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Stigma against mental illness: Perspectives of mental health service users

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ABSTRACT

This study aimed to understand the perception, management and experience of stigma among people with mental illness in Japan. Interviews with people with mental illness were conducted and the data were analysed using grounded theory approach. The results showed that participants' major concerns appeared to obtain or keep a job, and being regarded as 'abnormal'. Overall, there were more affinities rather than differences between Japan and Western countries, whilst some cultural factors which seem to be related to the differences are also discussed.

1. Introduction

Stigma can be understood as an overarching term referring to problems of knowledge (ignorance), problems of attitudes (prejudice) and problems of behaviour (discrimination; Thornicroft, 2006). Research has shown that people with mental illness often perceive and experience stigma (Alonso et al., 2009; Lasalvia et al., 2013; Thornicroft et al., 2009). It also is common for them to employ their own strategies in order to avoid being stigmatised, such as concealment of their psychiatric diagnosis or educating others about mental illness (Chung & Wong, 2004; Ilic et al., 2011). These strategies are collectively referred to as stigma management.

When exploring stigmatic experiences among people with mental illness, it also is important to understand how these people perceive and manage stigma, since these two factors lie behind their stigmatic experiences. Whilst there are voluminous studies regarding the perception, management and experience of stigma among those with mental illness in Western countries, little research has been conducted in Japan, where mental healthcare is still hospital-based.

Japan has 2.7 psychiatric beds per 1000 population compared to, for instance, 0.5 in the UK (OECD, 2014). Long-term hospitalisation is another characteristic of psychiatric care in Japan. In 2012, the average duration of stay for patients in psychiatric beds was 292 days (MoHLW, 2013), which is significantly longer than the average length of stay of adult patients with mental illness in England in 2011–2012 (53 days; DoH, 2012). The background of these characteristics of psychiatric provision in Japan is complex, with one of the possible reasons being a high proportion of private psychiatric hospitals to public hospitals (95%; MoHLW, 2012) and stigma against mental illness in the community (Kurihara et al., 2000; Kurumatani et al., 2004; Griffiths et al., 2006; Masuda et al., 2009; Nomura, 2010; Chiba, Kido, Miyamoto, & Kawakami, 2012).

There has been a large body of research on stigma against mental illness in Japan. Ando, Yamaguchi, Aoki, and Thornicroft (2013) systematically reviewed 19 studies which examined mental-health-related stigma in Japan. The findings showed that mental illness was considerably stigmatised, with schizophrenia being more stigmatised than depression. Prejudice related to the inabilities, dangerousness and unpredictability of persons with schizophrenia appeared to be strongly associated with negative attitudes. The general public often lacked accurate knowledge about mental illness. Psychiatric staff generally exhibited less negative attitudes towards patients with schizophrenia than the general public and physicians, with years of experience in psychiatric care being negatively correlated with negative attitudes.

With regard to studies other than those included in the review by Ando et al. (2013), studies using a national or local representative sample showed that vignettes with severe symptoms, such as hallucinations and suicidal thoughts, had more frequently received stigmatising responses than vignettes with less severe symptoms (Hanzawa, Nakane, Yoshioka, & Nakane, 2007a, 2007b; Itayama, Takada, & Tanaka, 2012). A large proportion of laypeople (36–50%) believed that psychiatric hospitals were needed because the majority of the mentally ill were violent (Zenkaren, 1984, 1998). On the other hand, it was also found that those who have had contact with mentally ill persons were more willing to accept those affected than people who have had little or no contact. In particular, active contact, not passive contact, seemed the most effective in reducing social distance (Oshima, 1992; Oshima, Ueda, Yamazaki, & Siiya, 1992; Oshima, Yamazaki, Nakamura, & Ozawa, 1989). However, this is not always the case. In fact, Taneda, Morita, and Nakatani (2011) found that respondents who had frequent contact with those affected had showed greater social distance to them than respondents who had little contact.

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As shown above, mental illness are largely stigmatised in Japan. Views on mental illness, however, have been gradually changing. This is particularly true for depression. As Kitanaka (2012) pointed out, depression became 'one of the most talked about illnesses in recent Japanese history' (p. 2), due to the rapid increase in the number of people who were diagnosed with depression as a result of excessive work and took their own lives in the late 1990s.

Whilst social attitudes towards mental illness have been the subject of a large body of research, few studies have focussed upon the experience of stigma among people with mental illness in Japan. It is important to understand the personal perspectives of people with mental illness regarding stigma, as this information will contribute to suggesting a possible way for reducing stigma.

This study's objective was to understand the perception, management, and experience of stigma among people with mental illness in Japan. Whilst psychiatric diagnoses include a variety of mental illnesses, this study focussed upon schizophrenia and depression specifically. Indeed, these two illnesses have different images among the general public (Griffiths et al., 2006; Pescosolido et al., 2010), and thus the perception, management, and experience of stigma may be different between those with schizophrenia and those with depression. Comparisons between these two disorders may contribute to a clearer understanding of mental illness stigma.

This study defined perception as 'what an individual thinks most people believe about the stigmatised group in general' and 'how each individual believes society views him/her personally because he/she is a member of the stigmatised group'.

(LaBel, 2008, p. 414). In addition to this, management was defined as strategies for coping with stigma and experience as actually being stigmatised.

2. Methods

2.1. Participants

The present study employed qualitative interviews in order to understand the theoretical relationships between the perception, management, and experience of stigma and what lies behind each element. Following the university's ethical approval, recruitment was conducted through community activity support centres for psychiatric patients and psychiatric hospitals in Tokyo. The intent was to recruit people with depression and people with schizophrenia. At this end of this recruitment, twenty people stated that they wished to participate in the study.

Table 1 shows the demographic, diagnostic, and employment profile of the participants. The total population of the participants was equally divided into men (n=10) and women (n=10), of whom 12 had a diagnosis of schizophrenia, while 8 were diagnosed with depression. They were all well-functioning psychiatric outpatients, with stable symptoms. The average duration of treatment was 14 years (ranging from 1 to 40 years). A total of 13 participants experienced psychiatric hospitalisation, and the average duration of stay was 8 months (ranging from 1 to 13 months).

All the participants received both an oral and written explanation about the study prior to interviewing, and only those who wished to participate voluntarily had an interview. The participants gave a written consent form before interviewing. People that had any problems with participation were excluded according to the judgement of mental health professionals.

2.2. Procedure

Interviews were individual-based and semi-structured. The author alone conducted all of the interviews, with all of them being recorded with each participant's agreement. Interview questions were as follows:

Table 1
Demographic, diagnostic and employment profile of participants.

	Men n	Women n
Diagnosis		
Schizophrenia	8	4
Depression	2	6
Age (years)		
20–25	0	1
26–34	4	7
35–44	4	1
45–54	0	1
55–64	0	0
65–74	2	0
Employment status		
Job training	4	1
Sheltered job	1	0
Employment for people with disabilities/disorders[a]	3	1
Employed (full time)	1	4
Employed (part time)	0	1
Looking after home and family	0	1
Unemployed	1	2

[a] Some companies have a special recruitment policy for people with disabilities/disorders, including those with mental illness. This is not a sheltered job, and yet people who were employed in this recruitment may deal with less complex work than other workers do, with a lower salary than other workers.

1. What images do you think people have of mental illness or people with it?
2. Have you told your diagnosis to others? Could you tell me why or why not?
3. Have the relationships between you and others changed after you told them that you had a diagnosis of mental illness? If so, how have they changed?
4. Have you done something because you did not want to be prejudiced or discriminated against (for instance, concealing your diagnosis)?
5. Have you been treated differently from others in a negative sense? Have you been told negative things because you have a psychiatric diagnosis, or because of others' lack of knowledge about mental illness? If yes, could you tell me how it happened and how you felt about it?
6. Do you think there are any differences between prejudice and discrimination against mental illness in the past and those in the present? Do you think people know more about mental illness now than before?

The participants were also asked to talk freely about their experiences, feelings, and thoughts concerning stigma against mental illness. Interviews took between approximately 25–50 min, with an average duration of 38 min.

2.3. Data analysis

Interview data was analysed by employing the grounded theory approach (Corbin & Strauss, 2008). A recording of each interview was transcribed verbatim and read several times. Following this, the transcripts were divided into segments, with natural breaks as cut-off points for coding. Codes and categories were reviewed as the results of the analysis accumulated, and were accepted, modified, discarded, or replaced with new ones. Theoretical relationships between categories were examined by comparing them with one interview case, contrasting them across interview cases, and by reviewing analysis memoranda. Through clarifying these relationships, a core category emerged, namely 'living with the self that has changed because of mental illness itself and a psychiatric diagnosis label'.

After these analyses, a theory about the perception, management,