The Stigma of Mental Health Problems. A Cross-sectional Study in a Representative Sample of Spain

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Abstract

Background. Mental health stigma is a relevant phenomenon with implications for the people who suffer from it. Despite its importance, no studies have been carried out in Spain at national level with a representative sample of the population.

Aims. The aim of this research is to analyze the stigma associated with MHPs in a representative sample of the Spanish population for the first time.

Method. A cross-sectional quantitative descriptive study was carried out with a representative sample of the population ($N = 2746$). Descriptive analyses and regressions are carried out on the different dimensions of stigma such as attitude, attribution and intention of social distance.

Results. Medium levels of stigma are obtained in stigmatizing attitudes and attributions, and medium-low levels in the intention of social distance. The best predictors of stigma in its different dimensions are attitudes, attributions and intention of social distance themselves. Progressive political ideology is related to less stigma in all dimensions. Knowing someone with mental health problems and talking openly about it together with higher education are also relevant protectors. Mixed results are obtained regarding age, gender and help-seeking.

Conclusion. National programs and campaigns focused on attitudes, attributions and behavioral intentions are necessary to reduce the stigma still present in Spanish society.

Keywords: stigma, social stigma, attitudes, general population, mental health, psychological problems

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Stigma associated with mental health problems (MHPs) can be understood as a dynamic process of social construction, which refers to negative cognitions, emotions and behaviors towards people with a diagnosis (Ottati et al., 2005). Moreover, this stigma is articulated on different levels that constantly interact with each other (Corrigan & Watson, 2004), distinguishing between structural stigma, which exists in laws and institutions; personal stigma, such as the stigma felt by each person; and social stigma, the subject of the present research, which includes the beliefs of the general population and of different social groups.

MHPs stigma has gained increasing interest in recent years, and different studies have shown that, in general, despite the growth of mental health literacy, this does not translate into improved social acceptance (Angermeyer & Schomerus, 2017). Beliefs of dangerousness, incompetence or guilt are still present in society, leading to effective discrimination, intention of social distance and authoritarianism towards people with MHPs (Angermeyer & Dietrich, 2006; Angermeyer & Schomerus, 2017; Parcesepe & Cabassa, 2013; Tzouvara et al., 2016).

Different systematic reviews have focused on the research on stigma in different countries or cultures, highlighting particular characteristics of the phenomenon. For example, in the United States, perceptions of dangerousness were significantly associated with social distance, (Parcesepe & Cabassa, 2013), while in Latin America the influence of family, dignity and respect, or even gender, is emphasized (Mascayano et al., 2016). In Asia, the presence of common elements in several countries is pointed out, as well as the importance of stigma in the request for professional help (Kudva et al., 2020), the need to support families (Nine et al., 2021) and to develop anti-stigma campaigns (Ando et al., 2013; Gurung et al., 2022).

In the European context, Tzouvara et al. (2016), in Greece, highlight the presence of stigma in moderate and high proportions in various population groups. Hellström et al. (2022) point out how in the Nordic Countries studies focused on the system, and interventions to reduce stigma are scarce. While in Germany, it is highlighted that, although there has been an increase in mental health literacy and acceptance of professional help, no improvement in attitudes is observed (Angermeyer &

Schomerus, 2017). In Spain, a recent review (Zamorano et al., 2023) found similar results to other European countries, with controversial results regarding gender and higher levels of stigma in older people.

However, despite the importance of MHPs stigma, studies carried out with representative national samples are relatively scarce. In the United States, a national survey highlights the neurobiological conception of MHPs as a stigma-generating perspective (Pescosolido et al., 2010). In comparison, with data from the Pacific Islands, greater stigma was reported there, probably making it more difficult to seek professional help (Subica et al., 2019). There are also studies with representative populations from Australia, noting the possibility of improving knowledge about MHPs, but also the difficulty in recognising them (Reavley & Jorm, 2011). In Europe, it is necessary to cite the English Time to Change campaign, which together with the English health surveys, has provided information on attitudes and behaviors towards MHPs since 2009 (Evans-Lacko et al., 2014; González-Sanguino, Potts, et al., 2019; Ilic et al., 2014; Sampogna, Bakolis, Evans-Lacko, et al., 2017; Sampogna, Bakolis, Robinson, et al., 2017). Over time slight improvement in knowledge, attitudes and intention of social distance (Henderson et al., 2020) is shown, highlighting the importance of geographical settings rather than individual socio-demographic characteristics (Bhavsar et al., 2019). Other national studies are developed in Germany, revealing the impact of labelling on attitudes (Angermeyer & Matschinger, 2003, 2004). As well as a national study in Sweden, which evaluates the usefulness of an anti-stigma campaign over time, showing improvements in knowledge about MHPs (Hansson et al., 2016).

In Spain, it is possible to cite the Catalan Health Survey, which linked to the Obertament campaign (Rubio-Valera et al., 2016), found medium-low levels of stigmatization in the representative population of this area (Aznar-Lou et al., 2016). However, these studies are limited exclusively to the Catalan territory and population, and to date there has been no research on stigma carried out with a nationally representative sample in Spain.

In view of the above, the aim of this research is to analyze the stigma associated with MHPs in a representative sample of the Spanish population for the first time. To this end, an evaluation of the different stigmatizing attitudes and attributions towards MHPs was carried out together with

several sociodemographic variables, analyzing the main predictors of social stigma of the Spanish population towards MHPs.

Methods

Sample

The final sample had a size N = 2,746 people, composed of the general population over 18 years of age. The sampling conditions guarantee a confidence level of 95.5% and p = q = 50%, the error is ±1.88% for the total sample, ±10% for communities with 100 cases, ±8.16% for 150 cases and ±5.76% for 300 cases. Quotas by sex and age group are included, as well as data for each of the 17 Spanish Autonomous Communities (AC) by simple allocation, ensuring a minimum of 100 surveys per AC.

Procedure

The results presented in this study are part of a broader investigation on the assessment of stigma of various conditions (Zamorano et al., 2022), carried out by the Chair Against Stigma of the Complutense University of Madrid and Grupo 5. A Computer Assisted Web Interview (CAWI) was conducted on a representative sample of the Spanish population obtained through consumer panel methodology. For the design of the survey, a qualitative assessment of stigma was carried out through in-depth interviews with people with MHPs in order to find out the most relevant issues and to be able to introduce questions that were important for the people who suffer from MHPs themselves. In addition, a review of previous literature on stigma assessment at the national level was carried out in order to select similar instruments and thus favour the comparison of results (Aznar-Lou et al., 2016; Hansson & Björkman, 2005; Ilic et al., 2014). Assessments were conducted from January 19 to February 8, 2022, via email contact from company Grupo Análisis e investigación. The average time to complete the evaluation protocol was around 20 minutes. All results obtained are processed in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of personal data. Prior to completing the assessment, information about the study was provided and informed consent was requested, although participation in the study was anonymous. The study was approved by the Deontological Commission of the School of Psychology

of the Complutense University of Madrid (Ref. 2020/21-026) and was registered in Clinical Trials (NCT05174962).

Variables and Instruments

Sociodemographics

Ad hoc questions on socio-demographic data were collected: age; gender (male, female, non-binary/rather not to answer); educational attainment (no studies, primary; secondary, university); size of place of residence (≥ 500,000, 100,000-500,000, 20,000- 100,000, < 20,000); political beliefs (conservative, middle, progressive); employment status (unemployed, unpaid housework, student, retired, employee, self-employed or entrepreneur, permanent disability, others).

Contact with MHPs

Three *ad hoc* yes-no questions on the level of contact with mental health: "Have you ever consulted a specialist for mental health problems?"; "Do you currently live with or have you ever lived with a person with a mental disorder?"; "Do you currently know or have you ever known a person (friend, neighbour, partner, etc.) with a mental disorder?".

Disclosure of MHPs

Ad hoc question, regarding who would you be willing to talk to about your mental health problems: "When I have had a mental health problem, or if I had one in the future, who would I talk to". The alternatives were: "I would discuss it openly with everyone"; "I would discuss it with people I trust (friends, work colleagues, etc.)"; "I would discuss it with my psychologist"; "I would discuss it with my psychiatrist"; "I would discuss it with my family doctor"; "I would discuss it with my closest family members"; "I would try not to tell anyone".

Attitudes towards MHPs

Attitudes towards mental disorders were assessed by means of the Community Attitudes to Mental Illness (CAMI; Taylor & Dear, 1981) in its Spanish version (Ochoa et al., 2016). In this case, the 12-item Likert-type version (1-5) was used. The 12- item version has been used in previous national studies assessing mental health attitudes (González-Sanguino, Potts, et al., 2019; Ilic et al., 2014; Sampogna, Bakolis, Evans-Lacko, et al., 2017). A recent publication has also revealed the reliability and construct validity of the instrument 40 years after its publication (Bernadàs et al.,

2022). The total score is calculated by adding together each single item. Scores are corrected so that a higher score indicates greater stigma. Cronbach's alpha for this sample was .784.

Attributions Towards MHPs

Attributions about stigma in mental health problems are assessed using the Attribution Questionnaire-9 (AQ-9; Corrigan et al., 2014), a shortened 9 items version of the Attribution Questionnaire-27 (Corrigan et al., 2003). The AQ-27 has a Spanish version (Muñoz et al., 2015) and the shortened version of it has been used in several studies (González-Domínguez et al., 2019; González-Sanguino et al., 2021; González-Sanguino, Muñoz, et al., 2019).Through the initial presentation of a fictitious character in a vignette, 9 stigmatizing attributions towards people with mental health problems are assessed using Likert-type items (1-9): responsibility or guilt, anger or rage, dangerousness, fear, help, coercion, segregation, avoidance and pity or sorrow. The minimum score for each dimension is 1 and the maximum score is 9. In the total score the minimum score is 9 and the maximum score is 81. In all cases, a higher score indicates greater stigma. Cronbach's alpha for this sample was .733.

Social Distance Intention

Future intention to have contact with people with MHPs is analyzed using the Reported and Intended Behaviour Scale (RIBS; Evans-Lacko et al., 2011). This scale has been used to assess the intention of social distance in previous national studies (González-Sanguino, Potts, et al., 2019; Ilic et al., 2014; Sampogna, Bakolis, Evans-Lacko, et al., 2017) and in the Spanish context (Aznar-Lou et al., 2016; Rubio-Valera et al., 2016). In this study, the scale is adapted using three of the four original items, asking about future intentions to live with, have friendships with or let children associate with people with mental disorders (Likert-type 1-5). The minimum score was 5 and the maximum score was 15. Scores are corrected so that for all three dimensions and the total, a higher score indicates greater stigma. Cronbach's alpha for this sample was .853.

Data Analysis

Descriptive statistical analyses of socio-demographic data, variables of contact with and disclosure of MHPs are carried out. In relation to gender, only 8 respondents said they did not feel represented by the category of male or female, so, due to the low representativeness and impossibility

of performing statistical analysis with such a limited number of respondents, their information has been analyzed qualitatively and is not included in this work.

Descriptive statistics were reported in relation to the sociodemographic variables and main results in the variables assessing stigma. Three hierarchical regression models were adjusted, with each measure (CAMI, RIBS, and AQ-9) serving as the dependent variable. Theoretical related variables were selected as predictors and introduced using a block-wise selection approach. In the first block, the other two psychometric measures (e.g., RIBS and AQ-9 when CAMI was the dependent variable) were added. In the second block, the remaining sociodemographic predictors were introduced. The forward method was used to select predictors within each block. The assumptions of multiple linear regression were met for all three models. All predictors exhibited a linear statistical and/or theoretical relationship with each dependent variable, satisfying the linearity assumption. The Durbin-Watson statistics ranged between 1.5 and 2.5, indicating independence of the residuals. Residuals of the regressions were normally distributed, satisfying the assumption of multivariate normality. Variance Inflation Factor (VIF) values were below 10, indicating no multicollinearity issues. Lastly, plots of standardized residuals versus predicted values showed that points were uniformly distributed across all values of the independent variables, indicating homoscedasticity. SPSS 25 was used for data analysis. Significance level was set at .05 for all analyses.

Results

Sociodemographic Characteristics, Contact with and Disclosure of Mental Health Problems

The sample consisted of 2746 people with a mean age of 46 years (*SD* = 15.7), ranging from 18 to 89 years. There was a slight majority of women (54.3%), the majority reported university (47.4%) or high school (46%) studies, lived mainly in large cities (48.9% resided in cities with more than 100,000 inhabitants), being employed (63.1%) and reported a progressive (47.2%) or centrist (37.9%) political ideology. Regarding contact with mental health problems, 21% of the people in the sample had consulted, at some time, a mental health specialist, 63.9% knew someone with such a problem and 21.7% lived or have lived with a person with mental health problems. Regarding disclosure of mental health problems, 40.2% would talk about it with people they trust, 38.2% would talk about it with a health professional (16.5% with a psychologist, 6% with a psychiatrist and 15.7%

with their family doctor) and 13% would talk about it with their closest relatives. Table 1 shows the results in detail.

Attitudes, Attributions, and Intention of Social Distance

Attitudes assessed using the CAMI revealed medium-low scores on the total instrument, ranging from 12 to 60, $M = 27.54$, $SD = 7.12$. Regarding stigmatizing attributions assessed with the AQ9, the scores ranged from 9 to 81, $M = 40.03$, $SD = 10.11$, indicating medium levels of stigma in terms of attributions regarding people with mental disorder. Regarding intention of social distance (RIBS), the scores ranged from 3 to 15, $M = 7.23$, $SD = 3.06$, indicating a medium-low social distance intention, occurring in all three social distance conditions assessed. Table 2 shows these results in more detail.

Regression Models

The regression model predicting CAMI total scores (Table 3) included nine predictors in the final step. The two variables in the first block accounted for 37.7% of the variance in CAMI scores. In the second block, seven more predictors increased the variance accounted for to 43.5%. CAMI scores were positively related to RIBS and AQ-9 scores. Lower stigma, as measured by the CAMI, was associated with several factors, including having a more progressive political ideology, knowing someone with mental health problems, being willing to discuss mental health problems with a trusted individual, seeking help from a mental health specialist for mental health problems, having a university education, being younger, and being female.

The regression model for AQ-9 total scores (refer to Table 4) included nine predictors in the final step. The two variables in the first block accounted for 27.7% of the variance in AQ-9 scores. In the second block, seven more predictors increased the variance accounted for to 29.3%. AQ-9 scores were positively related to CAMI and RIBS scores. Lower stigma, as measured by the AQ-9, was associated with several factors, including having a more progressive political ideology, being willing to talk about MHPs openly with everyone, being willing to talk about MHPs with a close person, and having elementary studies (compared to no studies). On the other hand, higher stigma was associated with being female, being an employee (compared to being unemployed), and having seen a specialist for MHPs.

The regression model predicting RIBS total scores (see Table 5) included eight predictors in the final step. The two variables in the first block accounted for 27.7% of the variance in RIBS scores. In the second block, six more predictors increased the variance accounted for to 30.1%. RIBS scores were positively related to CAMI and AQ-9 scores. Lower stigma, as measured by the RIBS, was associated with several factors, including knowing someone with mental health problems, currently living with someone who has mental health problems, and having a more progressive political ideology. In contrast, higher stigma was associated with being self-employed or an entrepreneur, being younger, and being retired (compared to being unemployed).

Discussion

The present research focuses on social stigma in the Spanish population. Particularly noteworthy is the high level of contact of the Spanish population with MHPs, where more than 20% had experienced a problem at personal level and between 21% and 65% had or had had close contact with MHPs. However, despite these data, MHPs still seems to be a taboo subject, as less than half of the people evaluated would talk about it with people they trust (40.2%) or health professionals (38.2%), and only 13% of people would talk about it with close family members. These data seem to reflect the lack of normalization in society on this issue, in line with the difficulties in seeking professional help found by other studies (Subica et al., 2019).

In terms of attributions and attitudes, the results show that in general the levels of stigma in the Spanish population are medium, together with medium-low levels of social distance intention. These results are similar to those found in Aznar-Lou's study in Catalonia (2016), although in that case the presence of authoritarian attitudes was highlighted to a greater extent. Also the intention of social distance seems to be slightly lower than in other international studies (Pescosolido et al., 2010; Tzouvara et al., 2016). This small discrepancy may account for differences in stigma depending on the geographical setting within the same country (Bhavsar et al., 2019). Or they may reveal a slight trend of positive change towards greater openness (Zissi, 2022).

The regression models on attitudes, attributions and intention of social distance show that the best predictors are the attitudes, attributions and behavioral intentions themselves, explaining between 29% and 38% of the variance in each of the models. These results support the findings of a recent

review which shows the importance of working on stereotypical beliefs about MHPs, affective responses to them and behavioral intentions in reducing stigma (Na et al., 2022). As well as explain the usefulness of media campaigns and interest group interventions focused on these variables rather than sociodemographic characteristics of the population (Gronholm et al., 2017). Additionally, the progressive political ideology is also found as a stigma protector for either attitudes, attributions and behavioral intention. This is consistent with previous research in the US, with a longer tradition of studying of these variables, and where political conservatism and right-wing authoritarianism have been found to be related to greater stigma (DeLuca et al., 2018; DeLuca & Yanos, 2015). The connection between conservative political ideology and stigma has also been found in Europe, with more equitable political tendencies to Spain. For example, in western societies liberal values seem to be in conflict when dealing with people with MHPs (Schomerus & Angermeyer, 2021). And in Sweden a more conservative ideology and conservative party affiliation showed more stigmatizing attitudes toward depression (Löve et al., 2019).

In relation to the sociodemographic variables, the results show that in general, knowing someone with a MHP, talking about MHPs and a higher level of education are protective factors against stigma in its different manifestations. This is consistent with previous research, which point to education as a protective factor as well as the importance of social contact (Aznar-Lou et al., 2016; Hansson & Björkman, 2005; Zamorano et al., 2023). In addition, mental health talk and discourses of disclosure have previously been shown to be key to reducing stigma in both theoretical models and intervention programs (González-Sanguino, Castellanos, et al., 2021; Rüsch et al., 2019; Sampogna, Bakolis, Evans-Lacko, et al., 2017). On the other hand, and in relation to employment, the results show that having a job was a predictor of worse attitudes, while being self-employed or an entrepreneur was related to worse behavioral intentions. This last result is relevant, since these individuals hire personnel, which could have repercussions for the labor market inclusion of individuals with MHPs (Brohan & Thornicroft, 2010). Additionally, some contradictory results were found with respect to certain sociodemographic variables such as age, gender and help-seeking, acting sometimes as predictors of stigma and at other times as protectors. These results are contrary to those found in other studies in Catalonia, where being female and younger was associated with less stigma

(Aznar-Lou et al., 2016; Rubio-Valera et al., 2016). However, other research has pointed out the lack of consistency in relation to stigma in these variables in Spain and internationally (Bradbury, 2020; Zamorano et al., 2023).

The present research has several limitations. Firstly, it should be noted that, although the sample was representative of the Spanish population, it is possible that certain groups were not fully represented, such as people living in rural areas, young people or those over 65 years of age. In addition, the sample did not guarantee the territorial representativeness of the country, so that the presence of stigma was not analyzed according to the Autonomous Community or region. On the other hand, although the study included valid and reliable measures, it should be pointed out that some instruments have not yet been validated in Spanish despite having been used on numerous occasions. Difficulties have also been encountered in the comparison with other studies, mainly due to the differences in the reporting of the results, as well as the different ways of coding and expressing the scores of the instruments.

This study is the first to analyze stigma in a representative sample of the Spanish population. The results indicate average levels of stigma, as well as the importance of attitudes, attributions and social distance as key variables when intervening on stigma. As sociodemographic variables, political beliefs stand out, as well as education, contact and talking about MHPs. Actions aimed at improving attitudes and attributions, resulting in less effective discrimination, are necessary. Proven effective national-level intervention programs and campaigns (Gronholm et al., 2017) together with structural-level policies and actions aimed at protecting human rights (Schomerus et al., 2022) regardless of the political framework for action are needed in Spain to improve social stigma.

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Declaration of Conflicting Interest

The Authors declare that there is no conflict of interest.

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