WHAT MATTERS MOST': STIGMA TOWARDS SEVERE MENTAL DISORDERS IN CHILE, A THEORY-DRIVEN, QUALITATIVE APPROACH

ASPECTOS SOCIOCULTURALES DEL ESTIGMA HACIA LAS ENFERMEDADES MENTALES EN CHILE: UN ABORDAJE TEÓRICO Y CUALITATIVO

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Abstract

Background: Stigma towards severe mental illness manifests in different ways across cultures and only recently has a theoretical perspective emerged to understand such cultural differences. The 'What Matters Most' framework identifies culturally specific dimensions of stigma by identifying the interactions between cultural norms, roles, and values that impact personhood.

Objective: This study explores the cultural underpinnings that create and maintain stigmatizing attitudes towards severe mental illness in Chile.

Methods: In-depth interviews developed using the 'Scale of Perceived Discrimination and Devaluation', and the 'What Matters Most' framework were conducted with twenty people identified as having a severe mental illness. Interviews were coded and discussed until agreement was reached, then analyzed by an independent reviewer to determine inter-rater reliability.

Results: A key factor shaping stigma among women was the loss of capacity to accomplish family roles (i.e. take care of children).or men, cultural notions of 'Machismo' prevented them from disclosing their psychiatric diagnosis as a means to maintain status and ability to work. A protective factor against stigma for men was their ability to guide and provide for the family, thus fulfilling responsibilities attributable to 'Familismo'. Social appearances could play either a shaping or protecting role,contingent on the social status of the individual.

Discussion: In Chilean culture, stigma is rooted in gendered social characteristics and shared familial roles. Interventions should aim to address these norms and incorporate culturally salient protective factors to reduce stigma experienced by individuals with serious mental illness in Chile and other Latin American settings.

Resumen

Antecedentes: Estigma hacia la enfermedad mental se manifiesta en diferentes formas dependiendo de la cultura, sin embargo solo recientemente se ha desarrollado una perspectiva teórica para entender dichas diferencias culturales. El abordaje de 'what matter most' es capaz de identificar dimensiones culturalmente específicas relativas al estigma por medio de la identificación y extracción de las normas culturales, roles y valores que impactan la identidad de las personas.

Objetivo: El presente estudio explora los cimientos culturales que crean y mantienen las actitudes estigmatizantes hacia las enfermedades mentales en Chile.

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Métodos: Se desarrollaron 20 entrevistas en profundidad en personas con trastorno mental severo utilizando la 'Escala de Discriminación y Devaluación Percibida' y orientadas por el enfoque 'What Matter Most'. Las entrevistas fueron codificadas y discutidas hasta alcanzar grados de acuerdo apropiados, cuestión determinada por un revisor independiente que calculó el grado de acuerdo inter-jueces.
Resultados: Un aspecto clave para moldear la expresión del estigma entre mujeres fue la pérdida de la capacidad para cumplir con su rol de dueña de casa (i.e. cuidar de sus hijos), mientras en los hombres nociones culturales asociadas al 'Machismo' impidieron que ellos develaran sus respectivos diagnósticos psiquiátricos para mantener su estatus social y habilidad para trabajar. Por otra parte, un factor protector en contra del estigma en hombres fue mantener su habilidad para guiar y proveer a su familia, y así cumplir plenamente con las responsabilidades atribuidas al 'Familismo'. Finalmente, las apariencias sociales pueden jugar tanto un rol moldeador o protector en contra del estigma, y esto parece ser contingente al estatus social del individuo.
Discusión: Estigma se asocia a características sociales y roles familiares enraizadas en la cultura Chilena. Intervenciones deberían abordajes éstas dimensiones e incorporar aquellos factores protectores que son potenciales recursos para reducir el estigma hacia la enfermedades mentales en Chile y en otros contextos Latinoamericanos.

Keywords: Stigma, Mental Illness, Culture, Qualitative methods, Chile
Palabras clave: Estigma, Enfermedad mental, Cultura, Metodología cualitativa, Chile

Introduction

Overview

For a long time many investigators have explored the nature and significance of stigma. In his seminal work, Erving Goffman defined stigma as any attribute, trait or behavior of an individual that engenders deep devaluation and social exclusion [1]. According to Goffman [1], stigma arises from a perceived discrepancy between a virtual social identity—the features a person should possess as defined by their cultural "norms"—and actual social identity, or the attributes a person actually possesses. In line with Goffman, Bruce Link et al. [2] has suggested that stigma leads to negative consequences and proposed a "Modified Labeling Theory" to explain the actual processes that occur during the stigmatization of mental illness. According to this theory, language is a powerful cultural tool that grants human beings the opportunity to learn and internalize concepts regarding individuals with mental illness.y creating categories to organize our social environments, these conceptualizations quickly become transformed into labels, such as "dangerous", "weak", "unpredictable", and "crazy", which are subsequently used to classify groups of individuals and discriminate against perceived "others" in society [3]. The detrimental impact of stigma on individuals and communities is an indisputable reality worldwide, evident not only in the diminished psychological and emotional well-being of individuals and their family members, but is also present through reduced productivity creating social and economic consequences [4]. While stigma is a universal phenomenon, it appears to be an especially strong barrier to treatment access within low-and-middle income countries (LMICs) and among vulnerable members of the population including the poor, women, and ethnic minorities [5]. For instance, in India, people with schizophrenia have reported high rates of perceived stigma primarily from the community (46%) and from family members (42%) [6]. In Nigeria, a sample of people with major depressive disorder reported that concealment of mental illness was most common due to anticipated discrimination in this population [7]. Thirdly, in Ethiopia, 75% of relatives of consumers with psychiatric diagnosis (psychotic and mood disorders) reported they had experienced stigma due to their association with ill relatives and 37% wanted to conceal the relative's mental illness [8].

As stated by Yang et al. [9] the effects of stigma have varied throughout history and across cultures. Like all social processes, the cultural context in which it emerges shapes the way stigma is created, expressed, understood, and adopted by community members. For example, family is a key priority for

many Asian cultures, and stigma may impede a person with mental illness from getting married and extending their family lineage [10]. We also find this to be true in Latin America, where families might play a double role: providing emotional assistance to the family member with a mental illness, yet at the same time being overprotective and becoming the main source of discrimination [11]. Additionally, phenomena such as 'machismo' or a 'culture of honour' can affect manifestations of stigma in a gender based manner. Namely, women may be more stigmatized if they lose their capacity to fulfill familial roles, and men may hide their psychiatric diagnosis to avoid losing status and the ability to work [12].

What matter most (WMM)

Despite the importance of valid measurements to assess stigma, standard approaches have stunted the impact of anti-stigma programs for mental illnesses. In large part, the majority of stigma initiatives have focused on the development of global and standardized assessments under a "one-size-fits-all" approach. Often, forms of measurement are generated and validated in Western cultures (USA, UK), include samples of Western-European descent, and are rarely culturally and linguistically adapted for other contexts [13]. This tendency towards etic (or "outsider") approach to measurement has certainly lead to the development and widespread dissemination of various anti-stigma campaigns. However, the inherent failure to "account for the influence of emic, or "culturally-specific", concepts on measurement" has greatly limited their effectiveness in other contexts [13].

In response to this problem, Yang et al. [9] have developed a theory called 'What Matters Most' (WMM) that guides the development of more precise and accurate assessments to incorporate various culturally-specific dimensions of stigma and guide interventions to reduce the stigma experienced by people with mental disorders. Their formulation of culture includes "interactions that 'matter most' to individuals within a cultural group" and focuses on "local worlds [which] refers to a somewhat circumscribed domain within which daily life takes place" (pg. 1528) [9]. Yang and Kleinman believe that stigma impacts people with mental disorders primarily in their ability to fully participate in their unique local worlds—or engage in socially meaningful practices. As such, the integration of people in their "social world" appears to be contingent on whether they are able to participate in activities that grant them a full personhood status and community respect [9]. However, due to their circumstances, people with mental illnesses often "have something to gain or lose, such as status, money, life changes, health, good fortune, a job, or relationships" (pg. 1528) [9]. From this perspective, stigma can threaten participation and risk the loss of 'what is most at stake' in their culture—ultimately resulting in social exclusion from their immediate networks. Guided by this conceptualization, the "WMM" theory facilitates a deeper cultural analysis of the mechanisms by which stigma compromises this moral experience (according to cultural values and social norms).

The WMM framework has been used to assess perceived and self-stigma in Chinese-American consumers in New York City [14], to compare public stigma between German and Tunise populations [15], and also to characterize experiences of stigma and discrimination among people with schizophrenia in India [16]. It must be noted that the study by Koschorke et al. is one of the largest mixed-methods studies of stigma and discrimination faced by individuals with schizophrenia (n = 282) and caregivers (n = 282) in an LMIC setting. This study identified "what matters most" within India, which was related to meeting gender role expectations in regards to work and marriage (economic importance is further magnified in the context of frequent poverty), and adhering to codes of conduct and socially acceptable behavior as dictated by traditions of Dharma [16]. Therefore, the authors were able to suggest that messages to reduce public stigma in the Indian context might therefore be most effective if they promoted the possibility that individuals with schizophrenia can attain these role expectations signifying "what matters most" with proper supports, rather than messages aimed at generic stereotypes (e.g., "people with mental illness are not dangerous") [5].

Mental health in Chile

Since fifteen years the National Mental Health and Psychiatry Plan established a model of integrating mental health into routine (general) health care settings by aiding the development of community-based care with strong interventions rooted on primary care. Some researchers called this mental health reform as 'mental health revolution', becoming in a best practices model for other LMICs [17]. National programs concerning depression, bipolar disorders, first episode of psychosis and drug abuse have been launched from 2000 reporting positive results in terms of reducing mental symptoms, improving quality of life and adherence to treatment [18,19,20]. One of the key of this plan its progressive

implementation, resulting in an increased number of mental health facilities, with greater decentralization and better accessibility, and an improved community-based model of services [21].

Within this plan reducing stigma has been established as a major objective to promote the full social inclusion of people with severe mental disorders, along with strategies to improve the mental health status of Chileans. According to Minoletti "Chile has approved new regulations that contribute to the promotion, protection and recovering of mental health, and also to the rehabilitation, social inclusion and citizenship of persons with mental disability (p 11)" [22]. However, in the current national evaluation of mental health services, Minoletti et al. found that Chilean legislation does not fully recognize the rights of people with mental disability as indicated in the Convention of the United Nations, and also identified a serious increase of freedom restriction measures such as involuntary hospitalizations, physical restraint and seclusion [23].

In Chile very few studies of stigma have been conducted. Of note, Chuaqui [24] carried out a study assessing the effects of stigma on job attainment within mental health consumers. He found that 68% of employers believe consumers would perform poorly even on simple tasks and were perceived as dangerous, violent, unstable, and not very trustworthy. A second study in Chile by Vicente et al. [25] found that the "fear of the diagnosis" and "what others could think", both relating to stigma, were the most common reasons for not seeing a mental health worker. Lastly, the World Health Organization (WHO) conducted a study of the Chilean mental health system. It was discovered that stigma associated with mental illness presents itself as one of the greatest obstacles for the mental health system, in that individuals with mental illness are seen as incompetent, incapable of caring for themselves and managing their personal matters, as well as having the potential to be violent. Furthermore, this study found that many mental health workers partially or completely oppose the community model of services that is being implemented. Reason being that most workers were trained in hospital settings and have difficulty understanding the way in which the new system works, such as day hospitals and community mental health centers [26].

That being said, we believe that the socio-political climate and the direction mental health care is going in the country can facilitate future development of powerful anti-stigma campaigns on local and national levels. Our study incorporating WMM theory is the first study of its kind in Chile, and can set a precedent for future research in the field. By revealing salient features of Chilean culture to address the complex mechanisms of stigma, our research will serve to enhance information systems and establish an essential foundation for culturally-sensitive and effective interventions.

Method

This study is exploratory and descriptive in nature, following a grounded theory approach (WMM) to qualitative in-depth interviews with mental health consumers and supplemented with an extensive literature review. Our research aims include revealing i. Mechanisms of stigma: How does stigma look in Chile; ii. What Matters Most: Why and how are certain behaviors or attributes stigmatized, and more generally, how does this impact daily lives? This qualitative approach was chosen because of its effectiveness in capturing complex social variables, and answering why or how certain phenomenon exists. It is useful to understand how stigma is socially and culturally constructed because of its dependence on the interactions and engagements among individuals of particular groups. The most frequently occurring themes to arise from this exploratory process will suggest the generalizability of these culture-specific factors to the Chilean population [27].

Our sample consists of twelve consumers (n=20) sampled and interviewed by first author FM and coauthor AJ. The inclusion criteria consisted of: (1) either male or female; (2) between 18 and 50 years old; (3) Chilean nationality; (4) Diagnosis of a severe mental disorder, as defined by the ICD-10 (i.e. Schizophrenia, Schizoaffective disorder, Bipolar Disorder, and Major Depressive Disorder either single episode or with psychotic features); and (5) one to two years (or current) enrollment in treatment at the mental health center. The consumers were recruited from and interviewed in Pablo Hurtado Hospital, which is located in the capital of Santiago, but extends care to nearby municipalities (La Pintana, La Granja, San Ramon) for more coverage. This is a general hospital with one Psychiatric and Mental Health Unit (MHU) and provides care to more than 2,000 people with severe mental illnesses a year. The units are a direct result of the National Mental Health and Psychiatry Plan, and are designed to provide psychiatric care and substance abuse treatment for individuals of all ages.

Our in-depth interview methods were developed us-

ing a widely-used perceived stigma scale, called the "Scale of Perceived Discrimination and Devaluation (PDD)" [28] in addition to Yang & Kleinman's "What Matters Most" (WMM) framework [9]. This scale was applied as an open-ended interview to qualitatively elicit key culture-specific domains. The measure has been used in prior Spanish-speaking groups and is being translated/back-translated into Spanish and Portuguese by expert translators using the standard WHO 5-step process. PDD scale consists of statements gauging to what extent people with severe mental illness are believed to be devalued by others, feelings of being less than a full member of society, avoidance of social situations, and unfair treatment by others. Following the approach described above, respondents were asked in an open-ended manner whether they strongly agree, agree, disagree, or strongly disagree with each statement. Follow-up probes were used to elucidate stigma domains especially salient to each cultural setting and to ascertain 'what matters' locally.

Interviews were audiotaped and transcribed into Spanish, and then translated and transcribed into English by two of the co-authors, BR and KW. Thematic analyses were proposed to reveal how 'what matters most' shapes the most salient stigma domains across cultures. Two co-authors (FM and JT) then independently coded the interviews according to the master code list (see Figure 1)—which included items relating to WMM and stigma constructs—and then discussed each code together until we reached an agreement. Our codes were then compared by an independent reviewer (JS) to determine inter-rater reliability (Kappa Coefficient). To establish consensus on initial codes reflecting 'what matters most', four randomly-selected interviews were first be co-coded by the raters supervised by senior author LHY.

It is important to have multiple coders for the interviews in order to compare using a statistical method to find the agreements and disagreements between the coders. One method which is highly popular in the scientific community is the Kappa coefficient in order to reach the most accurate results [30]. A perfect agreement is signified by a kappa of 1 and agreement equivalent to chance is a kappa of 0. This statistic has limitations because it is based on observations of the coders FM and JT and is assumed that they are done as precisely as possible. Typically it is recommended that the interrater agreement be 80% or above [31]. As for this study the agreement reached roughly an 84% agreement.

For guiding our analyzes, we also conducted an extensive literature review exploring anthropological and ethnographic texts about Chilean identity and society, as well as its socio-political history as a potential factor for national identity formation. For instance, we found that the patriarchal system is prevalent in Chile and values prescribed gender roles for men and women—whereby the woman is the homemaker and the man is the breadwinner, the head of the household, and the pillar of the family [29]. Moreover, the man has responsibilities to himself and his family to secure financial resources to ensure family well-being and stability. This allowed us to establish codes of 'machismo' and 'gender roles', which were associated with several narratives from participants and represented how stigma might attack the capacities that determine 'what matters most' in Chile.

Results

Several consistent WMM themes emerged throughout the interviews, primarily: *(1) Gender Roles ("Machismo"); (2) Family Support ("Familismo"); (3) Work/Money "Pega"; and (4) Social Appearances/ Status.* These themes are significant because they operate differently within Chilean culture. That is, Machismo appeared to *shape* the stigma participants experienced from their community, while Familismo seemed to *protect* against stigma. Work and social appearances seemed to operate in both directions.

Machismo

In Chile, an internalized identity referred to as "machismo" contains implicit and explicit cultural expectations of behavior for what it means to "be a man": strong masculinity, chauvinism, austerity, emotional suppression, and unwavering pride. As a central feature in Chilean (male) identity, it was not surprising that themes of machismo resonated strongly throughout the interviews. Participants expressed how machismo in Chilean culture worked to shape stigma, especially for men; *"yes, some things I heard negative comments about...but more towards the men than the woman".* They conveyed that if men were not able to adhere to this culturally-sanctioned identity because of their mental illness status, they would anticipate and/or perceive negative reactions from family or community members. One participant emphasized how important this role is: *"…for him to be in charge, for him to be the pillar of the family [..] it's like the man always has to carry his house, has to be the breadwinner…".* Another par-

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	Yang and Kleinman (2007) "What Matters Most"
1	WMM - Work/Money (having work/money): Having a job and making money
2	WMM - Employment Support (emotional & monetary support): Support from the employer (emotional or monetary/instrumental or informational)
3	WMM – Family: Any mention of family members - family well-being, social status, family lineage, family solidarity
4	WMM - Family Support: Having family members support you (emotional, instrumental, informational)
5	WMM – Community Support; Having Friends: Peer support, community support, friendships
6	WMM – Education: Having a proper education, going to school, getting a degree
7	WMM - Economic Self-Sufficiency/Independence/Functionality (Full Person): Financial independence, autonomy, being able to support yourself & your family (tied to gender roles)
8	WMM - Achievement/Being Successful/empowerment: Being successful in life and achieving what you set out to achieve (a healthy family, a nice car, a house)
9	WMM - Social Status/Prestige (double code for family if relevant): Your own social status among the eyes of the community members (tangible)
10	WMM - Prestige of Business: Prestige and honor of the business (i.e. risky to hire someone who is ill because it may make the business itself look bad/might affect the business)
12	WMM – Physical Appearances: Physical appearances such as dressing well and carrying yourself with poise; but also the general appearances as in the reputation of yourself/your family within the community
13	WMM – Religion as social support: Religion or faith as a means of support and relief
14	WMM/Gender Difference - Machisimo; Gender Roles: Gender roles; whereby the man is the breadwinner and the woman takes care of the home, and the women is supposed to depend on the man to complete his role & vice versa
15	WMM - Treatment/Health Professional Support/Help-Seeking: Receiving help/treatment for a mental illness, getting help from a health professional, seeking help for your condition and getting the proper attention for your needs
16	WMM – Well-being: Being happy, healthy, productive, social, the more general aspects of what makes someone happy and complete
17	WMM - Helping Other Patients/Peer Support for Recovery: Peer support in the hospitals or psychiatric units, being there for one another and understanding/empathizing with each other
18	WMM – Privacy (privacy about the mental illness): Keeping the illness private from others (motives may be varied), private about personal matters (family business, personal)
19	WMM - What Matters Most Always Shifting Through Time: Variations of WMM may change with generations (i.e. young people are getting married less and less now because it is not a priority now that women can be financially independent)
20	WMM - Trust/Mistrust (Social): Ability to trust others in the community & depend on them
21.	WMM - social hypocrisy: When another's motives are hidden, for example: asking how you are doing as a way to protect yourself (i.e. "should I get close to this person?")
22.	WMM - Social Appearances (i.e. pride): In a personal sense, Chilean pride (not wanting to reduce oneself/degradation), How one appears in the eyes of others (intangible)
23.	WMM - Faith (having faith) – Praying, participating in religious activities (not related to social support). A form of community membership and participation.
24.	WMM - Mental illness explanation: Only personal attributions, not recounting of doctor's opinions, i.e. "How does this individual explain the causal factors of their mental illness?"
25.	WMM - Recovery – Any mention of the improvement of symptoms, or the importance of recovery to gain full-functionality

ticipant elucidated how emotional suppression and pride, two features of machismo, can be detrimental to a man's well-being and treatment-seeking; *"Because they believe themselves to be 'machistas'… because of that and nothing else….and they feel bad [sick] and they do not [admit or] acknowledge it…".* The reason given for this is because there is an implicit understanding that no matter what, *"the man, they say has to be stronger [than anyone else]"*. Also mentioned was the concern that a man appears like a *"failure"* to others, which participants admitted may prevent their opportunities to recover from their mental health condition; *"I think that a man with a mental illness is more inclined to not… come out from his illness (…) Because it feels like a failure, it feels like he's not going to be able to fulfill that role, the role that he gets from society, he will have to depend on someone else…".* In fact, participants stated that it is more important for a man to "come out of his illness" than a woman, she explains: *"I think that the majority thinks that because for example, 'No, my husband had depression... he*

has depression', 'NO, he has to come overcome it because he has a family [to support]', so then it's like. . . it more, its more urgent for the man to not have depression".

Familismo

In Chile, immediate and extended family ties are highly valued and respected --a term known as "familismo'. It is without a doubt that Chileans attribute the greatest importance to the family unit. This theme closely ties in with gender roles in Chile. Within the male machista identity, there is the need to protect and advise the family, while women are expected to support and care for her close and extended family members.

Interviews with our participants showed how maintaining this "familismo" worked to *protect* both men and women from stigma. Participants explained how forms of familial support helped them feel loved, *"cared for"* and *"accepted"*, which enhanced their likelihood to seek and adhere to treatment. Family members often took their mentally ill relatives to doctors, or provided them with transportation money for work and appointments; *"With the help of family, they helped me to…in all ways…. they go with me to the doctor, they talk to the doctor, they give me money for the metro…".* Aside from monetary or financial support, emotional support was also common. Parents would regularly check in on their child's well-being; *"My mom has always been the one who supported me, (…) She is one of the ones who call me, and she says 'Daughter what are you doing, Are you bored?, What's the matter?, come eat lunch with me, Daughter' she says to me, 'Let's go shopping, let's take a walk…'".* Unyielding familial support was said to be instrumental in the recovery process and to ease one's daily functioning; *"A disease of depression, two or three months, or four months, and it can pass. Well=treated and with family support otherwise, one does not recover […] When I first started here, I worked alone, so I had to wake up very early or very late to bathe because I could not close to do my things. As such she has been fundamental in my support that… it has been a bit more relaxed otherwise alone, no… it is very stressful being alone…".* Interestingly, family support was protective even among patients who have internalized the stereotypes and stigma or faced discrimination from community members, due to their mental health condition. As such, women and men perceived less stigma when they experienced this family support: *"Because my family knows, they know what I have gone through, they know that they've been with me during my crisis […] I think that supporting, always supporting, but it's difficult to support when a patient is so obviously embarrassing his family…I think it's difficult to support. They want to support (…)"*.

Work/Money "La Pega"

The machismo(male) identity is closely connected with the value of work to accumulate resources and support the family, but also to establish one's competency as a fully functional member of a working society. This is true for men and women alike. In fact, the popular idiomatic expression unique to Chile is "cuidar la pega", which literally means to *"protect your job"*, emphasizes the importance of work in Chile. Interviews highlighted the dual role that work, or *"la pega"* plays in this culture, where it either protected individuals against or shaped stigma.

Both men and women participants discussed the importance of being able to work and make money in order to support the family; *"... the only thing that matters to him is having a job, and that there is nothing lacking for our child because our child is sick".* Aside from supporting the family, work also appeared to play an instrumental role in affirming one's self-worth. Having a job instilled in people a sense of value and purpose when they otherwise feel *"lazy"* or *"down"* due to their mental health symptoms. If individuals were diagnosed with a mental illness but were also able to work, work became highly protective for them by aiding them in maintaining their self worth. Another participant explains; *"I always sought to make myself valuable and serve (...) I am someone with a mental illness... it was a mental illness or with mental problems, but it was always i could recover from but I always worked, I worked in the chemistry lab, I worked here and there....because I could, because if I had been diagnosed with 'such and such disease', and not being able to work or do anything, damn I would have been useless, and it is not like that, I was a person who had problems but I recovered from them and worked normally. Even as of now, I am working".*

On the other hand, if members were not able to work due to their mental illness, they would be perceived as a *"failure"* by their family or community members; *"Oh yes... because before I worked, and now I can't. It is like a failure and I don't know how I got sick...".* This feeling of *"being a failure"* is especially relevant for men who have to adhere to their "machista" identity. Additionally, participants faced a lot of discrimination at work due to their mental

health status. If the employer found out about their mental illness they would often be fired from their jobs which reduced opportunities for them. One nurse diagnosed with bipolar disorder describes, *"The doctor who sees the staff here told me once 'I'm going to let [you] work and hopefully we'll see each other as little as possible' [...] I was there a week, [I was] replaced and I left, why?, because people won't let me, won't let me work [because of my illness]…"*.

Social Appearances or "Status"

A common thread underlying these discourses about machismo, work, and family is the importance of keeping up social appearances, or *"status"* for Chileans. Participants often referred to how much they valued creating and maintaining a certain image for themselves and their family members; men cannot appear *"weak"*, women have to be *"good mothers"*, the family is expected to seem "unified" and free of problems, individuals are supposed to be "good" and businesses *"honest"* to upkeep a certain moral standing and *"prestige"*. Throughout the interviews, social appearances also seemed to both shape and protect against stigma.

Participants often explained that they would experience stigma and discrimination in the workplace due to their mental health status, resulting in a loss of employment opportunities. The apparent concern to maintain *"status"* played a clear role in shaping stigma, such as in instances where employers refused to hire a "mentally-ill" person due to fear of "jeopardizing the prestige" of their business; *"Because the employer puts his business at risk, its prestige…. Then he would not want to risk himself with a person like that"*. When asked about the importance of this prestige and status, another participant expressed that Chileans *"want to pretend to have a status half-inflated [exaggerated], which may not correspond well [to reality]…. And lowering oneself is like humiliating oneself…""*. Some narratives suggest that maintaining social appearances are particularly important for members of higher socioeconomic classes, who feel they have more to lose. Another participant suggests that such individuals are more resistant to admit their *"weaknesses"* because they risk losing the respect of others; *"Someone of high status will never say that they were in a psychiatric hospital. They will deny it in every way because they will not allow for other people to look at them as less because they were in a psychiatric hospital. Now, a person in a lower social stratum, their treatment is more severe, but at the same time they are closer, they are more helpful. A person of high status is not going to… is not going to…they will focus on themselves, they will not focus their energy on other people, in exchange a person of a lower status tries to help everyone else"*. Even for those who seek and receive treatment, the likelihood they will be stigmatized depends on aspects of these social appearances; *"… based on the class status of the person that is hospitalized, based on the level of education that the people who are hospitalized have and based on…the status of that person who is hospitalized, a lot changes…"*.

Social appearances also appeared to protect against stigma. Some individuals reported feeling protected from stigma regardless of their mental health status. The protective effects of social appearances were said to depend on how one physically presents themselves to others in how they dress and interact with others. One participant suggests that the reason why he does not experience stigma from others is *"Because I portray that I am well, I am okay (…) Because I have the desire to succeed. I have the desire to…I buy things, I dress myself the best I can, have my own things…and I show to my family I have demonstrated that I want to succeed"*. Aside from physical appearance to display social status, the ability to interact with other in socially desirable ways also played a huge role; "Gonzalo, realistically, you don't notice his sickness, he is cordial, he is intelligent, he always is conversing, and so you say *'no, no, nothing to see with Gonzalo no, no he is not like that [he is not mentally-ill]'*".

Discussion

The current study was an exploratory study aimed to identify and describe main socio-cultural dimensions associated to stigma and mental illness. We interviewed 14 consumers with severe mental illness who were attending to a general hospital in Santiago, Chile. After conducting a qualitative analysis, we were able to identify four cultural orientations, which may shape stigma expressions (Machismo, Familismo) or protect against the detrimental consequences of being stigmatized (Work, Social appearances). Potential explanations about these findings are discussed below.

First, it must be noted that Chile is founded on a patriarchal system which adheres to and values the prescribed gender roles for men and women, whereby the woman is the homemaker and the man is the breadwinner, the head of the household, the pillar of the family. The man's responsibilities

to himself and his family are to secure financial resources to ensure family well-being and stability, a role which has become equated with power and authority within the home and in society [32]. In Chile, a "male chauvinistic culture prevails", falling short of his male responsibilities is looked down upon because this means he will have to depend on someone else [29]. This would be shameful, embarrassing, and may threaten his role as the *"pillar"*, the provider. Therefore, what is *"most at stake"* when a man is stigmatized is the machista identity. According to Jorge Larrain [29] "Identity becomes a problem when there is a threat to the old-established ways" (p. 323). In these examples, perceived or anticipated stigma from community members regarding mental illness is contingent on adherence to socially constructed gender identities. If mental illness renders a man unable to fulfill his duties; he will internalize the anticipated stigma from others, causing him to feel useless.

Second, family support (or 'Familismo') proved to be a protective factor against perceived stigma and discrimination, which maintained participants' sense of well-being and acceptance. Stewart's research [33] supports this finding and claims: *"Mothers play the principal role in supporting the mentally ill. With the de-institutionalization of the past 10 years, families are becoming increasingly organized into mu*tual *aid groups"* (pg. 74). The involvement of the extended family in decision-making is also evident, especially in matters related to serious medical or mental health conditions. A study by Molina et al. [34] in Chile explored this aspect of decision-making in how family support affects early detection strategies. They explain, *"Latino/as are socialized to sacrifice and work for the benefit of the family as well as exhibit altruism, generosity and strong loyalty to family members. Familismo results in Latinas placing a high level of importance on the recommendations and suggestions of family members… "* (pg. 3). Through these means, family support mediated early detection strategies by increasing a member's *"perceived self-efficacy'*. The support and encouragement was reassuring for patients, making them feel more confident and competent in taking control of their health. This study emphasizes how important the family is for well-being and recovery

As a third point, *'work'* seems to play a salient role in protecting against stigma. Researchers theorize that the development of a consumer culture in Chile created a space in society that placed high value on financial accumulation and prosperity as an indicator of personal successes and achievement. National surveys point out that while most Chileans indicate that family ties are their main source of happiness, the "second factor that weight more in their felicity is money" [29]. According to Jorge Larrain [29] this finding is "not surprising given that the country *'owes'* [Augusto] Pinochet an economic and state system that, besides contributing to overcome a pervasive poverty, installed consumerism as a new national identity code" (pg 246). Pinochet's fiscal reform program adopted neo-liberal policies and encouraged the emergence of a *"new entrepreneurial bourgeoisie"*, which paved the way to a growing economic prosperity and allowed for more social mobility. This promoted *"the new entrepreneurial version of Chilean identity"*. As a result, Chile departed from its status as a developing nation and became a country unlike the others in Latin America. According to the international community, Chile became considered a "country where drive, dynamism, success, profit and consumption stand out as the central new values of Chilean society" [35]. This created avenues for Chilean citizens to show off their financial gains, facilitating attainment of material luxuries such as education, owning a home, and buying good clothing to enhance their appearances. In addition, this positioned many individuals and their families within a certain social status, granting them a personal sense of achievement and social worth. Work is central to this evolution because it facilitates personal achievement and individualistic development. Money appeared to have two functions in Chilean society —ensuring family well-being and validating self-efficacy.

On the other hand, the direction in which *"social appearances"* operated in shaping or protecting stigma seemed to be contingent on social status of the individual. Interestingly, some participant narratives suggest that this is particularly important for members of higher socioeconomic classes. That is, there is more "at stake" for individuals with mental illness and their families if their social appearances or reputation are threatened [29]. Having a relative with mental illness is perceived as shameful for those families who want others to believe in their high-status, successful, stable, and unified front. However, in other instances, admitting one's own mental illness and receiving treatment for it does not always lead to stigmatization and discrimination from community members. As long as these indi-

viduals "show" to their family members their "desire to succeed" through how hard they work or how well they carry themselves, or *"appear"* healthy by demonstrating politeness, intelligence and sociability, they will be shielded [31].

All in all, we have explored how Chile's unique value systems relate to, and shape, stigmatizing beliefs and discriminatory behaviors. Likewise, we have seen their powerful effect in protecting against stigma and other negative consequences. Future initiatives in Chile and, ideally, in other Latin American setting, should use the specific knowledge we have gathered as a key ingredient and develop cultural-specific anti-stigma interventions.

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