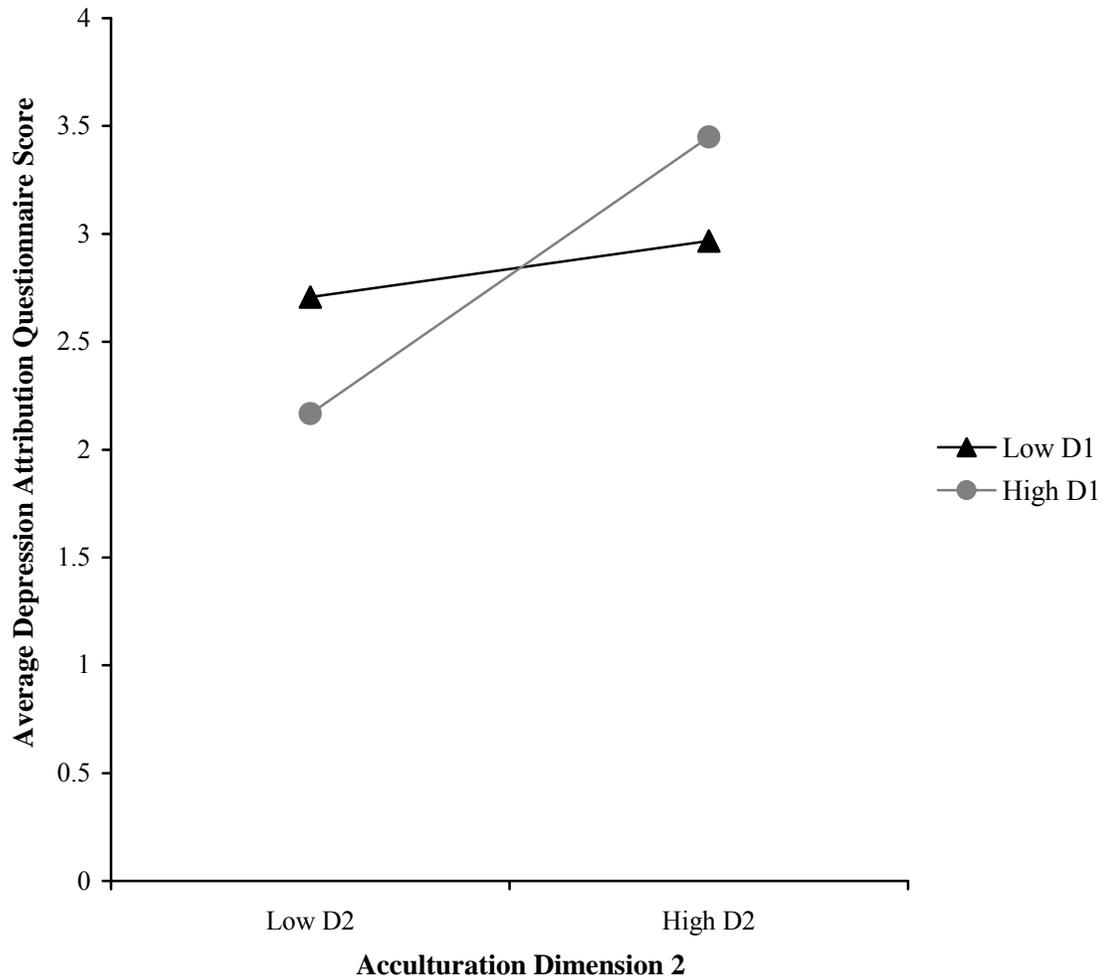
Depression symptom set AQ scores for those high on both D1 and D2 were signficantly

higher than AQ scores for those high on D1 and low on D2.

Chapter 4: Discussion

Although the stigma literature has indicated that African Americans stigmatize mental illnesses more than European Americans, little is known about whether within-group differences in mental illness stigma exist for African Americans. Examining African Americans separately from other groups would allow researchers to better understand the complexity of stigma for African Americans and better tailor interventions to decrease stigma. Thus, the goal of this study was to focus specifically on African Americans and examine the potential effects of type of symptoms, use of diagnostic labels, and acculturation on mental illness stigma. Overall, results of this study indicate that each of these factors does influence mental illness stigma for African Americans.

The first hypothesis tested was that schizophrenia symptoms would be most stigmatized and social phobia symptoms would be least stigmatized. The results supported this hypothesis. Regardless of whether a diagnostic label was included in the vignette or not, participants had the most negative attitudes and beliefs about and desired the most social distance from the person in the vignettes with symptoms consistent with schizophrenia. This is not surprising given that schizophrenia is a severe mental illness and greater severity of symptoms has been found to predict more negative attitudes towards people with mental illness (Socall & Holtgraves, 1992) and increased social rejection (Kirk, 1997). Interestingly, when the alcohol dependence diagnostic label was present in the vignettes, the amount of social distance desired did not differ from the amount of social distance desired from the vignette subject with the schizophrenia diagnostic label. Also, when presented with an alternative explanation for symptoms, there was no difference in negative attitudes and beliefs about vignette subjects with

symptoms of alcohol dependence and vignette subjects with symptoms of schizophrenia. Thus, in both of these cases, alcohol dependence and schizophrenia were stigmatized at equally high levels. The similarity in the stigmatization of alcohol dependence and schizophrenia may be due to drinking problems being viewed as something that a person should be able to control. Personal responsibility has been found to predict social distance (Feldman & Crandall, 2007), so if a person is seen as personally responsible for their alcohol dependence, there may be more stigma attached to it. Jones and colleagues (1984) suggested that the visibility of a disorder may also relate to stigmatization of people with the disorder. Alcohol dependence, like schizophrenia, is a disorder that has symptoms that can be difficult to hide, which could explain the high desire for social distance and negative attributions for both.

As predicted, symptoms of social phobia were least stigmatized, regardless of whether a diagnostic label was present. These findings are consistent with Feldman and Crandall's (2007) findings. Out of 40 mental illnesses, they found that social phobia was the fourth least stigmatized in terms of social distance. Perhaps the reason there were fewer negative attitudes and less desire for social distance towards that vignette subject was because social phobia is viewed as less severe than other mental illnesses. Indeed, findings from the manipulation check, 53.7% of participants said they either did not consider it a mental illness or were unsure if it was.

The second hypothesis tested was that having a diagnostic label would elicit more desire for social distance and more negative attributions than using an alternative explanation for symptoms. The results of this study indicated that this hypothesis was only supported for depression and social distance. Negative attitudes towards vignette

subjects were not predicted by the existence or non-existence of a diagnostic label. Overall, labeling did not have as much of an influence on stigma as expected. Prior research on labeling and stigma has yielded mixed results, and it may be that diagnostic labels are just not as influential as some researchers think, or the influence of labels may be important for some mental illnesses but not others.

In this study, the only disorder for which having a diagnostic label predicted social distance was depression. Results indicated that having a major depressive disorder diagnostic label predicted greater desire for social distance than the same depressive symptoms without a diagnostic label. Cormack and Furnham (1998) suggested that the general public may not identify a certain set of symptoms as a mental illness in the absence of a label, and may stigmatize the same symptoms more when a label is present. This may be the case with depression in this study. Without a label present, compared to all the other symptom sets, fewer participants thought the vignette subject with depressive symptoms (Mike) actually had a mental illness. In fact, 65% of the participants who did not have a diagnostic label in their vignette thought that Mike *did not* have a mental illness, but 66% thought Mike *did* have a mental illness when the same symptoms were presented with a diagnostic label. Thus, in the absence of a label, participants may not have identified the symptoms as being consistent with major depressive disorder, and therefore not consistent with a mental illness; consequently, they desired less social distance.

The final hypothesis tested in this study was that those who were higher in their identification with African ethnocultural beliefs and behaviors (Dimension 1) would have more negative attitudes about and desire more social distance from people with mental

illness overall, and those who were higher in their identification with Eurocentric culture (Dimension 2) would have fewer negative attitudes towards and desire less social distance from people with mental illness. Although the hypothesis was not supported, the results indicated that acculturation predicts mental illness stigma in a way that was unanticipated. Identification with African ethnocultural beliefs and behaviors (D1) did not predict either aspect of stigma that was measured, but identification with Eurocentric beliefs and behaviors (D2) emerged as a salient predictor of negative attributions about and social distance from people with social phobia. Further, D2 predicted negative attributions about people with depression, but this effect was qualified by an interaction between D1 and D2.

The direction of the relationship between D2 and stigma was opposite of what was hypothesized. Greater identification with Eurocentric beliefs and behaviors predicted increased negative beliefs about people with social phobia and increased desire for social distance from people with social phobia. It is interesting that people at all levels of D2 stigmatized the schizophrenia and alcohol dependence symptom sets equally, but were there was a difference with social phobia. Those with higher desire to adopt more Eurocentric beliefs and behaviors may socially reject and have more negative thoughts about a person with social phobia because they may value certain communication patterns or ways of interacting socially that conflict with the way a person with social phobia would act. Those with less desire to adopt Eurocentric beliefs and behaviors may not value things like an ability to speak up in front of others as much and may stigmatize an inability to do so less.

The relationship between D2 and negative attitudes and beliefs about people with depressive symptoms was qualified by an interaction between D1 and D2. For those high in their identification with African ethnocultural beliefs and behaviors, negative attributions were significantly higher for those who were also high in their identification with Eurocentric beliefs and behaviors than it was for those low in their identification with Eurocentric beliefs and behaviors. To revisit the terminology used by Obasi and Leong (2010) when crossing the two orthogonal acculturation dimensions, the difference occurs between those in the integrationist group, who merge African and Eurocentric cultural ideals, and those in the traditionalist group, who reject Eurocentric culture and embrace African culture. Results indicated that integrationists had more negative attitudes and beliefs about vignette subjects with depression than traditionalists. Integration is often regarded as the most adaptive acculturation strategy (Sam & Berry, 2006), so it may be difficult to empathize with depressive symptoms related to stress at work. Therefore, they may have more negative attitudes regarding a person who is not able to adapt to the situation and handle stress without experiencing depressive symptoms. Those who are traditionalists may have fewer negative attributions regarding a person with depression because of their communalist worldview, and the understanding that interaction with others at work can have the potential of negatively impacting a person's mood.

In this study, much more variance in negative attributions about vignette subjects with depression and social phobia was accounted for than the other dependent variables. About 32% of the variance in depression AQ scores and social phobia AQ scores was explained by the predictors, while just 12% and 14% of the variance in alcohol

dependence AQ scores and schizophrenia AQ scores, respectively, was accounted for by the predictors. There are certainly additional variables not included in this study that contribute significantly to negative attitudes about people with mental illness, particularly alcohol dependence and schizophrenia. Future studies should include some other variables that potentially account for more variance, such as personal responsibility, visibility of the mental illness, and whether one knows a person with a particular mental illness. Media such as videos could be used in these studies to actually show a person with mental illness or an actor portraying a person with mental illness to perhaps allow participants to more accurately rate their views on personal responsibility for the illness and how visible the illness appeared.

Also, the differences in variance explained lend support to the notion that it is important not to group all mental illnesses together when talking about stigma. As the results of this study show, the amount of stigmatization towards disorders varies, as do the factors that predict stigmatization of each disorder. Further, certainty about whether certain disorders are mental illnesses is different for different disorders. While participants overall were certain that schizophrenia is a mental illness, they were more divided regarding alcohol dependence, with about 54% considering it a mental illness and about 30% not considering it a mental illness. About 25% of participants were unsure as to whether or not to consider major depressive disorder and social phobia to be mental illnesses. These factors should also be kept in mind when designing interventions to reduce stigma. If different variables predict stigmatization of different mental illnesses, then different interventions would probably be needed to reduce the stigmatization of different mental illnesses. Also, the public may need to be educated about some mental

illnesses more than others. The study also indicated that attributions about people with depression varied by acculturation group. Additional research is needed to better understand how members of different acculturation groups differ in stigma. Future studies could group participants based on acculturation strategy (i.e., integration, traditional, assimilation, marginal) and use qualitative methods such as focus groups to better understand how cultural values influence their views of various disorders.

Study Limitations

This study provided additional information regarding mental illness stigma among African Americans and how it may vary by acculturation, label, and symptom set. However, like all studies, it has limitations. One limitation is that the study measured attitude as opposed to behavior. This is a limitation in much of the research on mental illness stigma (Stier & Hinshaw, 2007). This study assumed that social distance and the negative attributions about people with mental illness were good indicators of stigma for African Americans. Although these measures are widely utilized in stigma research, they may or may not adequately assess the ways in which African Americans stigmatize mental illnesses. Additional research is needed to clarify the construct of mental illness stigma for African Americans and the validity of the SDS and AQ-20 in measuring the construct for them. As well, future research should not only replicate these findings regarding attitudinal variables, but should also include other constructs such as behavioral and situational variables, as research in other areas of psychology (e.g., Ajzen, 1996; LaPiere, 1934) has found that situational factors influence how attitudes translate into behavior and that the same attitudes may be expressed in a variety of behaviors.

Additionally, although being able to test within-subjects differences in the stigmatization of different disorders was a strength of this study, having participants complete the same stigma measures four times may have led to fatigue effects. The overall battery of questions participants were asked to respond to was relatively lengthy, and the length of the battery may have deterred people from participating and also likely contributed to rate of missing data that reduced this study's sample size. In future studies, a between-subjects design could be considered so that participants would not have to complete the same measures so many times. Another limitation is that, although the study sample was a community sample, it was not a good representation of the general African American population due to lack of variation in education and income level. Results may differ in a sample that is more diverse in those areas. The online format of the study may have limited access for those with lower income. Providing a paper-and-pencil option for the study and doing more in-person as opposed to online recruitment would help to improve the diversity of future samples.

Conclusion

Despite its limitations, this study has several significant strengths. One is that it used an experimental design with random assignment to groups and allowed for within-group and between-group examination of the influence of symptom set, labeling, and acculturation on attitudes about people with mental illnesses. Additionally, this is one of few studies that has examined stigma specifically using an African American sample, as opposed to comparing African Americans to Whites, and it is the only known study to date that examines acculturation bidimensionally as a predictor of mental illness stigma among African Americans. The findings of this study reveal that schizophrenia and

alcohol dependence are generally more stigmatized than depression and social phobia. While schizophrenia and alcohol dependence seem to be stigmatized across the board, African Americans differed in their stigmatization of social phobia based on acculturation, and they differed in their stigmatization of depression based on the presence of a label as well as acculturation.

This line of research is particularly important as mental illness among African Americans is a topic that is increasingly gaining attention with high-profile African Americans such as politician Jesse Jackson, Jr., and professional basketball players Metta World Peace (Ron Artest) and Royce White recently acknowledging that they have mental illnesses, and with the suicides of other high-profile African Americans such as former Soul Train host Don Cornelius and music industry executive Chris Lighty. Fortunately, most conversations about mental illness among African Americans do not occur without some commentary on the existence of mental illness stigma. Missing from these conversations, however, are ideas regarding combating stigma. Thus, there is a clear need for more extensive research to better understand mental illness stigma among African Americans, which can inform interventions as well as policy to reduce the stigma. As this area of research continues to be cultivated, it should focus not solely on changing African Americans' views towards mental illness and mental health treatment, but also on improving clinicians' cultural competence and enhancing the quality and outcomes of mental health treatment for African Americans.

Appendix A

Measurement of Acculturation Strategies for People of African Descent (MASPAD)

1 = Strongly Disagree   2 = Disagree   3 = Slightly Disagree
4 = Slightly Agree   5 = Agree   6 = Strongly Agree

1. I take a great deal of pride in being a person of African ancestry (African, African American, Black Cuban, Black Brazilian, Trinidadian, Jamaican, etc.).

2. If I have children, I will give them an African naming ceremony.

3. I do not feel connected to my African heritage.

4. If I have children, I will raise them to be American first and a person of African ancestry second.

5. I was raised to maintain cultural practices that are consistent with people of African descent.

6. I have difficulty accepting ideas held by the Black community.

7. I tend to generate friendships with people from different racial and cultural backgrounds.

8. I was socialized to treat my elders with respect.

9. Everyone has an equal opportunity to be financially successful in this country.

10. I am comfortable putting on the mask in order to fit in.

11. Despite facing potential discrimination, it is important for me to maintain my cultural beliefs.

12. I have acted in ways that are consistent with people of African ancestry even if other cultural groups do not accept it.

13. The way that I behave in public (work, school, etc.) is different than how I behave at home.

14. I consider myself to be a spiritual person.

15. I do not take things from the Earth without giving back to it.

16. I consider myself to be a religious (Christian, Catholic, Muslim, etc.) person.

17. It is vital for me to be actively involved in the Black community.

18. The word "communalistic" describes how I interact with other people.

19. I prefer to be around people who are not Black.

20. I participate in many social events where few Blacks are in attendance.

21. I actively support Black owned businesses.

22. People should modify many of their values to fit those of their surroundings.

23. I express different cultural values in order to fit in.

24. I was socialized to support Black owned businesses.

25. My beliefs are largely shaped by my religion (Christianity, Catholicism, Islam, etc.).

26. Most of my closest friends and past romantic partners are from a variety of different cultural groups.

27. I prefer entertainment (movies, music, plays, etc.) that highlights Black talent.

28. I buy products that are made by people of African ancestry.

29. I do not purchase products from Black owned businesses.

30. I believe festivals maintain spiritual and physical balance in my community.

31. I perform various rituals for my departed ancestors.

32. I see no problem assimilating into other cultural values to be financially successful.

33. People of African descent should know about their rich history that began with the birth of humanity.

34. I am actively involved in an African spiritual system.

35. Verbal agreements do not mean as much to me as written contracts do.

36. I do not own products that were made by people of African descent.

37. I use words from an African language when participating in my spiritual practices.

38. People in America should only speak English.

39. I will probably marry someone that is not Black.

40. Members of my culture should have an appreciation for African art and music.

41. My individual success is more important than the overall success of the Black community.

42. I expose myself to various forms of media (television, magazines, newspapers, internet, etc.) in order to keep up with current events that impact my community.

43. Blacks should not obtain reparations for being descendents of enslaved Africans since we are all reaping the benefits of slavery today.

44. I choose not to speak out against the injustices that impact people of African descent.

45. In embracing my culture, I can also recognize the dignity and humanity of other cultural groups.

Appendix B

Balanced Inventory of Desirable Responding

Select a number for each statement to indicate how true it is.

1	2	3	4	5	6	7
Not True			Somewhat True			Very True

1. My first impressions of people usually turn out to be right.

2. It would be hard for me to break any of my bad habits.

3. I don't care to know what other people really think of me.

4. I have not always been honest with myself.

5. I always know why I like things.

6. When my emotions are aroused, it biases my thinking.

7. Once I've made up my mind, other people can seldom change my opinion.

8. I am not a safe driver when I exceed the speed limit.

9. I am fully in control of my own fate.

10. It's hard for me to shut off a disturbing thought.

11. I never regret my decisions.

12. I sometimes lose out on things because I can't make up my mind soon enough.

13. The reason I vote is because my vote can make a difference.

14. My parents were not always fair when they punished me.

15. I am a completely rational person.

16. I rarely appreciate criticism.

17. I am very confident of my judgments

18. I have sometimes doubted my ability as a lover.

19. It's all right with me if some people happen to dislike me.

20. I don't always know the reasons why I do the things I do.

21. I sometimes tell lies if I have to.

22. I never cover up my mistakes.

23. There have been occasions when I have taken advantage of someone.

24. I never swear.

25. I sometimes try to get even rather than forgive and forget.

26. I always obey laws, even if I'm unlikely to get caught.

27. I have said something bad about a friend behind his/her back.

28. When I hear people talking privately, I avoid listening.

29. I have received too much change from a salesperson without telling him or her.

30. I always declare everything at customs.

31. When I was young I sometimes stole things.

32. I have never dropped litter on the street.

33. I sometimes drive faster than the speed limit.

34. I never read sexy books or magazines.

35. I have done things that I don't tell other people about.

36. I never take things that don't belong to me.

37. I have taken sick-leave from work or school even though I wasn't really sick.

38. I have never damaged a library book or store merchandise without reporting it.

39. I have some pretty awful habits.

40. I don't gossip about other people's business.

Appendix C

Questionnaire Vignettes

Please read the following description of Mike/Chris/James/Will. After reading the

description, please respond to the questions that follow regarding how you think and feel

about Mike/Chris/James/Will. There are no right or wrong answers.

Depression/Stress

Mike has a job that pays well and he usually has a fairly active social life with several

close friends. Recently, Mike has had a lot of pressure put on him at work. Over the past

month, he has been waking up with a heavy feeling that sticks with him all day long.

Mike's recent feelings are *due to the enormous amount of stress he is under at*

work./consistent with major depressive disorder. His usual positive attitude has been

replaced by a gloomy outlook. He pushes through his days, but finds even the smallest

tasks difficult to accomplish. Mike has withdrawn from his family and friends.

Occasionally, he wonders whether life is worth living, but Mike would never act on those

thoughts. He has been finding it more difficult to fall asleep at night despite being very

tired.

Social Phobia/Inability to Relax

Over the past year, Chris has noticed that he's fearful that he will embarrass himself in

certain situations like public speaking, meeting new people, interviews and at parties.

Whenever Chris is in situations like this, he feels excessive distress and is very

uncomfortable. Chris realizes that his fears are extreme. His symptoms are *a result of his*

inability to loosen up and relax his nerves./ consistent with social phobia, an anxiety

disorder. Sometimes, he tries not to go to places where he knows he will have to speak in front of others. He even skipped a class because of his fear about doing the presentation he was scheduled to do that day. This resulted in Chris nearly failing the class.

Alcohol dependence/Coping with marital problems

During the last two months, James has been having some marital problems. Lately, James has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as usual to get the same effect. James's drinking is *an effort to cope with the problems he is having with his wife./consistent with alcohol dependence.* Several times, he has tried to cut down or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty, and couldn't sleep, so he took another drink. His family has complained that he is often hungover and has become unreliable.

Schizophrenia/Insomnia

Up until a year ago, life was fine for Will. But then, his behavior began to change. He has been unable to sleep at all. He began thinking that people around him were making disapproving comments and talking behind his back. The changes Will has been experiencing are due to *insomnia/schizophrenia.* Even when no one else is around, Will hears voices that tell him what to think and do. He is convinced that people are spying on him and that they can hear what he is thinking. Will has lost his drive to participate in his usual work and family activities and pretty much stays at home.

Appendix D

Social Distance Scale

0= Definitely Willing   1= Probably Willing   2= Probably Unwilling   3= Definitely

Unwilling

1. How would you feel about renting a room in your home to

    [Mike/Chris/Will/James]?

2. How about as a worker on the same job as [Mike/Chris/Will/James]?

3. How would you feel having [Mike/Chris/Will/James] as a neighbor?

4. How about as the caretaker of your children for a couple hours?

5. How about having your children marry [Mike/Chris/Will/James]?

6. How would you feel about introducing [Mike/Chris/Will/James] to a young

    woman you are friendly with?

7. How would you feel about recommending [Mike/Chris/Will/James] for a job

    working for a friend of yours?

Appendix E

Attribution Questionnaire-20

1= not at all   9= very much so

Fear/Dangerousness – Fear and dangerousness of people with mental illnesses

I would feel unsafe around [Mike/Chris/Will/James].

[Mike/Chris/Will/James] would terrify me.

How frightened of [Mike/Chris/Will/James] would you be?

How dangerous would you feel [Mike/Chris/Will/James] is?

I think [Mike/Chris/Will/James] poses a risk to his neighbors unless he is

hospitalized.

I would feel threatened by [Mike/Chris/Will/James].

How scared of [Mike/Chris/Will/James] would you feel?

Help/Interact – Willingness to help and interact with people with mental illnesses

If I were an employer, I would interview [Mike/Chris/Will/James] for a job.

I would be willing to talk to [Mike/Chris/Will/James] about his problems.

I would share a car pool with [Mike/Chris/Will/James] every day.

How likely is it that you would help [Mike/Chris/Will/James]?

How certain would you feel that you would help [Mike/Chris/Will/James]?

If I were a landlord, I probably would rent an apartment to

[Mike/Chris/Will/James].

Forcing Treatment – Forcing treatment on people with mental illnesses

How much do you agree that [Mike/Chris/Will/James] should be forced into

treatment with his doctor even if he does not want to go?

I think it would be best for [Mike/Chris/Will/James]'s community if he were put

away in a psychiatric hospital.

How much do you think an asylum, where [Mike/Chris/Will/James] can be kept

away from his neighbors, is the best place for him?

If I were in charge of [Mike/Chris/Will/James]'s treatment, I would force him to

live in a group home.

Negative Emotions – Negative emotions towards people with mental illnesses

I would feel aggravated by [Mike/Chris/Will/James].

How angry would you feel at [Mike/Chris/Will/James]?

How irritated would you feel by [Mike/Chris/Will/James]?

Appendix F

Manipulation Checks

Manipulation Check for Mental Illness Label Condition

Recall the descriptions of Mike, Chris, James, and Will you read earlier.

1. How believable was it that Mike was feeling the way he was because of major

    depressive disorder? (1- not believable at all, 2- somewhat hard to believe, 3- pretty

    believable, 4- very believable)

    a. What did you think was going on with Mike? _____

    b. How likely is it that Mike's symptoms were due to something else?

        (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

    c. Do you consider major depressive disorder to be a mental illness?

        (Yes/No/Not Sure)

2. How believable was it that Chris's symptoms were a result of social phobia, an

    anxiety disorder? (1- not believable at all, 2- somewhat hard to believe, 3- pretty

    believable, 4- very believable)

    a. What did you think was going on with Chris? _____

    b. How likely is it that Chris's symptoms were due to something else?

        (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

    c. Do you consider social phobia to be a mental illness? (Yes/No/Not Sure)

3. How believable was it that James's drinking was due to alcohol dependence? (1- not

    believable at all, 2- somewhat hard to believe, 3- pretty believable, 4- very believable)

    a. What did you think was going on with James? _____

    b. How likely is it that James's symptoms were due to something else?

(1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

   c. Do you consider alcohol dependence to be a mental illness? (Yes/No/Not
      Sure)

4. How believable was it that Will's behavior changes were due to schizophrenia? (1-
   not believable at all, 2- somewhat hard to believe, 3- pretty believable, 4- very
   believable)

   a. What did you think was going on with Will? _____

   b. How likely is it that Will's symptoms were due to something else?

      (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

   c. Do you consider schizophrenia to be a mental illness? (Yes/No/Not Sure)

Manipulation Check for Alternative Explanation Condition

Recall the descriptions of Mike, Chris, James, and Will you read earlier.

1. How believable was it that Mike was feeling the way he was because of the enormous
   amount of stress he was experiencing at work? (1- not believable at all, 2- somewhat
   hard to believe, 3- pretty believable, 4- very believable)

   a. What did you think was going on with Mike? _____

   b. How likely is it that Mike's symptoms were due to a mental illness?

      (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

   c. If you marked probably so or very likely for the previous question, which

      mental illness do you think Mike's symptoms were due to? _____

2. How believable was it that Chris's symptoms were a result of his inability to loosen

   up and relax his nerves? (1- not believable at all, 2- somewhat hard to believe, 3-

   pretty believable, 4- very believable)

   a. What did you think was going on with Chris? _____

   b. How likely is it that Chris's symptoms were due to a mental illness?

      (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

   c. If you marked probably so or very likely for the previous question, which

      mental illness do you think Chris's symptoms were due to? _____

3. How believable was it that James's drinking was an effort to cope with the problems

   he is having with his wife? (1- not believable at all, 2- somewhat hard to believe, 3-

   pretty believable, 4- very believable)

   a. What did you think was going on with James? _____

   b. How likely is it that James's symptoms were due to a mental illness?

      (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

   c. If you marked probably so or very likely for the previous question, which

      mental illness do you think James's symptoms were due to? _____

4. How believable was it that Will's behavior changes were due to insomnia? (1- not

   believable at all, 2- somewhat hard to believe, 3- pretty believable, 4- very believable)

   a. What did you think was going on with Will? _____

   b. How likely is it that Will's symptoms were due to a mental illness?

      (1- not likely at all, 2- probably not, 3- probably so, 4- very likely)

   c. If you marked probably so or very likely for the previous question, which

      mental illness do you think Will's symptoms were due to? _____

References

Abdullah, T., & Brown, T. L. (2012). Acculturation and alcohol use among African American college students: An exploration of potential moderators. *Journal of Black Psychology, 38*(4), 421-441. doi: 10.1177/0095798411431981

Abrams, K. K., Allen, L. R., & Gray, J. J. (1993). Disordered eating attitudes and behaviors, psychological adjustment, and ethnic identity: A comparison between Black and White female college students. *International Journal of Eating Disorders, 14(1)*, 49-57.

Ajzen, I. (1996). The social psychology of decision making. In E.T. Higgins & A.W. Kruglanski (Eds.), *Social Psychology: Handbook of Basic Principles*, 297-328.

Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2008). The experience of stigma among Black mental health consumers. *Journal of Health Care for the Poor and Underserved, 19*(3), 874-893. doi: 10.1353/hpu.0.0058

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: American Psychiatric Association.

Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services, 57*(6), 857-862. doi:10.1176/appi.ps.57.6.857

Atkinson, D. R., & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36*(2), 209-212.

Ayalon, L., & Alvidrez, J. (2007). The experience of Black consumers in the mental health system – identifying barriers to and facilitators of mental health treatment

using the consumers' perspective. *Issues in Mental Health Nursing, 28*, 1323-1340. doi: 10.1080/01612840701651454

Berry, J. W., Kim, U., Power, S., Young, M., & Bujaki, M. (1989). Acculturation attitudes in plural societies. *Applied Psychology: An International Review, 38*, 185-206.

Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (2006). Immigrant youth: Acculturation, identity, and adaptation. *Applied Psychology: An International Review, 55*(3), 303-332.

Bord, R. (1971). Rejection of the mentally ill: Continuities and further developments. *Social Problems, 18*, 469-509.

Brown, S. A. (2008). Factors and measurement of mental illness stigma: A psychometric examination of the Attribution Questionnaire. *Psychiatric Rehabilitation Journal, 32*(2), 89-94.

Cabassa, L. J. (2003). Measuring acculturation: Where we are and where we need to go. *Hispanic Journal of Behavioral Science, 25*(2), 127-146.

Cormack, S., & Furnham, A. (1998). Psychiatric labeling, sex role stereotypes, and beliefs about the mentally ill. *International Journal of Social Psychiatry, 44*(4), 235-247. doi: 10.1177/002076409804400401

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625. doi:10.1037/0003-066X.59.7.614

Corrigan, P.W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work, 52*(1), 31-39.

Corrigan, P. W., & Kleinlein, P. (2005). The impact of mental illness stigma. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.

Corrigan, P. W., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior, 44*, 162-179.

Corrigan, P. W., & Wassell, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing, 46*(1), 42-48.

Crandall, C. S., & Warner, R. (2005). Social distance. In S. Best & B. Radcliff (Eds.), *Polling America: An encyclopedia of public opinion* (pp. 762–766).Westport, CT: Greenwood.

Crino, M. D., Svoboda, M., Rubenfeld, S., & White, M. C. (1983). Data on the Marlowe-Crowne and Edwards social desirability scales. *Psychological Reports, 53*, 963-968.

Cruz, M., Pincus, H. A., Harman, J. S., Reynolds, C. F., & Post, E. P. (2008). Barriers to care-seeking for depressed African Americans. *International Journal of Psychiatry in Medicine, 38*(1), 71-80. doi: 10.2190/PM.38.1.g

Duncan, L. E. (2003). Black male college students' attitudes toward seeking psychological help. *Journal of Black Psychology, 29*(1), 68-86. doi: 10.1177/0095798402239229

Farina, A., Felner, R., & Boudreau, L. (1973). Reactions of workers to male and female mental patient job applicants. *Journal of Consulting and Clinical Psychology, 41*, 363-372.

Farina, A., & Hagelauer, H. (1975). Sex and mental illness: The generosity of females. *Journal of Consulting and Clinical Psychology, 43*, 122.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*, 175-191.

Feldman, D. B., & Crandall, C. S. (2007). Dimensions of mental illness stigma: What about mental illness stigma causes social rejection? *Journal of Social and Clinical Psychology, 26*(2), 137-154.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Graves, R. E., Cassisi, J. E., & Penn, D. L. (2005). Psychophysiological evaluation of stigma towards schizophrenia. *Schizophrenia Research, 76*, 317-327. doi: 10.1016/j.schres.2005.02.003

Hinshaw, S. P. (2007). *The mark of shame: Stigma of mental illness and an agenda for change*. New York: Oxford University Press.

Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D. T., & Scott, R. (1984). *Social stigma: The psychology of marked relationships*. New York: Freeman.

Jorm, A. F., & Oh, E. (2009). Desire for social distance from people with mental disorders: A review. *Australian and New Zealand Journal of Psychiatry, 43*, 183-200.

Kim, B. S. K. (2007). Adherence to Asian and European American cultural values and attitudes toward seeking professional psychological help among Asian American

college students. *Journal of Counseling Psychology, 54*(4), 474-480. doi:

10.1037/0022-0167.54.4.474

Kim, B. S. K., & Omizo, M. M. (2003). Asian cultural values, attitudes toward seeking

professional psychological help, and willingness to see a counselor. *The

Counseling Psychologist, 31*, 343-361.

Kirk, S. (1974). The impact of labeling on rejection: An experimental study. *Journal of

Health and Social Behavior, 15*, 108-117.

Klonoff, E. A., & Landrine, H. (1999). Acculturation and alcohol use among Blacks: The

benefits of remaining culturally traditional. *Western Journal of Black Studies,

23*(4), 211-216.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of

college students' attitudes toward seeking psychological help. *Journal of

Counseling Psychology, 47*(1), 138-143.

Kumar, A., & Nevid, J. S. (2010). Acculturation, enculturation, and perceptions of mental

disorders in Asian Indian immigrants. *Cultural Diversity and Ethnic Minority

Psychology, 16*(2), 274-283. doi: 10.103/a0017563

LaPiere, R. T. (1934). Attitudes vs. actions. *Social Forces, 13*, 230-237.

Lee, C. C. (1997). *Multicultural issues in counseling: New approaches to diversity.*

Alexandria, VA: American Counseling Association.

Li, A., & Bagger, J. (2007). The Balanced Inventory of Desirable Responding (BIDR): A

reliability generalization study. *Educational and Psychological Measurement,

67*(3), 525-544. doi: 10.1177/0013164406292087

Link, B., & Cullen, F. (1983). Reconsidering the social rejection of ex-mental patients: Levels of attitudinal response. *American Journal of Community Psychology,11*, 261-273.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92*(6), 1461-1500.

Link, B. G., & Phelan, J. C. (1999). Labeling and stigma. In C.S. Aneshensel and J. C. Phelan (Eds.), *The handbook of the sociology of mental health*. New York: Plenum.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services, 52*(12), 1621-1626.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P.Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin, 30*(3), 511-541.

Loman, A., & Larkin, W.E. (1976). Rejection of the mentally ill: An experiment in labeling. *The Sociological Quarterly, 17*(4), 555-560.

Loo, R., & Loewen, P. (2004). Confirmatory factor analyses of scores from full and short versions of the Marlowe-Crowne Social Desirability Scale. *Journal of Applied Social Psychology, 34*(11), 2343-2352.

Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: The role of "disturbing behavior," labels, and causal attributions in shaping public attitudes

toward people with mental illness. *Journal of Health and Social Behavior, 41*, 208-223.

Miville, M. L., & Constantine, M. G. (2007). Cultural values, counseling stigma, and intentions to seek counseling among Asian American college women. *Counseling and Values, 52*, 2-11.

Mishra, S. I., Lucksted, A., Gioia, D., Barnet, B., & Baquet, C. R. (2009). Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health Journal, 45*, 117-126. doi:10.1007/s10597-008-9157-4

Obasi, E. M., & Leong, F. T. L. (2009). Psychological distress, acculturation, and mental health-seeking attitudes among people of African descent in the United States. *Journal of Counseling Psychology, 56*(2), 227-238. doi: 10.1037/a0014865

Obasi, E. M., & Leong, F. T. L. (2010). Construction and validation of the Measurement of Acculturation Strategies for People of African Descent (MASPAD). *Cultural Diversity and Ethnic Minority Psychology, 16*(4), 526-539.

Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & S. Wrightsman (Eds.), Measures of personality and social psychology attitudes (pp. 17-59). New York: Academic Press.

Penn, D. L., Guynan, K., Daily, T., Spaulding, W. D., Garbin, C. P., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin, 20*(3), 567-578. doi: 10.1093/schbul/20.3.567

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences

on stigma (FINIS). *Social Science & Medicine, 67,* 431-440.

doi:10.1016/j.socscimed.2008.03.018

Pillay, Y. (2005). Racial identity as a predictor of the psychological health of African

American students at a predominantly White university. *Journal of Black*

Psychology, 31(1), 46-66.

Rao, D., Feinglass, J., & Corrigan, P. (2007). Racial and ethnic disparities in mental

illness stigma. *The Journal of Nervous and Mental Disease, 195*(12), 1020-1023.

doi: 10.1097/NMD.0b013e31815c046e

Sam, D. L., & Berry, J. W. (2006). *The Cambridge handbook of acculturation*

psychology. New York: Cambridge University Press.

Scheff, T. J. (1984). *Being mentally ill: A sociological theory* (2nd ed.). New York: Aldine

Publishing Company.

Shah, A. A., & Beinecke, R. H. (2009). Global mental health needs, services, barriers,

and challenges. *International Journal of Mental Health, 38*(1), 14-29.

doi:10.2753/IMH0020-7411380102

Shea, M., & Yeh, C. J. (2008). Asian American students' cultural values, stigma, and

relational self-construal: Correlates of attitudes toward professional help seeking.

Journal of Mental Health Counseling, 30(2), 157-172.

Snowden, L. R., & Hines, A. M. (1998). Acculturation, alcohol consumption, and AIDS-

related risky sexual behavior among African American men. *Journal of*

Community Psychology, 26(4), 345-359.

Socall, D. W., & Holtgraves, T. (1992). Attitudes toward the mentally ill: The effects of

label and beliefs. *The Sociological Quarterly, 33*(3), 435-445.

Star, S. (1955). *The public's ideas about mental illness.* Chicago: National Opinion
    Research Center (mimeographed).

Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with
    mental illness. *Australian Psychologist, 42*(2), 106-117. doi:
    10.1080/00050060701280599

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American
    Psychologist, 54,* 1070–1077.

Tata, S. P., & Leong, F. T. L. (1994). Individualism-collectivism, social-network
    orientation, and acculturation as predictors of attitudes toward seeking
    professional psychological help among Chinese Americans. *Journal of
    Counseling Psychology, 41*(3), 280-287.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the
    Surgeon General.* Rockville, MD: U.S. Department of Health and Human
    Services, Substance Abuse and Mental Health Services Administration, Center for
    Mental Health Services, National Institutes of Health, National Institute of Mental
    Health.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia
    Bulletin, 25,* 467-478.

Wallace, B. C., & Constantine, M. G. (2005). Africentric cultural values, psychological
    help-seeking attitudes, and self-concealment in African American college
    students. *Journal of Black Psychology, 31*(4), 369-385. doi:
    10.1177/0095798405281025

Whaley, A. L. (1997). Ethnic and racial differences in perceptions of dangerousness of

persons with mental illness. *Psychiatric Services, 48*(10), 1328-1330.

Zhang, N., & Dixon, D. N. (2003). Acculturation and attitudes of Asian international

students toward seeking psychological help. *Journal of Multicultural Counseling

and Development, 31*, 205-222.

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National Multicultural Conference & Summit Travel Grant, *American Psychological Association of Graduate Students,* 2009

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Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and culture: An integrative review. *Clinical Psychology Review, 31*, 934-948.

Abdullah, T., & Brown, T. L. (2012). Acculturation and alcohol use among African American college students: An exploration of potential moderators. *Journal of Black Psychology, 38*(4), 421-441.

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