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Stigmatising attitudes towards people with mental disorders: Results from a survey of Japanese high school students

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ABSTRACT

The aim of the current study was to assess the stigmatising attitudes of Japanese high school students towards people with depression, social phobia and psychosis/schizophrenia. In 2011, 311 students aged 15–18 years filled out an anonymous self-report questionnaire, which included a case vignette describing either depression, schizophrenia or social phobia and two questionnaires to assess stigmatising attitudes towards people with these disorders. Exploratory Structural Equation Modelling (ESEM) was used to determine the dimensionality and loading pattern of the stigma items in the two scales, to establish dimensions of stigma and to compare levels on these dimensions between genders. Stigmatising attitudes towards people with mental disorders in young Japanese people are substantial. ESEM revealed that the structure of stigmatising attitudes in young Japanese people is comparable in personal and perceived attitude stigma, with each forming distinct dimensions and each comprising 'weak not sick' and 'dangerous/unpredictable' components. The social distance dimension of stigma was separate from other components. Stigmatising attitudes relating to dangerousness/unpredictability were the lowest for social phobia and highest for schizophrenia. Females had lower stigmatising attitudes than males. These findings echo those of Australian studies and extend them by demonstrating a similar structure of stigma in another cultural group, namely young Japanese people.

1. Introduction

Stigma is often cited as an issue of major concern to those with mental disorders. Stigma involves both attitudes and behaviour, but research has generally focussed on attitudes, which are more enduring than intermittent behaviours and more easily measurable. Stigmatising attitudes towards people with mental disorders are common in adolescents (Hinshaw, 2005; Walker et al., 2008). Such attitudes may interfere with help seeking and treatment adherence, and may adversely affect quality of life, causing a young person to feel abnormal, socially disconnected and dependent on others (Sirey et al., 2001; Corrigan, 2004; Meredith et al., 2009). The impact on help seeking is of particular importance, as evidence suggests that, despite adolescence being the period of peak onset of mental disorders, young people with symptoms of mental disorders are less likely seek appropriate help than those in other age groups (Zachrisson et al., 2006; Rickwood et al., 2007). In addition, stigmatising attitudes may lead to discriminatory behaviours towards others with mental disorders (Lasalvia et al., 2013).

A number of surveys have assessed stigmatising attitudes in adult Japanese populations. They include a survey of 2000 adults aged between 20 and 69 that was conducted in 2003/4. This survey assessed the respondent's personally-held attitudes (personal stigma) and also their beliefs about other people's attitudes (perceived stigma) towards someone with depression or schizophrenia (Griffiths et al., 2006). A more recent survey used the same questionnaire to examine attitudes to schizophrenia in psychiatric nurses (Hanzawa et al., 2012). Other studies include a web-based survey that examined attitudes towards schizophrenia in the general population, psychiatric staff, physicians and psychiatrists (Hori et al., 2010); a study examining stigmatising attitudes towards 'mental disorders' in 1211 members of the public (Tanaka et al., 2004); and a study of teachers' attitudes to schizophrenia (Kurumatani et al., 2004). Other studies have compared attitudes in Japan with those in other countries, including a study that compared desire for social distance from a person with schizophrenia in China and Japan (Haraguchi et al., 2009) and a comparison of stigmatising attitudes towards, schizophrenia, depression and obsessive-compulsive disorder in members of the public in Bali and Japan (Kurihara et al., 2000) These studies indicated that health professionals were less

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likely to have stigmatising attitudes than the general public and that levels of stigmatising attitudes vary across cultures.

Most of these Japanese studies did not assess differences according to age and gender, although Tanaka et al. (2004) found that older age was associated with more stigmatising attitudes. Studies of adolescents in other countries do not point to clear gender-related differences, although they do suggest that stigma declines with increasing age (Dietrich et al., 2006; Jorm and Wright, 2008). While some studies have found that females have less stigmatising attitudes than males (Griffiths et al., 2008a; Calear et al., 2010), reviews of associations between stigmatising attitudes and gender have not generally found reliable gender differences in stigmatising attitudes (Jorm and Oh, 2009; Jorm et al., 2012a). However, there have not been any studies of stigmatising attitudes in young Japanese people.

Surveys of stigmatising attitudes in other countries show that these are common among young people, particularly those relating to dangerousness and unpredictability (Calear et al., 2010; Kasow and Weisskirch, 2010). Stigmatising attitudes tend to vary by disorder and are higher in relation to schizophrenia than to depression and anxiety disorders (Reavley and Jorm, 2011). Studies also suggest that stigma is a multidimensional construct, with previous analyses using data from large surveys of the Australian population showing that stigmatising attitudes, as measured by the Depression Stigma Scale (DSS; Griffiths et al., 2004), has two components, relating to beliefs that a person with a mental disorder is 'weak not sick' and 'dangerous or unpredictable'. Scales reflecting these dimensions had different patterns of association with respondent age and gender, and the type of mental disorder portrayed in the vignette. Stigmatising attitudes relating to dangerousness/unpredictability were the lowest in response to social phobia and PTSD and the highest in response to schizophrenia, whereas attitudes relating to 'weak not sick' were highest for social phobia (Jorm and Wright, 2008; Yap et al., in press). However, further work is needed to establish whether the dimensions are comparable in different cultures.

Given the lack of data on stigmatising attitudes in Japanese youth, the aim of this study was to carry out a survey assessing high school students' stigmatising attitudes towards those with depression, schizophrenia and social phobia. We also aimed to use the data gathered in the survey to determine the factor structure of stigmatising attitudes in Japanese youth as measured by the DSS (Griffiths et al., 2004) and the Social Distance Scale (SDS: Link et al., 1999) and to establish the number of dimensions these items tap. We also sought to compare levels on these dimensions between males and females.

2. Methods

2.1. Participants and procedure

Initially, one author (KY) approached local high schools and met with principals and teachers to explain the purpose of the study and seek the support of the school. Schools that agreed to participate were provided with hardcopy surveys, which were distributed by homeroom teachers of Grades 1 to 2 (ages 15–17 years) during one homeroom period of approximately 40–50 min. Student participants were provided with information regarding the study, and their freedom to decline participation, on the survey paper. Consent to participate was implied by survey completion. Three hundred and eleven surveys were distributed in two schools, during December 2010. All distributed surveys were returned by students to their homeroom teachers, then to the research staff. The study was approved by the University of Fukuoka Ethics Committee.

2.2. Instruments

The survey was based on the Mental Health Literacy Interview developed by Jorm and colleagues (Jorm and Wright, 2007, 2008), which presents to participants a vignette of a young person with a mental disorder and then asks a range of questions regarding problem recognition, help-seeking intentions, beliefs about treatment and stigmatising attitudes. Vignettes describing young people with depression, psychosis or social phobia have been used and validated in previous research on youth mental health literacy in Australia (Jorm and Wright, 2007; Jorm et al., 2008; Wright et al., 2011). These vignettes were translated into Japanese by one of the authors (KY) with the assistance of a psychiatrist and checked by a second person. All surveys were completed in Japanese.

In order to limit respondent burden, students were randomly allocated one of three vignettes: depression, psychosis or social phobia, with each package of surveys containing equal numbers of each vignette, randomly distributed throughout the package. The gender of the character described in the vignette was also randomly allocated; the English language character 'John' was translated to 'Shōta-san' and the English language character 'Jenny' was translated to 'Ai-san'. The character in the vignette was described as being 15 years old. The Japanese vignettes are available from the author on request.

After reading the vignette, students were asked what, if anything, they thought was wrong with the person described. They were also asked about where they would go for help if they had a problem like the person in the vignette, their beliefs about a range of interventions and self-help behaviours, barriers to help seeking (reported in Yoshioka et al. (submitted for publication)) and also about their stigmatising attitudes, which are the focus of the current paper. Questions about sociodemographic characteristics were also included. These included age, gender and living situation (both parents, mother only, father only, with neither parent).

Stigmatising attitudes were assessed with two sets of statements, one assessing the respondent's personal attitudes towards the person described in the vignette (personal stigma) and the other assessing the respondent's beliefs about other people's attitudes towards the person in the vignette (perceived stigma). The items were adapted to be suitable for young people (Jorm and Wright, 2008) based on a scale for adults (Griffiths et al., 2004, 2006).

2.2.1. Personal stigma scale

The personal stigma items were: (1) people with a problem like (Shota-san/Ai-san)'s could snap out of it if they wanted; (2) a problem like (Shota-san/Ai-san)'s is a sign of personal weakness; (3) (Shota-san/Ai-san)'s problem is not a real medical illness; (4) people with a problem like (Shota-san/Ai-san)'s are dangerous; (5) it is best to avoid people with a problem like (Shota-san/Ai-san)'s so that you do not develop this problem; (6) people with a problem like (Shota-san/Ai-san)'s are unpredictable; and (7) if I had a problem like (Shota-san/Ai-san)'s I would not tell anyone.

2.2.2. Perceived stigma scale

The perceived stigma items covered the same statements but started with 'Most other people believe that…' Ratings of each were made on a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. As these scales have not previously been used in young Japanese people, percentages of people agreeing with individual items are reported here. For these analyses the 'agree' and 'strongly agree' categories were combined.

2.2.3. Social distance scale

Self-reported willingness to have contact with the person described in the vignette was measured using by a social distance scale suitable for young people (Jorm and Wright, 2008) which was an adaptation of a scale developed by Link et al. for adults (Link et al., 1999). The items were rated according to the person's willingness to (1) go out with (Shota-san/Ai-san) on the weekend; (2) to invite (Shota-san/Ai-san) around to your house; (3) to go to (Shota-san/Ai-san)'s house; (4) working closely with (Shota-san/Ai-san) on a project; and (5) to develop a close friendship with (Shota-san/Ai-san). Each item was rated on a 4-point scale ranging from definitely willing to definitely unwilling. For the analyses of agreement with individual items, the 'definitely unwilling' and 'probably unwilling' categories were combined.

2.3. Statistical analysis

2.3.1. Exploratory structural equation modelling

Previous exploratory Principal Components Analyses (PCA) which included self and perceived stigma items in the same analyses in an Australian sample have been equivocal regarding the number of factors and loading pattern (Griffiths et al., 2004; Jorm and Wright, 2008). However, it is clear that the set of items is multidimensional. Jorm and Wright (2008) named two of the factors they found 'Dangerous/unpredictable' and 'Weak not sick'. A limitation of PCA is that cannot accommodate the parallel nature of the personal and perceived stigma items and mixes all items together. In the current study, a novel technique – Exploratory Structural Equation Modelling (ESEM) – was used. This simultaneously fitted separate two-factor exploratory factor models to both the personal and perceived stigma items, but allowed testing of constraining the pattern of loadings of items on these factors. Testing these constraints sought to determine whether the measurement structure of personal and perceived stigma was comparable. The establishment of parallel measurement structures allowed scores on the personal and perceived stigma scales to be meaningfully compared.