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COMMENTARY TO SPECIAL ARTICLE

Tackling the mental illness stigma in low- and middle-income countries: lessons learned from high-income countries and mistakes to avoid

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The stigma of mental illness and the discrimination experienced by people with mental health problems has been extensively studied in many countries across several continents (Lauber & Rossler, 2007; Abdullah & Brown, 2011; Stith, 2011). And, as reported by the overview of Semrau *et al*. (2015), there are virtually no societies or cultures in which people with mental disorders are as equally valued as people who do not experience these conditions.

Although the literature shows that participants in studies across the world express largely similar types of expectations from and experiences of the mental illness stigma, some cultural differences do exist (Miville & Constantine, 2007; Kohrt & Hruschka, 2010; Quinn & Knifton, 2014). Empirical evidence demonstrates differences in symptom expression and understanding of illness, and cultural influence has been noted in care seeking and public acceptance of the illness (Patel, 1995; Blignault *et al*. 2008; Carpenter-Song *et al*. 2010). In addition, initial findings suggest that there are also some differences in levels of perceived discrimination between high-income countries (HICs) and low- and middle-income countries (LAMICs) (Chung & Wong, 2004; Koschorke *et al*. 2014), with much lower rates of discrimination in LAMICs. This finding has been reported for both common (e.g., major depression; Oshodi *et al*. 2014; Lasalvia *et al*. in press) and severe mental disorders (e.g., schizophrenia; Thornicroft *et al*. 2009; Koschorke *et al*. 2014), regardless of diagnosis. A number of possible reasons may be put forward to explain this, including the nature of employment, the broader socio-economic context, the nature of community support, *the e*xplanatory models of mental disorders *and* self-attribution and strength and the diffusion of user movement (Lasalvia *et al*. in press). This seems to support the findings of early cross-cultural research on stigma, suggesting that the stigma of mental illness may be less marked in non-industrialised societies due to a more supportive environment with more social cohesion and therefore less risk of prolonged rejection, isolation, segregation and institutionalisation (Littlewood, 1998). This is also consistent with findings in the World Health Organization (WHO) collaborative studies, which reported better social outcomes for schizophrenia and related psychosis in LAMICs (Jablensky *et al*. 1992; Hopper *et al*. 2007), and the results of the studies were attributed to less stigmatisation of people with mental disorders who live in traditional societies (Rosen, 2006).

However, findings drawn from studies conducted in different cultural contexts are difficult to compare since research in this field has been conducted by using inconsistent and heterogeneous methodologies (e.g., qualitative research, ethnographic studies, population studies, interviews with key-informants and patients' first-person accounts). Moreover, cross-cultural research in this field has generally focused on attitudes of the general population towards mental health problems or towards people with mental health conditions (Tanaka *et al*. 2005; de Toledo Piza Peluso *et al*. 2008; Ting & Hwang, 2009; Sorsdahl & Stein, 2010) rather than on the ways in which behavioural consequences of the stigma (discrimination) are experienced by people with mental disorders themselves and how such processes affect their everyday lives (Oshodi *et al*. 2014).

Some recent international comparative studies assessed levels of anticipated and experienced

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discrimination among persons with schizophrenia (INDIGO schizophrenia) and major depressive disorders (ASPEN/INDIGO depression), in both HICs and LAMICs by using a consistent and standardised methodology (Discrimination and Stigma Scale, DISC). These studies report that experiences of discrimination are common and burdensome among people with mental health problems in both HICs and LAMICs. Multivariate analyses found that higher levels of perceived discrimination are associated with a number of individual characteristics (Thornicroft *et al*. 2009; Lasalvia *et al*. 2013). However, individual variables account for only a small fraction of total variance, thus suggesting that other additional variables that were not considered in the models, including contextual factors, should probably be taken into account. More recently a study conducted in the framework of the ASPEN/INDIGO depression (Lasalvia *et al*. in press) found that the context plays a relevant role in determining levels of reported discrimination among people with depression. Both experienced and anticipated discrimination widely differed across countries, with HICs displaying significantly higher levels of reported discrimination than LAMICs. Specifically, a sort of 'dose-effect' relationship was found between levels of anticipated discrimination and degree of socio-economic development, with levels of anticipated discrimination being progressively higher in parallel with levels of countries' human development as measured by the UN Human Development Index (UNDP, 2010); this difference remains significant also after having taken into account a full range of individual variables in multilevel analyses (Lasalvia *et al*. in press).

This is an interesting finding since anticipated discrimination (which occurs when a person limits his own involvement in important aspects of everyday life due to the expectation of being discriminated against) is the more subtle and severe form of discrimination due to the consequences it has on people's lives. Anticipated discrimination is closely related to self-stigmatisation (i.e., a process of internalising mental illness and formulating prejudice and discrimination against oneself) and it may take place also independently from actual experiences of discrimination (Thornicroft *et al*. 2009; Lasalvia *et al*. 2013). Anticipated discrimination and self-stigma usually trigger a vicious cycle that limits the life opportunities of people with mental disorders: in fact, due to anticipated discrimination, they may progressively withdraw from social and occupational activities and give up important life goals. As a result, these people may decide not to engage in opportunities that would hasten work, housing and other personal aspirations (the 'why-try' effect; Corrigan *et al*. 2009). It therefore seems that the context – as a reflection of social norms and values that are typical of a given socio-cultural group – matters in hindering people with mental health problems from involving themselves in a number of important life activities, with a more relevant impact being on those living in HICs.

It sounds somewhat paradoxical that, despite the growing efforts of national and international organisations and the increase of funding and resources employed in anti-stigma campaigns launched over the last decades in HICs (both at international, national and local levels), discrimination experienced by people with mental health problems is still considerably higher in HICs with respect to the less-resourced LAMICs (where anti-stigma campaigns are scanty or non-existent).

There may be something wrong with (or at least ineffective in) the content of the core messages conveyed by anti-stigma campaigns. The assumption that underlies most anti-stigma campaigns in HICs is that educating people about mental disorders and their biological basis (i.e., 'mental illness is a disease like any other') may eventually lead to the improvement of their attitudes towards people with mental health problems. Indeed, the majority of people in HICs nowadays tend to attribute mental disorders to neurobiological causes (Pescosolido *et al*. 2010): the percentage of the general public who endorse this view has steadily increased over the last 15 years, in parallel with the spread of the message launched by most anti-stigma campaigns worldwide that claim that 'mental illness is a disease like any other'.

However, social distance and the perceived danger associated with people with mental health problems has not decreased significantly over the same period in both Western Europe (Angermeyer & Matschinger 2004; Angermeyer *et al*. 2009) and the USA (Pescosolido *et al*. 2010). Therefore, holding a neurobiological conception of mental disorders seems to be ineffective in changing the stigma, and when the stigma is associated with the neurological basis, the effect of the association seems increase, not decrease, community rejection (Read 2007; Angermeyer *et al*. 2014). Because the public holds a tacit understanding of the aetiology of mental illness, our efforts need to move past this message. Probably the time has come to revise and reframe the content of the messages of anti-stigma campaigns. Reconfiguring stigma reduction strategies in HICs may require providers and advocates to shift towards competence and inclusion (Pescosolido *et al*. 2013).

The traditional messages conveyed by 'Western' anti-stigma campaigns ('mental illness is a disease like any other'), whose efficacy is at least questionable in HICs, may be totally ineffective (or dangerous) in other contexts, such as some LAMICs, where the societal structure is *sociocentric*: primary emphasis is on social relations and a range of conventions, rules and roles that tend to sustain long-term relationships and make isolation unusual even for the most disabled of people. The risk is that together with the 'globalisation' of Western psychiatric paradigms (both in terms of causal explanations and treatment approaches) (Watters, 2010), HICs also export the structure of anti-stigma programmes that are based on values and assumptions that may be conceptually valid (though not completely effective) only in their own contexts. We should be careful because the homogenisation of paradigms and healing processes may contribute to the loss of diversity of different understandings surrounding mental illness. Cultural variations and beliefs about how to achieve mental health might disappear before we can identify their value, and this would represent a great loss.

For the time being, there is still insufficient evidence on which types of intervention may be effective and feasible in LAMICs and how best to target key groups and how far they may need to be locally customised to be acceptable for large-scale use in these settings (Semrau *et al*. 2015). More research is still needed to understand what really works in a given cultural context. The few existing data suggest that the extrapolation of 'Western' interventions to LAMICs is neither feasible nor advisable. International organisations, such as the WHO, and transnational research networks should aim to promote the development of context-specific anti-stigma interventions based on natural facilitators, cultural influences and other potential resources already existing in LAMICs.

There are specific factors within LAMICs that may contribute to the favourable implementation of anti-stigma projects:

> '(a) communities that are more able to tolerate and protect people with mental disorders; (b) social solidarity by offering work opportunities in local businesses (e.g., tribal or village associations in Latin America); (c) participation in traditional and religious healing rituals such as musical rituals in Sudanese culture; (d) more flexible job requirements (e.g., agrarian work within rural China); (e) family and extended kinship or a communal network to support individuals with a mental disorder (e.g., kinship ties in Ethiopia and Tanzania); (f) attribution of cultural or spiritual value to psychotic experiences such as visions, or what might be interpreted as prophetic encounters (e.g., Uganda)' (Mascayano *et al*. 2015, pp. 2–3).

Professionals and researchers involved in researching the mental illness stigma should be aware of the wealth of informal and societal resources in LAMICs and should tailor context-specific anti-stigma programmes by carefully taking those resources into account.

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