2 Cross-Cultural Aspects of the Stigma of Mental illness

Bernice A. Pescosolido¹, Sigrun Olafsdottir², Jack K. Martin¹, ³ and J. Scott Long¹

¹Department of Sociology, Indiana University, Bloomington, IN 47405, USA
²Department of Sociology, Boston University, Boston, MA 02215, USA
³Karl F. Schuessler Institute for Social Research, Indiana University, Bloomington, IN 47405, USA

Prepared for Stigma in Mental Health: Interventions to Reduce the Burden, J. Arboleda-Florez and H. Stuart (eds.) John Wiley & Sons, Ltd. Based on a presentation at the World Psychiatric Association International Congress, October 2006, Istanbul. We acknowledge support from the Fogarty International Center, the National Institute of Mental Health and the Office of Behavioral and Social Science Research, all of the U.S. National Institutes of Health (Grant No.5 R01 TW006374). We also acknowledge financial support for the Icelandic data from the Icelandic Centre for Research and the University of Iceland.

Introduction

As noted in Healthy People 2010 [1], a striking finding of the landmark Global Burden of Disease Study [2] lies in the world-wide impact of mental illness on overall health and productivity. Profoundly under-recognized, mental illness constitutes 11% of the global burden of disease, with major depression alone currently ranking fourth and expected to rise to second by 2020. In some regions of the world (e.g., Western Pacific), mental disorders already represent the largest contributor to the total disease burden, and there is great concern with the “mortality crisis” related to mental illness in Eastern Europe [3].

In the face of these concerns, the World Health Organization’s (WHO) International Pilot Study of Schizophrenia (IPSoS), the International Study of Schizophrenia (ISoS) and the Study of the Determinants of Outcomes of Severe Mental Disorders (DOSMD) have all documented enormous heterogeneity in the outcomes of mental illness within and across countries [4–7]. While it is generally agreed that the reasons for these differences are “far from clear” [5], one predominant explanation revolves around culturally defined processes. Scholars and policymakers alike suggest that stigma may be the reason behind such findings and lies at the root of recovery from mental illness [8]. As such, understanding the cultural contexts that facilitate good outcomes may offer a lever for stigma reduction. In particular, whether individuals and others around them recognize mental illness, stigmatize these conditions and support seeking care is critical, since each represent key aspects of culture that can influence the outcome of mental illness [9,10].
Not surprisingly, there have been calls for systematic, comparable studies of stigma within and across social and cultural contexts in order to understand its origins, meanings and consequences [3, 4, 11–13]. Despite these calls and findings that document the pervasive existence and impact of stigma in different countries [14–18], we know relatively little about the cross-cultural distribution of stigma. Researchers across the globe have collected data on stigma, but differences in samples (often student or provider samples) and instrumentation make it difficult, if not impossible, to compare findings. Thus, questions about whether and how the social reaction to mental illness varies across countries, whether the underlying operative processes are similar, and whether it maps onto the distribution of outcome heterogeneity remain unanswered. Not surprisingly, then, the important question of whether these differences can offer a wedge into decreasing stigma’s negative impacts, also remains unanswered.

In sum, while the influence of cultural context on health and well-being is widely acknowledged, the empirical literature on the cross-cultural nature of stigma remains underdeveloped [19]. The World Psychiatric Association’s (WPA) Global Programme Against Stigma and Discrimination Because of Schizophrenia [20] has encouraged the development of a comparative catalogue of information and, to date there have been only a few large-scale studies (e.g., in Canada, the U.K., the U.S. and Germany). Even recent cross-national efforts, while springing from and being influenced by the WPA initiative, have not been linked in practice, making inference about comparative influences difficult. Moreover, there has never been, to our knowledge, a methodologically coordinated attempt to understand the extent to which mental illness is understood and stigmatized across countries (e.g., as an exception, see [21] for a comparison of the attitudes of German and U.S. high school students and mental health staff).

To answer this call and begin to explore the insights that differences across societies might offer to combat the stigma of mental illness, the Stigma in Global Context – Mental Health Study (SGC-MHS) was launched with the support of the U.S. National Institutes of Health (through the Fogarty International Center in collaboration with the National Institute of Mental Health and the Office of Behavioral and Social Science Research) and the Icelandic Centre for Research. The SGC-MHS is a theoretically based and methodologically coordinated collaborative study of the levels and correlates of the stigma of major depression and schizophrenia in 15 nations around the world.

Our goal here is to introduce the SGC-MHS by presenting early results from five European countries (Bulgaria, Germany, Hungary, Iceland, and Spain), focusing on three issues closely related to recovery – work, marriage and community acceptance. Since the ISoS found that the greatest differences in recovery across countries align with a nation’s level of development, the descriptive findings presented here may offer a conservative view of cross-national variation. By focusing on one continent, albeit with countries with varying GDPs and political and health care systems, this first exploration provides only an indicator of the potential for comparative analyses to assist the development of stigma-reduction efforts.

We begin by reviewing what we know about stigma from the wide range of studies that have been done. We then focus on studies of the outcomes of mental illness, first targeting the shift in emphasis from symptoms to “recovery” in its current usage, and then laying out arguments that have been made about the role of stigma in understanding outcomes. A brief description of WHO efforts on outcomes and some conclusions that appear in the scientific literature follows. After providing the background orientation for the SGC-MHS, we lay out
Taking Stock: Stigma in Cross-Cultural and Historical Frames

Stigma is an attribute that marks a person as tainted, calls their identity into question, and allows them to be devalued, compromised, and considered “less than fully human” [22, 23]. Thus, stigma deprives people of their dignity, challenges their humanity, and interferes with their full participation in society [24]. Fabrega [15] describes the pervasiveness of stigma historically and cross-culturally, and empirical studies reveal both the similarities across countries and changes over time. Importantly, the focus of the impact of stigma has broadened as research has continued, and as “recovery” has become the primary goal for practitioners, consumers, and advocacy groups. As Ware and colleagues have noted, too often persons with mental illness are “in the community, but not of it.” To increase social integration, they argue that both professionals and policymakers should focus on “connectedness” and “citizenship” [25, p. 469].

Below, we describe the widening concerns, the range of cross-national findings, and what we have begun to learn about large-scale changes in stigma.

Domains and Domain Shifts in the Study of the Outcomes of Mental Illness

Etiological issues aside, earlier work from the medical sciences focused on basic issues related to the “success” of the treatment of mental illness. Symptom reduction, rehospitalization, mortality, and debates about the course of diseases such as schizophrenia [26, 27] dominated the research discourse in psychiatry, psychology and mental health services research. Goffman’s 1963 classic work [28] put stigma at the forefront of most social science discussions of the outcomes of mental illness and received at least a passing mention in most other research. Social scientists, including those in public health, tended to focus more intensely on broader, community-based issues including lower quality of life, well-being, marriage and work possibilities, persistent social stress and low self-esteem [29–34].

However, with deinstitutionalization, the shift to community-based care, and growing calls for multidisciplinary work, outcome studies have become more integrated, inclusive, and multi-faceted, documenting the profound effects of stigma, including interference with the process of recovery [18, 35], the loss of legal rights [36], and discrimination, even among practitioners in both the general and mental health system [37, 38]. Researchers documented distressingly poor outcomes for mental illness cross-nationally. In Hong Kong, Mak and Gow [39] found former psychiatric patients living in deprived conditions regarding housing and social life, and reported that the lives of these people existed on the margins of society [31] in Austria; also [40] in Canada). In Singapore, former patients reported that stigma affected their self-esteem, relationships and job opportunities [41]. In Israel [42] and Australia [43], stigma resulted in an avoidance of mental health services [43]. Finally, these studies, as well as one from Nigeria, reported a greater social and medical vulnerability of persons with mental illness, compared to individuals with coronary disease, tuberculosis or cancer [44].

Only recently have we begun to get a picture of the larger, temporal dynamics of stigma. Pioneering survey work, begun in the U.S. in the 1950s [45–48] and continued in the
decades that followed, documented both the lack of understanding of mental illness, negative attitudes surrounding issues of cause, treatment and outcome, and a high level of public sentiment that favored the social rejection of persons with mental illness [21, 49–52]. However, innovations in treatment, advances in scientific knowledge, shifts in the locus and philosophy of treatment, and growth of a consumer advocacy movement shaped professional perceptions of stigma, and were often hailed as decreasing community-based stigma. Yet, such conclusions were based, almost exclusively, on personal observation and anecdotal evidence ([53–58]; see [59] for a review).

In the 1990s, researchers took up the challenge of collecting contemporary evidence, and where possible, matching it to data from the past. This growing body of empirical studies gives cause for both hope and despair. Several high-quality, representative regional and national studies report remarkably consistent findings, at least in Western nations. They indicate that the American, British, Irish and Canadian publics display a high level of acceptance of scientific advances marking biological and genetic causes of mental health problems; an acknowledgement of, and differential response to types of mental health and substance abuse problems (e.g., depression, schizophrenia, addictions); and a recognition of the existence of (and support for) effective treatments [14, 16, 17, 60]. Contact with persons with mental health problems was broadly in evidence. About half of those studied across surveys reported knowing someone with a mental health problem or someone who had used services or received some kind of treatment. In fact, in the American case, the MacArthur study was able to mark a real increase in public sophistication and knowledge of these matters over the last 40 years [59, 61, 62].

Coupled with these positive findings, other data revealed a darker side to cultural changes. A majority of the American and Canadian publics reported an unwillingness to work alongside or have intimate connections with persons with mental illness [17, 61, 63]. Many also agreed with images of persons with mental illness as unpredictable and dangerous. For example, in the U.S., where comparable data over time were available, Phelan et al. [59] reported an actual doubling, since the 1950’s, in spontaneous mentions of violence as descriptive of persons with mental illness. Further, a majority of respondents appeared to be quite willing to use legal means to coerce individuals into a range of treatments (e.g. doctors, clinics, hospitals), with near unanimous support for this approach when persons, despite the description of their problems, were labeled as “dangerous to themselves or others” [64].

Similarly, studies in other countries that targeted shorter time frames also reported mixed findings. In Hong Kong, public concerns decreased and knowledge of mental illness increased, but attitudes toward persons who had been treated in the mental health system had become slightly more negative [65]. In Canada, Brockman and D’Arcy’s [66] restudy of the classic Cumming and Cumming study [47] found only slight improvements. In Greece, among a very select sample, Lyketsos and colleagues [67] found little change over a 2-year period. However, Paykel et al. [68] found significant and positive changes regarding public attitudes toward depression in Great Britain from 1992 to 1996. In sum, this body of existing research shows deep and widespread negative attributes, reactions, and affect toward people with mental illness, together with increasing sophistication regarding causes and treatment.

In tandem with these research efforts, a set of clinically-based studies of the treated population of persons with schizophrenia and other serious mental illnesses has raised intriguing questions about stigma and its influence on outcomes. We turn to these studies.
Stigma and the International Study of Schizophrenia: The Paradox of Development

Technically, the WHO’s efforts to study schizophrenia represent a sustained research agenda which began in the late 1960s and has spanned 30 research sites in 19 countries. According to Hopper and his colleagues [69], the initial effort, the International Pilot Study of Schizophrenia (IPSS), helped establish the feasibility of such large scale studies while the second, the Determinants of Outcomes of Severe Mental Disorder (DOSMeD) replicated the initial IPSS finding that individuals who had more positive outcomes were likely to be found in those countries crudely classified as “developing”. Further, the most recent study, the ISoS, attempted to follow-up on this striking finding while correcting, where possible, for earlier methodological limitations which hindered claims of generalizability. Like the studies that came before, the ISoS continued to document better outcomes for those outside of the “developed” world [6].

Given that a country’s participation in these studies is voluntary and unfunded through a central source, the range and depth of these studies is truly impressive. That said, even with the ISoS, the set of sites involved is neither representative of existing countries nor large in number. What becomes remarkable in the face of limitations is the robustness of the finding noted above: Individuals who have been diagnosed as having schizophrenia or other serious mental illnesses appear to report better outcomes if they live in regions of the world considered to be “developing,” rather than those considered to be “developed.” Although social scientists have been increasingly skeptical of this particular conceptual distinction, the finding that individuals in Latin America, Africa or Asia seem to “do better” than those who live in the United States or Western Europe has been called “durable” [4, p. 836] and “the single most important finding” in comparative mental health services research [70].

To evaluate this finding in the context of the strengths and limits of the studies, Hopper and Wanderling [4] have provided the most thorough consideration and analysis of the developed-developing difference in the ISoS. Following up on the initial findings with data 13 years later and with two additional samples, they find that the outcomes of illness trajectories for study participants continue to favor the developing world. They go further to assess specific sources of potential bias including differences in follow-up methods, the grouping of data, ambiguities in diagnosis, selective outcome measures, and sociodemographic differences (i.e., gender, age) among the study participants. Finding that none of these can explain the differences in illness course and outcomes, they suggest that further research needs to focus on “the cultural”, including “auspicious or alternative beliefs” [4, p. 843].

While Hopper and Wanderling are clear about the complexity of what “culture” means to the entire course of an illness and the illness career it shapes, they nonetheless suggest that it is the local context that matters. And, while they are skeptical about the ability of structured questionnaires to get at the “local”, particularly everyday experiences, we believe that such approaches can at least explore, if not capture, the local cultural context of attitudes, beliefs, hopes and fears that surround the onset, recognition and response to mental illness. Such aspects of the non-material culture, according to the “new” sociology of culture, represent tools in a cultural toolkit that individuals can draw from as necessary to face life situations [71, 72]. This toolkit, shaped by the larger cultural climate, holds the resources that individuals, their families and others in the community use to understand the experience of mental illness; categorize problems, prospects and sources of care, and make decisions about their own behavior and, often, that of others [73, 74].
In sum, whether these beliefs, attitudes and opinions reveal concern, fear, or treatment efficacy, they reflect the prejudice and the potential for discrimination which fits our common understanding of the stigma that surrounds mental illness. The SGC-MHS was designed to take advantage of the opportunity to examine cross-national variation in cultural context and begin to calibrate how this one aspect of culture aligns with or contradicts our concerns about the differences in outcomes. In the next section, before we describe the specifics of the SGC-MHS, we discuss how the WHO paradox, coupled with other theoretical and empirical work on stigma and outcomes, motivated the specific study goals.

The Cultural Context of Stigma: How Do Countries Differ?

In the previous section, we brought together existing evidence of the breadth and depth of stigma across countries and provocative cross-national findings in what empirical work exists. Thus, while stigma is seen as “cross culturally ubiquitous” [24, 75], the earliest work [28] to the most recent [15, 24] conceptualizes stigma as a phenomenon shaped by cultural and historical forces. Early on, anthropologists described the different ways that cultures shape how individuals with mental illness are viewed and treated (e.g., [21, 76]). More recently, Lefley [77] contends that chronicity, itself, is a cultural artifact based, at least in part, on differing worldviews, religious traditions, the role of alternative healing systems, and differences in the cultural value of interdependence.

Even studies that have documented differences in outcomes for persons with mental illness across countries point to and call for further investigations across cultural contexts (see also [12, 24]). They suggest that future research must identify the collective properties of social, cultural, economic and physical environments that influence health and disease outcomes. And, the sheer range of differences that Lefley [77] describes above can be enormous. For example, Sartorius [78] reports that the ratio of psychiatrists to the population ranges from 1:1,000-5,000 in the more developed societies (e.g., Europe) to 1: 50,000-100,000 in the developing world to only 1:5,000,000 in some African countries. Of course, this is not independent of the availability of economic capital in a society which needs to be considered as well. For example, the WHO reports that countries in the Western Pacific Region devote less than 5% of their small health budgets to mental health and neurological disorders [79, p. 121]. Thus, existing research suggests that we need to examine cross-cultural issues directly, rather than making assumptions about their correlation with broad categories.

Even under the best designs, the ability to examine all of these issues fully is limited by funding and by the willingness and ability of researchers in different countries to mount a study to provide information about cross-national differences. Indeed, the existence of sufficient research infrastructure to mount such research reflects both happenstance (e.g., whether any individuals were trained in survey research methodology), and the existing resources of a country that enable a national-level study. Thus, as we undertook the SGC-MHS, we sought to focus on coverage, comparability, and representativeness. We describe the end result next.

The Stigma in Global Context – Mental Health Study: Foundations

The SGC-MHS basic questions are, at base, descriptive: Do people’s attitudes, beliefs and behavioral predispositions vary in response to descriptions of persons with symptoms/
behaviors that meet criteria for two major mental illnesses – schizophrenia and depression? And if so, how do they vary? The study does not target only conventional measures of stigma, per se, but seeks to understand what cross-national differences exist across a number of cultural factors that may play a role in shaping the response to mental illness. These include the profiles/levels of knowledge of mental illness, assessments of severity, recognition of and attribution for the profiles provided, the degree of prior contact with persons with mental illness, stigmatizing responses such as negative characterizations (e.g., dangerousness, long term negative impact) or rejection (e.g., a desire for social distance), and evaluations of the need for and utility of treatment, including specific provider types (e.g., “doctors”, psychiatrists).

At this writing, we are still in the field for many countries. So, we focus on our basic question with a broad-brush, inductive look at one continent, Europe. However, even with this preliminary look, we pay attention to the findings of the WHO studies: Does it appear, even at this point, that countries with higher levels of economic capital vary systematically in public attitudes toward mental illness?

The Design of the SGC-MH Project

Critical to a sound cross-national study is the assurance that, to the degree possible, each country will approach the collection of data in the same way, both logistically and culturally. To help ensure this, the SGC-MHS was based on an existing infrastructure with a history of cross-national collaboration and strict rules for the data collection of their own projects. The “platform” for the SGC-MHS is The International Social Survey Program (ISSP). The ISSP is an on-going, annual program of cross-national collaboration that brings together an international cadre of leading social scientists and expert survey researchers.

The SGC-MH study is not a part of the standard ISSP research program which involves modules developed and approved by the participants. Rather, we used the ISSP as an organizing platform to ensure the collection of high quality data, to select survey organizations with an established record of routine and successful cross-national collaboration, and to ensure a set of agreed-upon principles relative to sampling, data collection procedures, fielding guidelines, codebook construction, data sharing, and archiving.

We established a translation procedure which began with ISSP standard approaches but was supplemented with an in-house “cultural” review with a native speaker who was asked to give an oral translation of the target language instrument without having seen the original English language instrument. This allowed both an extra eye to culturally relevant language usage that enabled us to correct poorly worded items caused by too literal translation, and an opportunity to ask people from that country questions about local idioms, the nature of the mental health treatment system, and their perceptions about cultural differences that could potentially affect data collection. These individuals were not experts in the field of mental health and illness, nor were they professional translators; rather the primary criteria were fluency in both English and the target language, and cultural fluency gained from recent experience living in that country. With the information gathered during these sessions, which averaged in length from 3 to 4 hours, we returned to each country’s survey team with a set of questions, suggestions and concerns to negotiate a final instrument that was tailored for naturalness while maintaining the meaning necessary for comparability across countries.
Sampling and Fielding

Eligible respondents were non-institutionalized adults (i.e., eighteen years of age or older). Individuals who resided in institutional settings (e.g., hospitals, prisons, etc.) were not included in the sample frame. The selection of sample elements across all national cross-sections was based on multi-stage probability methods. Within each nation, sample weights were computed to offset any potential biases; however, analyses of the weighted and unweighted data revealed few systematic differences. Therefore, we utilize the unweighted data, unless otherwise indicated.

The complexity of the vignette strategy required face-to-face personal interviews conducted by trained interviewers. In line with ISSP procedures, all field data collection efforts were closely monitored by survey center employees who also served as liaisons to the SGC-MH team for translation, data coding and preparation and delivery of the data file.

Interview Schedule

The SGC-MH interview schedule consisted of two parts. The first 15 minutes tapped substantive issues related to the stigma of mental illness, with reference to the vignette person and more generally with regard to mental illness. These questions were asked in a single block, and in identical order for each country. The second part of the interview schedule consisted of an agreed upon set of background variables that have been tailored to each nation by the ISSP. The Zentralarchiv (the ISSP designated Archive in Germany; www.issp.org) holds a volume describing these background and socio-demographic variables which provide the basis for a comparable, but tailored, approach. To respond to specific theoretical, ethical, or cultural issues, any individual question was omitted after negotiation between the SGC-MHS team and survey center liaisons.

Vignettes

As discussed earlier, much of the SGC-MHS instrument involved assessing respondents’ reactions to and evaluations of the individual described in the hypothetical scenario. These vignettes described a person meeting criteria for a DSM-IV diagnosis of major depression, schizophrenia, or a physical health problem – in this case, asthma. Within vignettes, the individual’s race or ethnicity and gender were randomly assigned. Previous research suggests that this strategy avoids the problem of identifying and labeling a “case” for the respondent as someone who is “mentally ill”, and allows for better data collection on issues of knowledge and labeling [63]. In the current study we relied on two such unlabelled mental health vignettes (schizophrenia and major depression), and one physical health problem (asthma). Wording for the mental health problem vignettes was evaluated for accuracy by members of the nation-specific research teams and an international psychiatrist. Vignettes were randomly assigned to respondents.

Unlike the ISSP where non-literal translations are discouraged, and in addition to the second step cultural translation described above [82], the instrument was culturally tailored on two distinct issues. First, the SGC-MHS is primarily vignette-based, describing (but not categorizing) a person who meets clinical criteria for schizophrenia or depression. The vignettes were initially developed in accordance with the DSM-IV but were revised for cross-cultural applicability by the group of survey research experts leading each country’s effort in an early international meeting in Madrid in 2004. Indeed, even the selection of
which disorders to include was decided during the Madrid meeting. The vignettes were examined; rewritten for cultural applicability by a psychiatrist who had been involved in the WHO studies; and approved by the larger group. Second, the labels applied in the interview schedule were modified to include and/or substitute culturally relevant idioms (see below for a description of the vignette strategy). In addition, the list of “providers,” particularly regarding traditional or indigenous healers, was matched to parameters of the local formal and informal health care systems in each country.

The Present Analysis

For the analyses we present here, data came from 5 European countries and were collected by five survey organizations: 1) The Agency for Social Analysis, Sofia (Bulgaria); 2) Zentrum für Umfragen, Methoden und Analysen (ZUMA), Mannheim (Germany); 3) TARKI, Social Research Center, Budapest (Hungary); 4) Félagsvísindastofnun, Reykjavik (Iceland); and 5) Análisis Sociológicos, Económicos y Políticos, S.A. Madrid (Spain). The sampling procedures described earlier yielded samples of 1,121 respondents in Bulgaria, 1,255 respondents in Germany, 1,252 respondents in Hungary, 1,033 respondents in Iceland, and 1,206 respondents in Spain. Thus, the combined five nation sample we examine here is comprised of 5,867 respondents. Also, for the purposes of the current study, we only examined responses to the mental illness vignettes (i.e., major depression and schizophrenia). Thus, by eliminating respondents who received the asthma vignette, we reduced the nation-specific sample sizes by roughly one-third. The resultant samples that provide the data for our subsequent analyses are comprised of 764 respondents in Bulgaria, 847 in Germany, 840 in Hungary, in 673 for Iceland, and 847 in Spain. Thus, the total effective sample for the analyses reported here is comprised of 3,971 respondents, and includes only those who were asked to assess the depression and schizophrenia vignettes.

Measures: Stigmatizing Attitudes

In the analysis presented here, our dependent variables were cross-national public endorsements of stigmatizing attitudes toward persons with mental illness across three venues important for recovery: the community, the workplace, and the family. Each dimension is captured by a single-item, coded such that higher scores on each item indicated the endorsement of more stigmatizing sentiments. First, community stigma was tapped by the question, “A person like NAME has little or no hope of being accepted as a member of his/her community”, coded 1=strongly agree, 2=agree, 3=disagree, 4=strongly disagree. Second, workplace stigma was measured by the question, “If a person like NAME is qualified for a job, he or she should be hired like any other person”, also coded 1=strongly agree, 2=agree, 3=disagree, 4=strongly disagree. Third, relational/family stigma was indexed by the question, “How willing would you be to have NAME marry someone related to you?”, coded as 1=definitely willing, 2=probably willing, 3=probably unwilling, 4=definitely unwilling.

Results: What are the Levels of Stigma Across Five European Nations?

The presentation of our analysis proceeds in two steps. First, we examine the distribution on levels of the endorsement of the three stigmatizing attitudes for depression and schizophrenia
combined, and by condition, without regard to nation. Second, we examine the distributions for each condition for the five European nations individually.

**Stigma in Europe**

Table 2.1 displays the percentage of respondents residing in five European nations who endorsed stigmatizing attitudes relative to the hiring, community acceptance, and marriage of persons described with behaviors meeting DSM-IV criteria for depression and schizophrenia. Several notable patterns emerge from these data. First, without regard to nation, over half of respondents (56.4%) report being unwilling to have a person with depression or schizophrenia marry into his or her family, and more than a third (33.7%) believe that persons with depression or schizophrenia have little hope of being accepted in their respective communities. However, respondents report lower levels of rejection with respect to the workplace. Overall, only about 1 in 5 respondents (23.5%) reported that a qualified person with a mental health problem should not be hired.

The data in Table 2.1 also reveal a pattern reported in previous studies of public preferences for social distance from persons with mental health problems (see, for example, [63]) that suggest that the public clearly distinguishes between persons described with symptoms of depressive disorders or schizophrenia. Regardless of the interactional venue (i.e., community, work, or family [marriage]), across the board, respondents in our five European nations are significantly more likely to report rejection of a person with schizophrenia, relative to a person with depression.

<table>
<thead>
<tr>
<th>Table 2.1</th>
<th>Distributions on Stigma Attitudes for Five European Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Combined</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td><strong>Don’t Hire, Even if Qualified</strong></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>5.0</td>
</tr>
<tr>
<td>Agree</td>
<td>18.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>54.4</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>22.2</td>
</tr>
<tr>
<td>N</td>
<td>3,652</td>
</tr>
<tr>
<td><strong>Unlikely to Be Accepted in Community</strong></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>4.6</td>
</tr>
<tr>
<td>Agree</td>
<td>29.1</td>
</tr>
<tr>
<td>Disagree</td>
<td>47.6</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>18.7</td>
</tr>
<tr>
<td>N</td>
<td>3,709</td>
</tr>
<tr>
<td><strong>Willingness to Have Marry Into Family</strong></td>
<td></td>
</tr>
<tr>
<td>Definitely Unwilling</td>
<td>27.2</td>
</tr>
<tr>
<td>Probably Unwilling</td>
<td>29.2</td>
</tr>
<tr>
<td>Probably Willing</td>
<td>31.0</td>
</tr>
<tr>
<td>Definitely Willing</td>
<td>12.7</td>
</tr>
<tr>
<td>N</td>
<td>3,539</td>
</tr>
</tbody>
</table>
Stigma Differences Across Europe

Table 2.2 reports the percentage of respondents, by country, who endorsed stigmatizing attitudes with regard to depression and schizophrenia for the same three items. For the most part these nation-specific estimates mirror the patterns observed in Table 2.1. Specifically, in each nation, regardless of the interactional venue (i.e., work, community, or family), respondents are more likely to prefer social distance from a person described as having symptoms of schizophrenia when compared to a person described as meeting criteria for depression. Also as before, regardless of nation or disorder type, the lowest levels of rejection are observed in the workplace setting, with higher levels of rejection reported in community and family settings.

However, the findings suggest that there are distinctions that can be drawn between the proportions of respondents in the five nations who are likely to endorse stigmatizing responses. Indeed, for each social venue and both disorder types, the proportion of stigmatizing attitudes differs significantly across the five nations. One the one hand, the highest levels of rejection are reported by respondents from the two Eastern European nations (i.e., Bulgaria and Hungary) and Spain. On the other hand, respondents in both Germany and Iceland report substantially lower levels of rejection. More specifically, almost one third to one half of the respondents in Bulgaria, Hungary and Spain believe that the individual described with schizophrenia should not be hired, compared to only 10 to 20 percent of those in Iceland and Germany, respectively. A similar pattern, although with fewer individuals

Table 2.2  Percentage of Respondents Endorsing Stigmatizing Attitudes With Regard To Depression and Schizophrenia Across Five European Nations Arranged by Level of Development (GDP per capita, low to high)

<table>
<thead>
<tr>
<th></th>
<th>Depression %</th>
<th>Schizophrenia %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Don't Hire, Even if Qualified</strong> (Strongly Agree/Agree, combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>17.6</td>
<td>32.5</td>
</tr>
<tr>
<td>Hungary</td>
<td>26.1</td>
<td>31.7</td>
</tr>
<tr>
<td>Spain</td>
<td>29.8</td>
<td>43.1</td>
</tr>
<tr>
<td>Germany</td>
<td>13.1</td>
<td>20.6</td>
</tr>
<tr>
<td>Iceland</td>
<td>8.1</td>
<td>10.0</td>
</tr>
<tr>
<td><strong>Unlikely to Be Accepted in Community</strong> (Strongly Agree/Agree, combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>35.2</td>
<td>49.0</td>
</tr>
<tr>
<td>Hungary</td>
<td>26.3</td>
<td>36.1</td>
</tr>
<tr>
<td>Spain</td>
<td>30.4</td>
<td>40.2</td>
</tr>
<tr>
<td>Germany</td>
<td>34.1</td>
<td>45.6</td>
</tr>
<tr>
<td>Iceland</td>
<td>17.6</td>
<td>23.0</td>
</tr>
<tr>
<td><strong>Willingness to Have Marry Into Family</strong> (Definitely/Probably Unwilling, combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>56.4</td>
<td>73.7</td>
</tr>
<tr>
<td>Hungary</td>
<td>61.6</td>
<td>70.6</td>
</tr>
<tr>
<td>Spain</td>
<td>47.2</td>
<td>67.4</td>
</tr>
<tr>
<td>Germany</td>
<td>46.8</td>
<td>54.9</td>
</tr>
<tr>
<td>Iceland</td>
<td>38.0</td>
<td>50.2</td>
</tr>
</tbody>
</table>
expressing rejection, is reported for those who received the depression vignette. The percentage endorsing social distance is generally higher for acceptance in the community and even more so for marriage; but even here, one country stands out. In Spain, about 43% of respondents indicated an unwillingness to see individuals described with schizophrenia to be hired; about 30% express similar concerns about those described with depression. So, while the pattern is not exactly the same across all venues and across the disorders, there are clear national differences, with Icelanders always anchoring the bottom. Here, the lowest proportion of respondents endorses stigmatizing responses.

**Discussion: Preliminary Insights and Next Steps**

As Link and Phelan [85] point out, stigma matters for public health because it is a social cause of disease which compromises a person’s ability to cope with mental illness, produces stress, and exposes them to other disease-producing conditions. The disadvantages with regard to power, prestige and social connections translate into the possibility that individuals with mental illness will have restricted life styles and life chances, including but not limited to social relationships, community living options, and citizenship rights [86].

The SGC-MHS was designed to follow up on insights of the WHO studies which suggested that a lever for stigma reduction might be found in understanding whether there are places across the globe offering more auspicious settings for recovery from the challenges of mental illness. Are there cultures which can be characterized as less stigmatizing, that is, offering more community inclusion and less rejection across critical arenas of life? The early picture that we report here from five European countries offers both encouragement for cross-national differences but greater complexity than suggested by the original WHO studies. That is, we do find overarching differences, both by disorder and by country. In general, respondents report more stigma regarding schizophrenia than for depression.

Perhaps more surprising is the way the different European nations “stack up.” There are clear and significant national differences. But, these differences do not suggest that same direction for level of development that the larger WHO studies suggested. Within Europe, in post-communist countries which have a lower level of development based on GDP per capita, more respondents perceive rejection for mental illness, while those in the more economically advanced nations, particularly Iceland, report less rejection. These results point to the need for a consideration of many other potential conditions that shape stigma; for example, the tradition of social welfare in democracies.

As a first step, our analysis is intriguing but raises more questions than answers for understanding the cross-national dimensions of stigma. Considerations that are aligned along an illness career model will shape our analyses of whether the assessment and recognition of mental illness differs cross-nationally and whether labeling has differential effects on rejection. By having asked about issues from onset to recovery, we will have the possibility of seeing where and how nations differ. Following up on these initial findings will likely present an even more complex picture, as more nations and more issues such as recognition are added. But even these first analyses suggest that unscrambling the patterns in these data may help tailor stigma reduction efforts.

The public health ramifications of not knowing the underlying workings of stigma are costly. According to the U.S. Surgeon General, stigma is the “most formidable obstacle to future progress in the arena of mental illness and health” [87, p. 3]. Similarly, the WHO and the World Psychiatric Association mark public stigma and discrimination as the critical
barriers to the appropriate care and inclusion of persons with mental illness in society, and as the “chief nemesis” to improving and assuring the quality of life for persons with severe mental illness [79, 88]. The existing gaps in scientific knowledge leave little room to estimate the malleability of stigma by marking its cross-national variation and to offer science-based approaches that attempt to change the larger culture and climate of communities. The SGC-MHS attempts to address the important goal of understanding the etiology of stigma to assist in the development of “evidence-based interventions to prevent or mitigate stigma’s negative effect on the health of individuals, families and societies worldwide” ([89]; http://www.nih.gov/news/pr/aug2002/fic-28.htm). Along with the WHO efforts and those of the Institute of Medicine, we agree that research on both the individual and collective properties associated with health communities is expected to provide opportunities for prevention and/or intervention at lower cost than traditional individual level strategies [90, p. 91].

References


38. Scholsberg, A. (1993) Psychiatric stigma and mental health professionals (stigmatizers and des-


