

Application of mental illness stigma theory to Chinese societies: synthesis and new directions

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ABSTRACT

The rapidly-evolving literature concerning stigma towards psychiatric illnesses among Chinese groups has demonstrated pervasive negative attitudes and discriminatory treatment towards people with mental illness. However, a systematic integration of current stigma theories and empirical findings to examine how stigma processes may occur among Chinese ethnic groups has yet to be undertaken. This paper first introduces several major stigma models, and specifies how these models provide a theoretical basis as to how stigma broadly acts on individuals with schizophrenia through three main mechanisms: direct individual discrimination, internalisation of negative stereotypes, and structural discrimination. In Chinese societies, the particular manifestations of stigma associated with schizophrenia are shaped by cultural meanings embedded within Confucianism, the centrality of “face”, and pejorative aetiological beliefs of mental illnesses. These cultural meanings are reflected in severe and culturally-specific expressions of stigma in Chinese societies. Implications and directions to advance stigma research within Chinese cultural settings are provided.

Keywords: Chinese, culture, discrimination, mental illness, schizophrenia, stigma

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INTRODUCTION

The emerging consensus that stigma is greatly associated with recovery from health conditions—and in particular, mental illnesses—has been the focus of several national and international programmes, such as the recent conference on stigma held by the National Institutes of Health in the United States,⁽¹⁾ and initiatives directed by the World Psychiatric Association⁽²⁾ and the National Alliance for the Mentally Ill.⁽³⁾ Policy recommendations

from the West, such as the United States' *Surgeon General's Report on Mental Health* (1999), highlights stigma as one of the most important barriers to effective recovery for persons with mental illness, and states that overcoming the effects of stigma is foremost to promoting the mental health of the general population.⁽⁴⁾

Recent research in Chinese societies, including those in Mainland China,⁽⁵⁾ Hong Kong⁽⁶⁾ and Singapore,⁽⁷⁾ identifies stigma as a prominent factor that has pernicious effects on individuals with mental illness and their families. Such negative effects include discrimination faced by individuals with mental illness and their relatives, in addition to help-seeking delay, underutilisation, and non-compliance with mental health treatment among mental health service users. It is believed that historical, cultural, philosophical, and religious values that are deeply held by people from Chinese societies, such as the importance of preserving “face”, contribute to severe forms of stigma and act as a significant barrier to accessing mental healthcare. To date, a great deal of theoretical and empirical work has emerged. These studies have attempted to operationalise the stigma construct and to specify the mechanisms by which stigma exerts its harmful effects on people with mental illness. However, there are presently no fully articulated applications of current stigma theories to illustrate how stigma processes may work among Chinese groups.

This paper addresses this need by first introducing several major definitions and models of stigma, and by specifying how these models provide a theoretical rationale to understanding how stigma broadly acts on individuals. It then describes how these stigma models have contributed to the development of current anti-stigma interventions. The paper then discusses how influences from Chinese sociocultural contexts may act through such stigma mechanisms to intensify devaluation and discrimination of people with mental illnesses. The paper focuses on the most severely stigmatised of mental illnesses, schizophrenia, as a case example for illustrating how stigma processes occur. The focus on schizophrenia is derived in part from the huge amount of empirical work in Chinese societies conducted, and available, within this group. Linking

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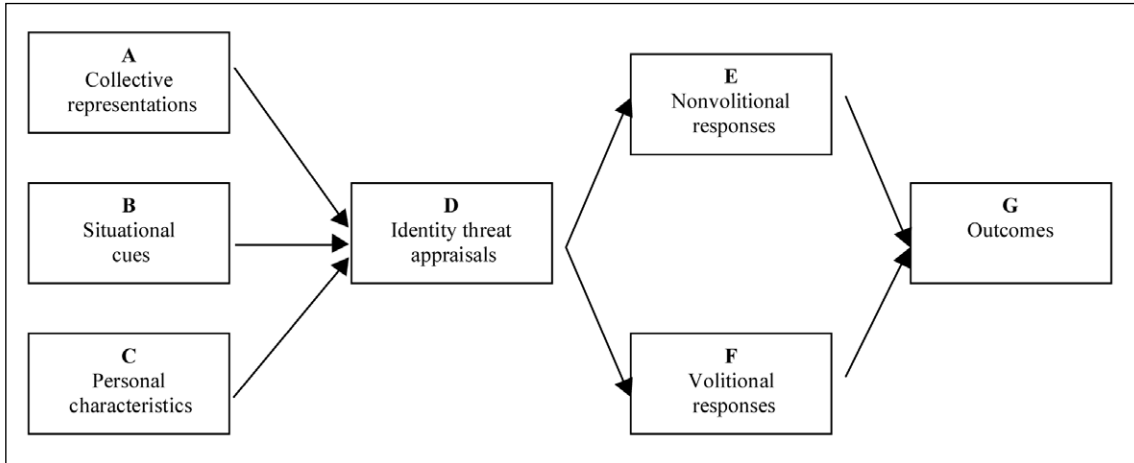


Fig. 1 An identity-threat model of stigma.

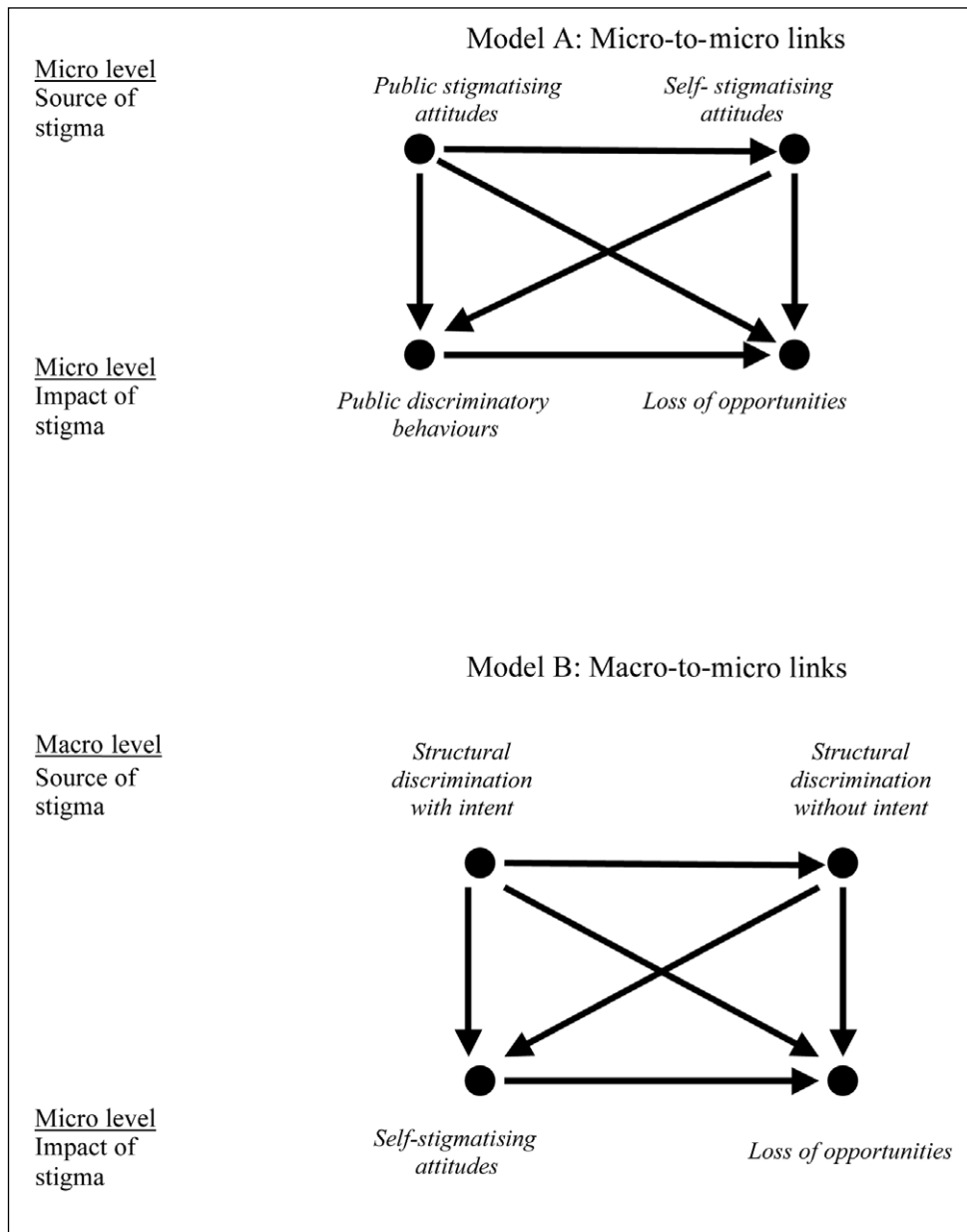


Fig. 2 Macro and micro levels of analysis in mental illness stigma and discrimination.

stigma theory to mental health outcomes within a particular psychiatric condition also enables a more in-depth discussion of how stigma processes and models can be applied to a specific diagnostic group.

DEFINING STIGMA

Since Goffman's seminal work, stigma has been identified as a social force that has profound consequences for stigmatised persons and their status in the social world. Goffman initially conceptualised stigma as a discrediting attribute that reduces the bearer "from a whole and usual person to a tainted, discounted one".⁽⁸⁾ The process of stigma has also been described as one where a deviant "mark" links the identified person to undesirable characteristics that discredit him or her in the eyes of others.⁽⁹⁾ The definition of stigma has recently been expanded from such an individualistic focus to incorporate a set of essentially social processes that links component concepts under one umbrella concept.⁽¹⁰⁾ Stigma is thus defined as occurring when human differences are labelled, stereotyping and cognitive separation of "us" from "them" occurs, and status loss and discrimination result in reduced life opportunities within the context of a power situation that allows these processes to unfold. The spectrum of emotional reactions that the stigmatiser (e.g., disgust) and the stigmatised (e.g., shame) experience has also been added as a key component to this process.⁽¹¹⁾ Rather than consider stigma to be a psychological process that is felt solely by the individual, this article seeks to consider how the stigma of mental illness manifests within Chinese communities in the context of the broader and multidimensional conceptualisation mentioned above.

MODELS OF STIGMA AND HOW STIGMA EXERTS ITS EFFECTS ON INDIVIDUALS

Several theorists from various disciplines have proposed models of how stigma affects the individual (for a more detailed review, see Reference no. 12). Two major social psychological models emphasise the internalisation of stereotypes as a key mechanism in mediating stigma outcome. In addition to the effects of direct discrimination felt by individuals, the first of these models emphasises maintenance of the integrity of self-esteem via the cognitive construction of social identities.⁽¹³⁾ In response to potentially damaging stereotypes, stigmatised individuals utilise cognitive strategies (e.g., using social comparisons with other individuals and social groups to enhance self-esteem) to avoid threat to personal or social self-esteem. The main outcomes in this stigma model are decreased psychological health (e.g., lowered self-esteem) and impaired role performance.

The second social psychological theory, while acknowledging the effects of direct discrimination, locates the stigma process primarily within an identity threat model (Fig. 1).⁽¹⁴⁾ Stigmatised individuals appraise potentially identity-threatening circumstances by considering collective representations of cultural stereotypes relevant to the self, and situational cues that signal the risk of being devalued; this appraisal is further modified by personal traits of the individual. Identity threat occurs when the demands of a stressor are appraised as exceeding the subject's resources to deal with this stress. Individuals may then respond to the perceived identity threat via involuntary responses (e.g., anxiety) or through cognitive coping responses that decrease threat to the self. The stigma outcomes identified by this model include effects on self-esteem, academic performance, and health.

A set of models specific to mental illness stigma also highlights the stigmatised individual's subsequent emotional and behavioural responses, in conjunction with cognitive internalisation of stereotypes, as critical to outcome.^(15,16) One prominent sociological model, termed "Modified Labelling Theory",⁽¹⁷⁾ begins with the notion that all members of a society internalise stereotypes of mental illness. These internalised conceptions comprise the degree to which all members of a society perceive that people with psychiatric illness will be: (1) devalued, and (2) discriminated against. These beliefs only gain personal relevance when official labelling takes place through contact with mental health treatment. One key difference from the two social psychological models is that in Modified Labelling Theory, labelled individuals, in addition to using cognitive coping strategies, may then respond *behaviourally* to anticipated social rejection. For example, individuals may cope through actions such as concealing one's treatment from others, withdrawing from social contact, or educating others about mental illness stereotypes. Harmful effects may arise from internalised conceptions of anticipated stigma (which may result in feelings such as shame) or from the stigma coping response enacted. Labelling thus negatively affects one's psychological state and social/vocational opportunities, which in turn may predispose labelled individuals to future psychiatric relapse.

One final model of stigma provides a unique focus on the structural sources of mental illness stigma and discrimination that originate from historical, socio-political, and economic forces (Fig. 2).⁽¹⁸⁾ Corrigan et al differentiated between two types of structural discrimination: (1) intentional institutional discrimination, where the decision-making group for an institution purposely enacts policies to restrict the rights of people with mental illness; and (2) unintentional

Table I. Stigma theories and the broad mechanisms of stigma.

Stigma mechanisms	Stigma theories		
	Social psychological	Sociological	Institutional
Individual discrimination	Emphasised	Emphasised	Not emphasised
Stigma through individuals themselves	Emphasised	Emphasised	Not emphasised
Structural discrimination	Not emphasised	Emphasised*	Emphasised

*Link et al (2001) includes a discussion of power in his definition of stigma,⁽¹⁰⁾ but Link et al's (1989) "Modified Labelling Theory" does not address how the use of power shapes how stigma actually works on individuals.⁽¹⁷⁾

institutional discrimination, when policies reduce life chances for such persons in an unintended manner.⁽¹⁸⁾ This theory emphasises that discriminatory policies which act systemically, rather than actions occurring on the interpersonal level, account mainly for the restriction in the rights and loss of opportunity that people with mental illnesses encounter.

STIGMA AND NEGATIVE PSYCHOLOGICAL OUTCOMES ON PEOPLE WITH SCHIZOPHRENIA

The above models provide a theoretical basis for understanding how stigma manifests and exerts its adverse effects on individuals. Each of the above models identifies elements of stigma that are critical to its manifestation, and each emphasises a different core element of the stigma process which impacts mental health. These key elements can be viewed as underlying the broad mechanisms by which stigma has been reported to affect people with schizophrenia (Table I). Three main mechanisms have been identified: (1) direct discrimination from individuals; (2) stigma enacted through stigmatised individuals themselves and; (3) structural discrimination.

Direct discrimination from individuals

As the social psychological models highlight,^(13,14) direct discrimination from individuals is the most readily observable mechanism in the stigma process. Research from Western societies, which are used to frame the existing stigma research in Chinese societies to be presented later, strongly corroborate that people with schizophrenia *experience direct discrimination from others* on the individual level. Such discrimination may impact health outcome as overtly as denying equal access to medical care.⁽¹⁹⁾ Yet people with schizophrenia also suffer psychologically from other forms of interpersonal rejection and discrimination. In one survey of 74 American outpatients diagnosed with a schizophrenia-spectrum disorder, 50% of respondents reported that they had "at least sometimes" been treated as less competent by others, and 42% of this sample reported similar frequencies of having been "shunned or avoided" when others

learned of their psychiatric treatment.⁽²⁰⁾ This type of directly experienced stigma has been shown to negatively impact both positive and negative self-esteem by affecting perceptions of mastery among a sample of schizophrenic outpatients.⁽²¹⁾ Sources of direct discrimination are also diverse; discrimination can stem from community members, employers, mental health caregivers, family members and friends.^(20,22)

Stigma enacted through stigmatised individuals themselves

Even more prominent among the stigma models^(13,14,17) are the effects that the internalisation of stereotypes have on, and the cognitive coping responses utilised by, stigmatised individuals, to counter these negative images. These mechanisms are utilised by people with schizophrenia *to further devalue themselves*. In public attitude surveys, the label, "schizophrenia", is commonly linked to pejorative stereotypes, ranging from "dependent on others" and "helpless",⁽²³⁾ to "dangerous to others" and "unpredictable".⁽²⁴⁾ The stereotype that people with schizophrenia are likely to commit violence against themselves or others is held pervasively by the public,⁽²⁵⁾ especially in relation to psychosis.⁽²⁶⁾ As a result of the prevalence and strength of these beliefs, when internalised, these negative stereotypes may be particularly damaging and difficult to modify.

The "Modified Labelling Theory" further specifies that the patient's behavioural response to anticipated stigma (e.g., through withdrawal or secrecy) can negatively impact life chances and result in adverse psychological and social outcomes.⁽¹⁷⁾ Several studies demonstrate that negative internal stereotyping, in conjunction with coping actions, predict mental health outcomes among people with schizophrenia. Increased endorsement of anticipated stigma and stigma-withdrawal (a specific coping response) has predicted decreased self-esteem among a sample of psychiatric outpatients at six- and 24-month follow-up, even after controlling for depressive symptoms.⁽²⁷⁾ Anticipated stigma and coping responses have also been found to predict depressive symptoms among this sample.⁽²⁸⁾

Structural discrimination

Recent definitions of stigma⁽¹⁰⁾ and Corrigan et al's stigma theory⁽¹⁸⁾ emphasise how structural forms of discrimination shape stigma outcome. People with schizophrenia encounter this type of discrimination *when institutional practices disadvantage stigmatised groups*, even when institutions do not intentionally enact this discrimination. Although structural discrimination towards people with schizophrenia has not been extensively studied, examples that can be highlighted include lower levels of research funding for schizophrenia and unequal treatment by health insurers towards people with psychiatric conditions, in comparison to those with physical afflictions.⁽²⁹⁾

STIGMA THEORY AND ANTI-STIGMA INTERVENTIONS

The above models of how stigma works have shaped current stigma-reduction strategies. Because of the fundamental role pejorative stereotypes play in both person-to-person discrimination and self-inflicted stigma, numerous anti-stigma efforts were initiated to diminish negative attitudes through public mental health awareness and education campaigns. Such informational programmes have utilised publicity materials, such as books, film, slides and other audiovisual media, to dispel false conceptions about persons with mental illnesses and to supply facts that challenge these misperceptions. Specific mental illness stereotypes can be targeted within such sessions. For example, one study demonstrated that a group receiving information about the base rates of violence in persons with psychiatric disorders (relative to other disorders) showed lower stigma than a group which did not receive such information.⁽³⁰⁾ While participation in such short psychoeducation programmes on psychiatric illness and treatment has led to improved attitudes among audiences ranging from university students, community members, adolescents, to people with mental illness,⁽³¹⁾ it appears that personal contact with a person with mental illness who moderately disconfirms a pre-existing stereotype acts as the key agent in these educational change programmes.⁽³²⁾

Accompanying these efforts in changing communal perceptions of the mentally ill, is an emerging focus on countering the self-inflicted effects of internalised stereotypes among stigmatised individuals. As noted earlier, stigma leads to negative psychological outcomes among the mentally ill, including lowered self-esteem, diminished self-efficacy, and greater depressive symptoms. Internalised stigma (or "self-stigma") may be conceptualised as negative self-statements and cognitive schemas that are derived from stereotypes prevalent within a cultural setting.⁽³³⁾ Cognitive-

behavioural therapies focused on modifying these schemas and reducing their effects on psychological health, such as focusing on a person's catastrophic interpretation of his or her symptoms and diagnosis of mental illness have been developed.⁽³⁴⁾ Personal empowerment of the mentally ill can be regarded as the positive benchmark to a continuum, in which the self-stigmatised represent the opposite end.⁽³⁵⁾ This empowerment can be initiated by actively engaging the patient in planning his or her treatment, and continued by gradually rebuilding self-esteem through the reintegration of the individual in terms of employment, housing opportunities and community life. The positive effects of these efforts become the countermeasure to the psychologically-damaging effects of internalised stigma.

Lastly, structural forms of discrimination have been shown historically to lead to disadvantaged circumstances for the mentally ill. To combat this, strategies that counter stigma have also been launched at the societal level. For example, several Western countries (including the USA) have included mental illness as a disability status that entitles a person to legal protection from many forms of discriminatory treatment.⁽³⁶⁾ In addition, consumer groups can collaborate to protest against acts of stigmatisation occurring in the public domain. Public pressure and consensus can serve as an impetus to legislation that offers equal protection to the mentally ill. Such measures include parity in insurance coverage for mental illnesses and the implementation of international human rights. Hence, while personal empowerment may counter internalised stigma at the individual level, collective undertakings are necessary to raise awareness and to combat stigma in the larger, institutional realm.

CULTURAL DEFINITIONS OF MENTAL ILLNESS AMONG CHINESE GROUPS

A critically-neglected area of inquiry in stigma research is how definitions and cultural forces produce particular patterns of stigma that shape and impede recovery from mental illness. The degree of stigma attached to an illness depends on its features, how the illness is symbolically interpreted by the particular culture, and the impact it has on the individual's social identity.⁽³⁷⁾ Prevailing sociocultural views on mental illness is essentially a reflection of the society's religious, political and kinship beliefs. Viewing stigma in light of these contextual elements necessitates a shift from an individual perspective to how stigma is intertwined with social forces and enacted in everyday life.

Due to these cultural and sociopolitical influences, stigma against mental illness in Chinese societies has been assessed as especially damaging and pervasive.⁽³⁸⁾

One key cultural and philosophical influence that has guided important aspects of Chinese social behaviour for over two millennia is Confucianism.⁽³⁹⁾ A central tenet of this philosophy states that each member of society is obligated to follow the clear moral demands that define an individual's role and actions in relation to others. Complying with these roles and actions are prerequisites to achieving personal harmony. When these obligations are neglected, personal and social disharmony occurs. Thus, the perceived unpredictability of the mentally ill is viewed with extreme disfavour and social sanction, because it threatens to violate the Confucian principles governing social order and harmony.⁽⁴⁰⁾

The cultural norm of “face” is also critically intertwined with stigma against the mentally ill in Chinese societies. Social interaction in Chinese groups is organised by a strict network of social relations (*guanxi*), of which maintenance is dependent on the reciprocating of favours (*renqing*).⁽⁴¹⁾ The returning of favours is directly connected to face (*mianzi*), which is central to social identity, and is representative of power and standing in the Chinese social hierarchy.⁽⁴²⁾ The diagnosis of schizophrenia results in a “loss of face” for the individual; he or she is deemed “faceless” or powerless to engage in social interaction.

The shame of an individual due to the onset of mental illness may be experienced strongly by family members, as “loss of face” occurs not just to the ill person, but may also be borne by all associated family members. This is largely due to widespread aetiological beliefs about psychiatric illness in Chinese societies, which ascribe a moral “defect” to sufferers and their families. Traditional Chinese beliefs suggest mental illness is a punishment for an ancestor's misconduct.⁽⁴³⁾ Psychosocial stressors—especially conflict in family relationships—are seen as having a causal role in the onset of schizophrenia.⁽⁴⁴⁾ Furthermore, common beliefs about the hereditary nature of mental illness implicate the family as pathogenic.⁽⁴⁵⁾

These social and cultural processes shape and create the ethnocentric forms of stigma taken up and perpetuated in the everyday life the Chinese. Given the diversity of histories, cultures and modernisation among the various Chinese societies (including China, Taiwan, Hong Kong, Singapore and immigrants from these regions to other countries), there are also a host of other sociocultural influences (including increasing exposure to Western values and biomedical models), that may further affect and shape attitudes towards mental illness. The cultural norms described above—an enduring Confucian tradition, the centrality of “face” in social interaction, and the pejorative aetiological beliefs attached to mental illness—suggest that stigma against

the mentally ill in the various Chinese societies will manifest in severe and pervasive forms.

IMPLICATIONS OF CULTURAL DEFINITIONS ON STIGMA OUTCOMES WITHIN CHINESE SOCIETIES

Having examined the prevailing sentiment and beliefs towards the mentally ill, peculiar to the Chinese societies, it is now necessary to integrate these political and sociocultural forces into the propagation of stigma via the main psychosocial mechanisms discussed earlier on. Ethnocentric forces result in unique manifestations of direct discrimination, internalised stigma and structural discrimination.

Direct discrimination from individuals

In examining how patients and families experience direct discrimination from others, a substantial proportion of a sample of 1,491 family members of schizophrenic patients in Mainland China reported a “moderate” or “severe” effect of stigma on the patient and the family (60% and 28%, respectively).⁽⁴⁶⁾ Similarly, a significant percentage among a study of 320 schizophrenic outpatients in Hong Kong reported that they had been laid off after revealing their mental condition (44.5%) and that their family members had been treated unfairly due to their illness (41.1%).⁽⁶⁾ These rates of direct discrimination, particularly towards family members (which suggest that relatives suffer severe “social contamination” due to their familial link to patients), are as high or higher than rates reported in Western studies.^(22,47) These results imply that the ethnocentric social beliefs peculiar to Chinese communities shape discrimination against the mentally ill at the individual and familial level.

Stigma enacted through stigmatised individuals themselves

The cultural stigma attached to mental illness in Chinese societies also suggests the prevalence of highly pejorative stereotypes. Persons with mental illness are often perceived as dangerous and disruptive by the public.^(48,49) In one study of 1,007 community respondents in Hong Kong,⁽³⁸⁾ almost half of the sample described people with mental illness as “quick-tempered” and a significant proportion (28.9%) of respondents agreed that, “people who had been mentally ill are dangerous no matter what.” Similarly, in a comparative study of 176 Chinese respondents from Hong Kong and 163 non-Chinese respondents living in England,⁽⁵⁰⁾ the Chinese subjects were significantly more likely to endorse items emphasising unpredictability, such as, “At any time, a schizophrenic may ‘lose control’,” and “Many schizophrenics commit outrageous acts in

public places.” The results from the public attitude surveys suggest a Confucian desire to preserve social order, especially in the light of the general reaction to the perceived notion of unpredictability and dangerousness, which the mentally ill apparently possess. One comparative study reported that Chinese-born college students in the USA scored higher on Authoritarianism and Social Restrictiveness and lower on Benevolence (factors on the Opinions of Mental Illness Scale) towards persons with mental illness than did Anglo students.⁽⁵¹⁾ These extreme and negative stereotyping and social restriction in the Chinese community may then become internalised by people with schizophrenia in the manners specified by the social psychological stigma models,^(13,14) resulting in harmful psychological outcomes.

Internalisation of these negative conceptions of mental illness in Chinese societies may also lead to anticipation of social rejection and discrimination by the mentally ill. This hypothesis is supported by results from Lee et al’s study⁽⁶⁾ of 320 schizophrenic outpatients in Hong Kong where 69.7% of respondents agreed that their chance of being promoted at work would be affected by revealing their mental illness and 59.7% of respondents anticipated that their partner would break up with him/her if he or she were to reveal the illness. In addition, Lai et al, in their study of 72 schizophrenic outpatients in Singapore, found that 51% thought that neighbours and colleagues would avoid them if they were aware of their illness.⁽⁷⁾ According to the “Modified Labelling Theory”, such expectations will then predict the coping behaviours of the stigmatised individuals. The extremely high expectation of rejection by others in Chinese societies should lead the mentally ill to endorse secrecy as a predominant coping strategy over other forms (e.g., educating others that mental illness is like any other physical illness). Lee et al’s results corroborate this hypothesis; over 50% of respondents in their sample deliberately concealed their mental illness from coworkers and friends.⁽⁶⁾ The fears associated with exposing one’s mental illness were shared by relatives as well—59.6% of the patients reported that family members also wished to conceal the illness from others.

Concealing mental illness, although allowing patients and family members to avoid certain forms of stigma, may then result in other negative outcomes (such as loss of self-esteem from feelings of shame and failure to comply with treatment). Although such a causal relationship has not yet been subjected to rigorous empirical testing in a Chinese social setting, the available evidence suggests that stigma does produce such harmful effects; 38% of Lee et al’s outpatient schizophrenic sample reported “feeling bad about

concealing the illness” and 23% reported defaulting on psychiatric clinic visits as a form of concealment.^(6,52) 52% of Lai et al’s sample of outpatient schizophrenic patients in Singapore also reported lower self-esteem subsequent to illness.⁽⁷⁾ The last component of Link et al’s theory then predicts that such negative outcomes may increase susceptibility to future episodes of mental disorders. However, this final step of “Modified Labelling Theory” remains to be empirically tested with a Chinese sample group.

Structural discrimination

Lastly, the pejorative conceptions of mental illness embedded within Chinese culture may result in certain forms of institutional discrimination that lead to unequal treatment of people with schizophrenia. Lee et al, in the first study to systematically examine this topic in a Chinese setting (Hong Kong), revealed several aspects of psychiatric treatment received by a group of 320 schizophrenic outpatients that could be construed as institutional discrimination. Lee et al noted that only 15% of schizophrenic patients in Hong Kong receive new generation antipsychotic medications. This is an area of concern as conventional antipsychotic medication can cause perceptible dopaminergic system side effects, such as tremor or restlessness. This may contribute to the perceived strangeness of schizophrenic patients and further entrench stigma against them. The authors noted that cost-saving guidelines in Hong Kong restrict use of new generation antipsychotics to treatment-resistant patients, leading to a relatively small proportion of patients being treated with these preferred medications. Sizeable proportions of Lee et al’s sample also reported adverse experiences during psychiatric hospitalisation, including not being informed of the side effects of oral medications (60%), being cheated or threatened by staff into signing up for voluntary admission (26%), and enduring excessive physical restraints even when emotionally stable (21%). These instances of discriminatory behaviour by hospital staff occur during routine clinical practice, where pre-existing status hierarchies privilege social control the mentally ill. Furthermore, Lee et al observed that Hong Kong spends a mere 2% of its healthcare budget on psychiatric care (1996–1997 figures), which is a much smaller proportion than what the USA and UK spend (6% and 10%, 2002 figures), respectively. Collectively, these examples illustrate how structural factors can contribute to the manifestation of psychiatric stigma in Hong Kong.⁽⁵²⁾

In addition to existing discriminatory policies against people with psychiatric disorders, Chinese immigrants to another country may face additional structural inequalities due to their disadvantageous standing as a migrant citizen. Take, for example, the case of Chinese

who immigrate to the United States. One example of how discrimination has manifested at the institutional level of the U.S. includes the difficulties in gaining initial government funding to create community mental health centres equipped with adequate bicultural and bilingual services for Chinese immigrant groups.⁽⁵³⁾ The prior shortage of such agencies likely exacerbated earlier patterns of mental health service underutilisation in this population. Clinical anecdotes reveal another example. Although people with psychiatric illness in the U.S. are protected against discrimination by employers (including hiring and firing based on their psychiatric disability) by the Americans with Disabilities Act,⁽¹⁸⁾ Chinese immigrants who enter the U.S. illegally are offered no such protection and thus rely heavily upon secrecy to maintain employment.⁽⁵⁴⁾ A critically understudied area is how stigma interacts with, and compounds, other social inequities that an immigrant Chinese may face, such as lower socioeconomic status or lack of health insurance.

CONCLUSION

Utilising existing stigma theory in Chinese ethnic groups will encourage investigation of the context-specific processes by which stigma occurs, and the testing of relationships between theoretically-linked stigma constructs. Several future areas of examination include:

- 1) Because mental illness stigma has been conceptualised as a multidimensional construct,⁽¹⁰⁾ it becomes imperative to examine how ethnic and cultural influences affect its different components. Because stigma is multifaceted, certain aspects may act in a harmful manner within Chinese groups while other aspects may have neutral or conceivably even protective effects. Our attention thus shifts away from globally characterising stigma as “more severe” or “less severe” in Chinese community groups, and instead towards determining how specific stigma domains exert their effects on outcomes that may specifically impede recovery.
- 2) A considerable body of anthropological and sociological literature describes how cultural norms relevant to stigma operate, such as how “face” governs social interaction in Chinese societies.⁽⁵⁵⁾ Incorporating in-depth knowledge of such cultural processes with existing stigma theory would greatly illuminate how “loss of face” associated with mental illness stigma impairs patients’ and family members’ social functioning within their communities.
- 3) Expressions of stigma are critically intertwined with what Kleinman terms “moral experience”, or “what is most at stake” for participants in a local social world. From this perspective, it is necessary to examine how stigma is incorporated into lived

experience and the local worlds in which patients and families engage in everyday social interactions. Observation and measurement of how stigma occurs during everyday social activities among particular ethnic groups would enable us to examine how stigma impacts critical life domains in such groups and to devise distinct and culturally-appropriate anti-stigma responses. Work to integrate the concept of “moral experience” with existing stigma theory has recently begun.⁽¹²⁾

- 4) Because much of the existing stigma research on psychiatric illnesses in Chinese societies has targeted schizophrenia, other mental disorders, in particular major depressive disorder (MDD), have yet to be extensively investigated. Preliminary results from studies in Singapore suggest that stigma attached to MDD, when compared with schizophrenia, differs in form and intensity; for example, Kua et al found that 85% of their 189 general medical practitioner respondents thought that schizophrenic patients would be discriminated against by community members, while only 46% thought that patients with MDD would suffer such treatment.⁽⁵⁶⁾ Interestingly enough, the stigma experiences of people with these two diagnoses in Chinese contexts appear to differ, as only 28% of Lai et al’s sample of outpatients with MDD in Singapore feared social rejection,⁽⁷⁾ as opposed to 51% of the schizophrenic outpatients. Stigma towards people with MDD in Chinese groups may be further ameliorated or transformed by the tendency of such patients to somatise their depressive symptoms, which is seen as a culturally-acceptable idiom of distress.⁽⁵⁷⁾ How stigma in Chinese settings manifests towards people with MDD—and the social and psychological mechanisms utilised by individuals to avoid or transform this stigma—merits empirical attention.

In summary, application of stigma theory has a great deal to offer in terms of the novel conceptualisation, measurement, design of studies, and eventual implementation of anti-stigma interventions among Chinese communities. Furthermore, discovery of new mechanisms of how stigma works within Chinese communities will provide innovative perspectives on the local and universal manifestations of stigma, as well as new advances in theory.

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