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Research report

Gender specific correlates of stigma toward depression in a Canadian general population sample

JianLi Wang [a,b,*], Gordon Fick [b], Carol Adair [a,b], Daniel Lai [c]

[a] *Department of Psychiatry, Faculty of Medicine, University of Calgary, Calgary, Canada*
[b] *Department of Community Health Sciences, Faculty of Medicine, University of Calgary, Calgary, Canada*
[c] *Social Work, University of Calgary, Calgary, Canada*

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Abstract

Objectives: To identify gender specific demographic, clinical, knowledge and attitudinal factors associated with stigma related to depression.
Methods: Data were collected between February and June 2006 in a probability sampled population-based survey of 3047 adults in Alberta, Canada. Measures included a depression stigma scale. Correlates of stigma were examined using bivariate analyses and linear regression modeling methods separately for men and women.
Results: In multivariate linear regression models, correct identification of depression in a case description and agreement with health professionals about treatments were associated with lower stigma scores, regardless of gender. Endorsing GP/family doctors and taking medications as being the best help for depression was negatively associated with stigma scores in women. In men, endorsing family/friends as the best help for depression or "don't know" the best help for depression was positively associated with stigma scores. Women who had family/friends with depression had less stigma than women who did not have. This was not observed in men. Among male participants, significant interactions between being a health professional, having close family/friends with depression and reporting "weakness of character" as a causal factor for depression were found.
Conclusions: Improving mental health literacy may be one of the promising ways to reduce stigma associated with depression. Personal contacts with individuals with depression may have positive effects on stigma in women. Mental health education and promotion should clarify misconceptions about causes, treatments and risk factors for depression. Gender differences related to stigma should be considered in stigma reduction initiatives.

Keywords: Mental health literacy; Stigma; Major depression; General population; Survey

1. Introduction

Stigma toward persons with mental illness exists in the general population worldwide (Phelan et al., 2000; Stuart and Arboleda-Flôrez, 2001). Although depressive disorders are prevalent and impose considerable burden on society, there is a paucity of studies investigating

* Corresponding author. Room 127, Heritage Medical Research Building, 3330 Hospital Dr. NW, Calgary, Alberta, Canada T2N 4N1. Tel.: +1 403 210 8653; fax: +1 403 944 3144.
E-mail address: jlwang@ucalgary.ca (J. Wang).

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stigma against depression. Previous research mainly focused on stigma associated with schizophrenia. Some measured stigma related to both schizophrenia and depression (Angermeyer et al., 2004; Lauber et al., 2005). Link and Phelan conceptualized stigma as having five interrelated components, i.e., labeling, stereotyping, separation, discrimination and exercise of power (Link and Phelan, 2006). In such a process (Link and Phelan, 2006), stigmatizing attitudes may be related to various factors — demographic and socioeconomic characteristics, illness status, knowledge about and attitudes toward mental illness and treatments. This stigmatizing process may operate differently for different disorders. The "Changing Minds" campaign demonstrated that different disorders are not stigmatized in the same way (Crisp et al., 2005).

Studies have been using social distance as a measure of stigma. The findings about demographic correlates (gender, age and educational levels) for social distance from people with mental illness have not been consistent across studies. These inconsistencies were discussed in detail in a recent review (Angermeyer and Dietrich, 2006). Endorsing biogenetic explanations was found to decrease the likelihood of social acceptance of people with schizophrenia and major depression (Dietrich et al., 2006). Endorsing biological factors as the cause of schizophrenia was associated with a greater desire for social distance from people with schizophrenia; the relationship between endorsing biological causes and social distance was less pronounced for major depression, but was still statistically significant (Dietrich et al., 2004). Recognizing major depression depicted in a case vignette had no effect on public attitudes towards people with major depression (Angermeyer and Matschinger, 2003). In studies investigating stigma associated with schizophrenia, Lauber and colleagues found that recommending pharmacological therapies was related to greater social distance (Lauber et al., 2005). Gaebel and Baumann reported that, in Germany, a film portraying the experience of a young man with schizophrenia actually strengthened negative and stereotyping attitudes of the audience and increased social distance (Gaebel and Baumann, 2003). Lauber and colleagues suggested that one unintended consequence of initiatives aiming at improving mental health literacy might be greater social distance from persons with mental illness (Lauber et al., 2005). Dietrich and colleagues also noted that improving mental health literacy could possibly increase stigma against depression (Dietrich et al., 2006).

Because men and women differ in their knowledge and attitudes towards mental illness (Jorm et al., 2006), the objectives of this study was to identify gender specific correlates of personal stigma in a general population sample.

2. Methods

2.1. Study population and sampling

Between February and June 2006, we conducted a study about depression literacy in Alberta, Canada. The target population was household residents in Alberta, who were between the ages of 18 and 74 years old. Sampling and data collection were conducted by interviewers of the Survey Unit, Calgary Health Region. Data were collected using the method of Computer Assisted Telephone Interview. A listing of provincial residential telephone numbers is maintained and updated by the Survey Unit. The Survey Unit subscribes to a frequently updated database of listed Alberta telephone numbers. For this study, a random sample of these numbers was initially selected. Rather than adopting a traditional random digit dialing technique, which requires clustering (Potthoff, 1994), numbers were generated by single digit substitution (i.e. replacing the last digit of a listed telephone number with a randomly generated one). This ensured inclusion of unlisted numbers in the sample while maximizing the probability of reaching households. When a household was reached, the "last birthday" method was used to randomly select a single subject from the household. The household contact was asked to retrieve, or provide contact information (e.g. a first name) of the household resident who had most recently had a birthday (Watson et al., 1995). Once an eligible participant in the household was identified, the interviewer explained the purpose and the procedures of the study. The telephone interview was conducted only if the person agreed to participate in the study. The study was approved by the Conjoint Health Research Ethics Board of the University of Calgary.

2.2. Outcome measure

2.2.1. Personal stigma

We used a 9-item personal depression stigma scale, reflecting the participants' personal attitudes. This scale was developed by Griffiths and colleagues (Griffiths et al., 2004). For each question, ratings were made on a five-point Likert scale — strongly agree, agree, neither agree nor disagree, disagree and strongly disagree. In our study, the stigma scores ranged from 0 to 34 in this study, with a higher score indicating a higher level of