Stigma towards people with mental health problems:

An individualism-collectivism cross-cultural comparison

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Abstract

This study explored whether the cross-cultural value paradigm 'individualism-collectivism' is a useful explanatory model for mental illness stigmatisation on a cultural level. This has never before been directly investigated despite numerous clues of its potential importance in previous related literature. The paradigm asserts that in 'collectivist' cultures, people are more strongly interdependent with their in-groups, and are more likely to give priority to the goals of their in-groups than people from 'individualistic' cultures, who are instead more likely to value and desire autonomy and independence from their in-groups, and give priority to their personal goals than to their in-group goals.

Three hundred and five individuals from four UK-based cultural groups (white-English, American, Greek/Greek Cypriot, and Chinese) were successfully recruited for a quantitative survey through the use of non-randomised snowball and quota sampling. Twenty-two of these individuals were later qualitatively interviewed in a one-to-one, semi-structured manner. Questions regarding where the four cultures fit within the individualism-collectivism paradigm, how acculturation affects the individualism-collectivism paradigm, what other factors explain stigmatisation, and the level of stigmatising attitudes present in these cultures, were also integrated into the methodological components in an attempt to explore these other important themes.

The results partially supported the hypothesis that the paradigm can be applied to explain mental illness attitudes. Increases in the paradigm's explanatory power corresponded with a cultures' stigmatisation level. Specifically, the more stigmatising a culture's mental illness attitudes are, the more likely collectivism effectively explains these attitudes. In contrast, the more positive a culture's mental illness attitudes, the more likely individualism effectively explains attitudes. Educational level, mental illness experience, and, particularly, mental illness knowledge, were other powerful and consistent stigma explanatory factors, although the stigma affect of these and impact of other key themes were unique to each cultural group. The results also revealed that successfully acculturating to a new culture can impact on one's cultural values including levels of individualism-collectivism. The American cultural survey group held the most positive mental illness attitudes, followed by the white-

English group. Both groups also scored high on levels of individualism. The Greek/Greek Cypriots and Chinese held the least positive attitudes and were also found to be generally collectivistic. None of the survey groups' scores were wholly stigmatising, which suggests a positive shift towards more tolerant attitudes having taken place in recent years even in the Greek/Greek Cypriot and Chinese cultures. This is illuminating as these are traditionally particularly stigmatising cultures, which qualitative interviewees also argued.

A number of important recommendations for policy and practice that aim to reduce stigma and highlight the importance of culture are proposed. These include anti-stigma campaigns needing to be culturally and linguistically appropriate and sensitive; using in-group, second-generation members of closed and collectivist communities/cultures to deliver of anti-stigmatising initiatives and; training practitioners to understand the impact of individualism-collectivism on mental health attitudes. Further, a consideration of the individualism-collectivism paradigm should be included in any future research aiming to provide a holistic understanding of the causes of mental illness stigma both on an individual and cultural level.

Chapter 1: Introduction

1.1 Background of the study

This thesis explores the stigma held towards people with mental health problems in traditionally labelled 'collectivist' and 'individualistic' cultures in the United Kingdom. My primary intention is to provide an understanding of the levels of stigma present in particular individualist and collectivist cultures, and the between-cultural and within-cultural reasons underlying stigma. Although there is a plethora of existing research literature on both mental health stigma and the individualism-collectivism framework, no previous enquiry has ever directly investigated the possible associations between the two. This is despite various, although tentative, clues from previous literature pointing to a possible link. Some of the main themes and concepts of this study shall now be introduced, which will be discussed and considered later in greater detail.

Understanding the issues of mental illness stigma is important for prevention, early detection and community treatment of psychiatric disorders (Malla and Shaw, 1987; Corrigan et al, 2005). The World Health Organisation (2001) highlights the damage resulting from stigma, stating that those being stigmatised can experience rejection by friends, relatives, neighbours and employers leading to aggravated feelings of rejection, loneliness and depression. They also highlight that possible denial of equal participation in family life, normal social networks, and productive employment, as well as the reduced chances of recovery, since their ability to find access to services may be hampered, and the type of treatment and level of support received may be

affected. Corrigan et al (2005) reminds us that stigma can have significant negative repercussions on not only those people with the mental health problem, but also their family members and friends, and mental health provider groups. Because of these concerns, the World Health Organisation (WHO) in 1996 launched a major worldwide campaign to attack the stigma attached to mental illness. They highlighted how stigma, if not combated, can create "a vicious cycle of alienation and discrimination which can lead to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalisation, all of which decrease the chance of recovery". A classic example of the employment problem was demonstrated by Farina and Felner (1973), where a male confederate, posing as an unemployed worker, sought jobs at 32 businesses. He provided the same work history to each business, although for half of the job interviews he included information about a past psychiatric hospitalisation. Subsequent analyses found that the interviewers were less friendly and supportive of hiring the confederate when he added his psychiatric past. The impact of stigma is discussed in greater detail in chapter 2.2.

Although not typically strong predictors, there are several personality and demographic variables that have been found to correlate with stronger negative attitudes towards people with mental health problems. These include older people (Brockington et al, 1993; Clark and Binks, 1966; Wolff et al, 1996a; 1996b; Hannigan, 1999), those with lower education (Clark and Binks, 1966; Murphy et al, 1993), those from lower social classes (Brockington et al, 1993; Heller et al, 1980; Whatley, 1959), and being male (Farina, 1981; Morrison et al, 1993; 1994). It has also been consistently shown that those who do stigmatise mental illness have low levels of contact and experience of people with mental illness, in addition to low levels of

knowledge of the subject (Yang, 1989; Hannigan, 1999; Ng and Chan, 2000). Roman and Floyd (1981) surveyed 200 married women in Milledgeville, Georgia, and compared their data with the results from three previous studies (Philips, 1963; Schoder and Ehrlick, 1968; Bord, 1971). After detailed comparisons, they discovered that having a state mental hospital in the community - thus providing people with experiences of people with mental health problems - contributed to a higher level of social acceptance towards the mentally ill. Wolff et al (1996a; 1996b) surveyed public attitudes to mental illness in two south London areas prior to the opening of supported houses for the mentally ill. They too found that a significant relationship between stronger negative attitudes and a lack of knowledge about mental illness. Papadopoulos et al (2002) similarly surveyed the attitudes of mental illness in an area of north London and found that both a lack of knowledge and previous contact with mental illness was associated with negative attitudes towards people with mental health problems. Further support of knowledge and contact level being a significant factor is put forward by Cumming and Cumming (1957), Trute and Loewen (1978), Angermeyer and Matschinger (1997), Ogedengbe (1993), and Farina (1982). However, Ng and Chan (2000) argue that knowledge might not be sufficient to change attitudes. Further, although contact is an important factor, the nature and quality of contact could be more important as direct contact and acquaintance with and closeness to the individual with mental health problems have been found to contribute more tolerant and understanding attitudes (Murray and Steffen, 1999; Hannigan, 1999).

It has also been highlighted that certain cultures are more likely to stigmatise mental health problems than others. Papadopoulos et al (2002) revealed that Greek and

Greek-Cypriot UK migrants held significantly higher levels of stigmatising attitudes than white-English UK born people on measures of authoritarianism and social restrictiveness. Further, Wolff et al (1996c) revealed that UK non-Caucasians were much more likely to object to an educational campaign about mental illness than Caucasians. Bhugra (1989) also reported that, in general, Caucasians carry more favourable attitudes towards the mentally ill. Westbrook et al (1993) found, after conducting attitudinal surveys on people with disabilities and mental health problems amongst Chinese, German, Italian, Greek, Arabic and Anglo Australian communities, that the German community, followed by the Anglo-Australian community, expressed greatest acceptance of people with disabilities and mental health problems. The Greek and Arabic groups, however, were found to express the least amount of tolerance. Studies by Jacques et al (1970; 1973) have provided evidence that Americans also hold favourable attitudes towards those with disabilities and mental health problems, whilst also revealing that the Chinese, and particularly, Greek cultures held some of the most negative attitudes. Cohen et al (2007), who conducted a systematic review on schizophrenia outcomes in low- and middle-income countries, revealed that high levels of public stigma towards mental illness exist in Nigeria, Ethiopia, and India. Their study challenged the assumption that individuals with schizophrenia have a better prognosis in such developing countries (WHO, 1979; Jablensky et al, 1992; Harrison et al, 2001), due partially to the notion that families in such collectivist countries offer relatively high levels of family support and tolerance (Hopper, 2007). Instead, they conclude that poor outcomes are likely to exist whenever care is not accessed, no matter what the socio-cultural context is. However, this may be particularly relevant in collectivist cultures, as if professional care is not accessed due to stigma, then the opportunity for the protective and clinically

beneficial support that collective, family-orientated cultures typically offer is missed. Indeed, Schomerus and Angermeyer's (2008) review of literature has provided compelling evidence that mental illness stigma does consistently negatively associate with professional help-seeking.

There has been extensive work on investigating the vast array of psychological differences that exist between cultures. For example, Hofstede (1980a), in an attempt to define and explain the main psychological differences between cultural groups, administered questionnaires in 1968 and 1972 to 117,000 IBM employees from 50 national cultures and three regions. Hofstede conceptualised culture in terms of meanings, and therefore studied it by assessing the values of people. Factor analyses on a cultural level, rather than individual level, produced four factors of value difference between cultures: 'individualism-collectivism', 'power distance', 'masculinity-femininity', and 'uncertainty avoidance'. In subsequent research, 'individualism-collectivism' far exceeded the other factors in importance and popularity. The three work goal items associated with individualism stressed having a job that gives one sufficient time for personal or family life, having freedom to adapt one's own approach to the job, and having challenging work to do (providing a personal sense of accomplishment). Those associated with collectivism stressed having training opportunities, having good physical work conditions, and having the possibility using skills and abilities on the job. Hofstede (2008) has since argued that America is an example of an 'individualistic' culture, where self-actualization and individual decisions are valued more highly than group decisions, meaning Americans like personal time, freedom, and challenge more than people from collectivist cultures.

Triandis (1995; 2001; 2002; 2006) has popularised and extensively developed the individualism-collectivism paradigm in cross-cultural psychology with a research program that started in the early 1970s and currently continues. He claims that the 'individualism-collectivism cultural syndrome' is the most significant cultural difference among cultures. He argues that in collectivist cultures, people are more likely to be interdependent within their in-groups (family, tribe, nation etc.), give priority to the goals of their in-groups, shape behaviour primarily on the basis of in-group norms, and behave in a communal way. People in individualistic cultures, rather, are more likely to be autonomous and independent from their in-groups and give priority to their personal goals than to their in-group goals. They behave primarily on the basis of their attitudes rather than the norms of their in-groups. However, he also has made it clear that categorising cultures as 'collectivist' or 'individualist' is a broad and generic framework. He therefore reminds us that there are many dimensions within the framework such as 'horizontal and vertical individualism and collectivism.' He defines people from 'horizontal individualistic' cultures as people who want to be unique and do 'their own thing' but who also emphasise the need for equality among their in-group members (e.g. Sweden, UK); 'vertical individualistic' cultures as people who want to do their own thing but also be 'the best' (e.g. USA, France); 'horizontal collectivist' cultures as people who merge themselves with their in-groups and emphasise the need for equality among in-group members (e.g. Israeli Kibbutz); and 'vertical collectivist' cultures as people who submit to the authorities of the in-group and are willing to sacrifice themselves for their benefit of the in-group, recognising and respecting the hierarchy that exists in their societal structure (e.g. India, Japan). However, Triandis states that future

research needs to be done to identify new dimensions, and/or to refine existing ones. A great deal of effort has been expended to devise methods for the measurement of individualism and collectivism, and while there are approximately 20 different methods, Triandis and Gelfand (1998) argue that none have proven entirely satisfactory.

There is also some evidence that suggests that acculturation affects the individualism-collectivism paradigm. For example, Altrocchi and Altrocchi (1995) researched Triandis' claim that people from collectivist cultures define themselves with reference to social entities. They found that the least acculturated Cook Islanders (collectivists) used 57% social content in describing themselves, whereas Cook Islanders born in New Zealand (an individualistic country) used 20% while indigenous New Zealanders used 17% social content. This finding supports Triandis' assertions but also reveals some evidence of acculturation impacting the individualism-collectivism paradigm. Triandis (2001) notes that as a global culture is emerging, cultures interact and acculturation is likely to result in changes to some (not all) cultural values and behaviours. He emphasises the need for further examination of how acculturation affects the individualism-collectivism paradigm. These issues are reviewed in greater detail in chapter 2.

1.2 Aims and objectives

The main objective of this study is further our understanding of the way culture influences stigmatisation to people with mental health problems, so that health-care

professionals are more culturally sensitive and competent when working with both patients and their families. This will be attempted by specifically aiming to:

- Explore the levels and types of stigmatising attitudes present in four UK-based cultures: white-English, Americans, Greek/Greek Cypriots, and Chinese.

- Explore the underlying cultural reasons for stigmatisation.

- Explore the individualism-collectivism paradigm in relation to stigmatisation to mental health problems in various cultures.

- Investigate where the four cultures to be studied fit within the individualism-collectivism paradigm.

- Explore whether and how acculturation affects the individualism-collectivism paradigm.

1.3 Hypothesis

As previously stated, a possible important link between individualism-collectivism and mental health stigma has been pointed to by various tentative clues from previous literature. For instance, cultures that researchers traditionally agree are more strongly individualist, such as the American, white-English, German, and Australian cultures, have been found to be less stigmatising to mental health problems (Jacques, 1973; Papadopoulos et al, 2002; Westbrook et al, 1993). Further, Triandis et al (1990), who

researched individualism and collectivism's antecedents, attributes and consequents, highlighted that for individualistic cultures, personal goals have primacy over in-group goals, and also that 'cultural complexity', where there are often more cultural choices and lifestyles (Chick, 1997), is more likely to be found. This is important because, as Triandis (2001) explains, the more 'complex' a culture, the more likely it is to be a 'loose' (as opposed to 'tight') culture. In loose cultures, Triandis explains that there is a stronger tolerance for deviation from norms found in relatively varied societies (where several normative systems coexist), where people do not depend on each other so much, and where population density, and thus the opportunity for surveillance, is low. It has also been established that 'tight' cultures are more likely to be collectivist (Carpenter, 2000). In such cultures, people have clearer ideas about what behaviours are appropriate; they agree among themselves that sanctions are needed when people do not follow the norms. Tight cultures tend to include members that are highly interdependent, and are to be usually more densely populated, in the sense that surveillance is high.

Because of such clues, I hypothesise that people from individualist cultures are less likely to stigmatise people with mental health problems. This is because, as previous literature indicates, people from individualist cultures are more likely to tolerate diversity and deviation from the norm because such cultures are extremely fragmented, with extensive individuality, due to the desirability of personal goals. In collectivist cultures, there is less diversity and fragmentation as people desire in-group goals and norms, and therefore people who deviate from the norm are more visible to the community due to higher surveillance levels. As a consequence, families are more likely to try to hide the existence of a member who has a mental health problem, and

are therefore less likely to attempt to access the appropriate services. In such

communities where there is less contact and knowledge about mental health problems,

stronger negative attitudes are likely to exist, as previous research indicates (Trute and

Loewen, 1978; Wolff et al, 1996b; Papadopoulos et al, 2002). These ideas and related

literature are considered and reviewed in chapter 2.

Chapter 2: Literature review

2.1 Stigma: The concept

The term 'stigma' was originally adopted by the ancient Greeks who used it to represent the marks that were pricked onto slaves to demonstrate ownership and to reflect their inferior social status. The ancient Greek word for prick was 'stig' and the resulting mark, a 'stigma' (Falk, 2001). It was subsequently used to signify any bodily sign that indicated something bad about the moral character of a particular person.

The first notable modern use of the term was by Erving Goffman (1963) in his classic work 'Stigma: Notes on the Management of Spoiled Identity'. Goffman stated that stigma reflects a social attitude toward mental illness that is deeply discrediting and a position of social disgrace. It also reflects a discrepancy between a person's 'virtual social identity', which refers to the societal assumptions of a particular person, and their 'actual social identity', which refers to any attributes that a person could be proved to possess. Further, he believed that stigma highlights any attribute which discredits a particular person and can lead to assumptions about the person's character and abilities, often resulting in various forms of discrimination: "[It is] an attribute that is deeply discrediting. Stigma can arise of [one] possessing an attribute that makes [that person] different from others... and of a less desirable kind... [s/he] is thus reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963: p2-3). Inherent to this is the idea that stigma dehumanises and reduces the social value of an individual because he or she is appraised as being 'marked', flawed, and less than average (Dovidio et al, 2000). The stigmatised

attribute deviates from what society considers normal, leading society to respond by "...interpersonal or collective reactions that serve to 'isolate' 'treat', 'correct,' or 'punish' individuals engaged in such behaviour" (Schur, 1971: p24).

Some scholars have developed frameworks for examining stigma. For example, Goffman (1963) identified three types of stigma: 1. 'Abominations of the body' (e.g. physical deformities); 2. 'Blemishes of individual character' (e.g. mental health problems, unemployment, crime), and 3. 'Tribal stigma' or 'tribal identities' (e.g, race, religion, etc.). Jones et al (1984) defined six dimensions that predict the strength of a stigma: 1. The degree to which the stigmatising attribute/behaviour can be concealed (i.e. visibility); 2. The expected long term result associated with the attribute/behaviour (i.e. salience and prognosis); 3. The degree to which activities of everyday life is impeded (i.e. disruptiveness such as during interpersonal interactions); 4. The physical appearance of the person who has the stigmatising attribute (i.e. attractiveness); 5. The degree to which the person is responsible for the attribute/behaviour, (i.e. congenital vs. acquired conditions and personal responsibility), and; 6. The degree to which the attribute/behaviour is dangerous to others (i.e. peril and threat of contagion).

Corrigan and Watson (2002) have argued that the stigmatised marker can be either obvious (such as skin colour) or subtle (for example, homosexuality). They also argue that such moral imputation has egregious affects on at least two levels, what they call 'public stigma' and 'self-stigma'. They define public stigma as "the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatised group [such as people with mental health problems]. Self-stigma is the loss of self-esteem

and self-efficacy that occurs when people internalise the public stigma" (Corrigan et al (2005: p1). Goffman (1963) referred to self-stigma as the internalised feelings of guilt, shame, inferiority, and the wish for secrecy and concealment. Whereas the damaging impact of self-stigma is mainly confined to the stigmatised individual, they state that public stigma impacts on people beyond those directly stigmatised, such as family and friends (Lefley, 1987; Phelan et al, 1998) and mental health provider/support groups (Dichter, 1992; Persaud, 2000). This stigma-by-association process has been previously coined by Goffman (1963) as 'courtesy stigma'. Corrigan et al (2005) argue that being aware of the public/self stigma distinction may be important for understanding, explaining, and building strategies to change stigma.

Although there is much consensus of what stigma is, there is no one unitary theory. As Smith (2002) states, this is perhaps not surprising as stigma represents a complex interaction between social science, politics, history, psychology, medicine and anthropology. However, there are some universally agreed ideas on how the stigmatisation process begins. As Smith explains, one of the first key steps is the perception of difference, an act that both humans and animals have an innate predisposition to since both depend on the predictable behaviour of their members for their functioning and safety. Thus, when we perceive a person or group as different, it is not surprising that we may feel threatened. However, for stigmatisation to occur, such differences must be associated with undesirable traits. For example, part of the reason stigma towards people with mental health problems exists is because of the associated stereotype of potential violence and unpredictability. Those stigmatised subsequently become labelled as 'them' rather than 'us'. Schur (1984), however, importantly noted that the kind of behaviours which are labelled as undesirable or

'socially deviant' varies considerably between cultures and over time. He stated that the term 'deviance' does not exist as an isolated category, but rather gives meaning within a particular context. Therefore, deviance and stigmatising behaviour are socially constructed and hence changeable over time within social and cultural contexts. Schur also believed that stigmatising something or someone as deviant may sometimes be a societal attempt to limit the power of the offending party. If a particular culture values social conformity, then to be outside the norm can result in the exclusion from a variety of social benefits, a view shared by other scholars including Howard Becker (1963) and Edwin Lemert (1951, 1972). Lemert also argued that as deviance is a process both ongoing and changeable, the roles of 'primary' and 'secondary' deviance must also be considered. He believed that primary deviance is the initial act or behaviour which conflicts with societal norms that may or may not result in the individual receiving a stigmatising label depending on the frequency, intensity and visibility of the behaviour. If stigmatisation does occur, the process of secondary deviation begins whereby the person employs the deviant behaviour or an associated role so to defend, attack, and/or adjust to the admonitions and stigma that their behaviour or act initially provoked. Secondary deviance involves the assumption of certain deviant roles which then become the predominant way through which society views and judges the labelled person. This labelling perspective further argues that the stigmatised person subsequently becomes marginalised, isolated and discriminated by non-stigmatised groups in society (Clinard and Meier, 1992). Discrimination refers to the inequitable treatment of stigmatised individuals, including a denial of their rights and responsibilities. Discrimination can occur on the interpersonal level when, for example, social distance and exclusion is experienced. Link and Phelan (2001) highlight its impact on a structural level when they

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demonstrated that people with mental health problems are overtly and covertly excluded from public life through a variety of legal, economic, social and institutional means.

It appears that considerable agreement exists for the idea that stigma is any mark that leads to disgrace or discredit and consequently sets that person or group aside from others. It is also clear that the strength and impact of a stigmatisation is multi-faceted and multi-structured, yet always negative and harmful.

2.2 The impact of mental health stigma

As stated above, despite stigma's various conceptualisations, there is little doubt that stigma attached to mental illness carries with it significant repercussions and various harmful effects, both to the individual and his/her close friends and family. Phelan et al (1998) highlighted the latter by examining the stigma among 156 parents and spouses of first-admission psychiatric patients. They found that half of these participants concealed information to others about their relative's hospitalisation. They also found that the family members were more likely to conceal knowledge of the mental health problem if they did not live with their ill relative, if their relative was female, and if the relative had more severe negative symptoms. Such findings demonstrate a level of shame and embarrassment that can burden close family members. Lefley (1987) further demonstrates stigma's impact on the individual's family. They examined the burden and coping strategies of 84 experienced mental health professionals who have family members suffering from chronic mental health problems. The study revealed that the respondents' personal reactions involved both

cognitive and attitudinal changes in their conceptions of psychotic disorders. They also showed guarded relations with their work colleagues by limiting self-disclosure and case involvement, and described various substantial financial and emotional burdens.

Corrigan et al (2005) argue that stigma can rob people afflicted with a mental illness stigma of two particularly important life opportunities that are vital for achieving life goals: 1. obtaining competitive employment and; 2. living independently in a safe and comfortable home. This is because there are inevitable housing and work problems associated with particular mental health problems. For example, some mental health problems result in impaired social and coping skills required to meet the demands of a competitive work force and for independent living. By virtue of their social position, landlords and employers who believe the stereotypes about mental health problems may respond in a discriminatory manner. This was evidenced by Wahl (1999) who highlights how landlords are often afraid of such people and decide not to rent property to them. Wahl also argued that employers also often believe that such people are incapable of competent and consequently choose not to hire them, which Farina and Felner's (1973) classic study poignantly demonstrated.

Stigma can also affect people with mental health problems who interact with the criminal justice system. As Watson et al (2004) describe, the criminalisation of mental illness occurs when people with mental health problems are dealt with by the police, courts and jails, instead of the mental health system. They argue that this is because of inadequate mental health services funding and 'get tough' crime policies. Lamb and Weinberger (1998) argue that the public's growing intolerance of criminals in general

has led to tougher laws and hampered effective treatment planning for mentally ill offenders. The problem is also highlighted by Teplin (1984) who compared the arrest rates of the American general public and found that people exhibiting mental health problem symptoms are more likely than others to be arrested by police. Steadman et al (1989) argue that this selective process continues if the person is jailed as their research found that such people spend more time incarcerated than people without a mental health problem. Such a role of events is likely to have various significant longer term impacts on the individual. As Corrigan et al (2005: p2) states, "Treating people with mental illness like criminals has implications not only for their life, liberty, and well being, but also for the larger community such as loss of potential contributions by viable citizens."

Individuals with mental health problems may also be afflicted in health care systems. As Druss et al's (2001) American health care system research demonstrates, people with mental illness receive fewer medical services than others, and are less likely to receive the same range of insurance benefits as people without mental health problems (Druss et al, 1998). Druss et al (2000) also examined the types of medical procedures after myocardial infarction in a sample of 113,653. They found that people with co-morbid psychiatric disorder were significantly less likely to undergo 'percutaneous transluminal coronary angioplasty' (PTCA). PTCA is a less expensive, less traumatic alternative to bypass surgery (American Heart Association, 2008).

Stigma can also impact the individual's self. Corrigan et al (2005) believe this can happen in at least two different ways. Firstly, through fear of social rejection, the individual may restrict their social networks which may lead to isolation,

unemployment, lowered income, and the other benefits a strong social network can deliver. Perlick et al's (2001) findings add weight to this. They found that in a sample comprised of 264 psychiatric inpatients that those who had concerns around stigma were significantly more likely to become psychologically isolated and avoid social interactions with those outside of their immediate family. Corrigan et al call this 'perceived stigma'. If such an event occurs, this is likely to cause the individual to experience significant self-esteem and self-efficacy decrements (Link, 1987); Markowitz, 1998). Link et al (2001) provided evidence of this by assessing self-esteem and perceived stigma in 70 people with serious mental health problems. After controlling for self-esteem, depressive symptoms, diagnosis, and demographic characteristics, their results showed that those with high perceptions of perceived stigma were significantly more likely to have low self-esteem than those with low perceptions of perceived stigma. Sirey et al (2001) demonstrated that perceived stigma can also play a significant role in psychiatric treatment adherence. After examining 134 newly admitted adults' treatment, they found that medical adherence was significantly associated with perceived stigma. Secondly, the individual could view the stigmatising ideas as self-relevant, believing that they are less valuable because of their disorder in the way seen by others. Corrigan et al view this as 'self-stigma'. This can also result in losses of self-esteem, self-efficacy and persistent depression (Link et al, 1997; 2001) which can hamper the chances of recovery. It is important to also note that not all people suffering from mental health problems experience a loss of self-esteem and self-efficacy, and, in fact, self-protect themselves due to perceived stigma (Crocker and Major, 1989). Corrigan and Watson (2002) also note this by detailing a model of personal reactions to stigma in which people may: 1. self-stigmatise and suffer a loss of self-esteem; 2. remain relatively indifferent to

stigma and; 3. become empowered by stigma and advocate on behalf of themselves and others with mental illness.

There is evidence that psychiatry also suffers from the negative effects of stigma. For example, Angermeyer et al's (1999) study on German public choices on mental health care pathways revealed that only one-third of their large-scale general-population survey would recommend psychiatrists as a potential source of help for schizophrenia. This suggests what Persaud (2000) argued: that psychiatrists are suffering from their own type of public stigma. He argued that this can also be seen by the fact that the lay public and politicians would prefer practically any other health care specialist to determine mental health care policy and delivery. Persaud also argued that because of the stigma surrounding psychiatrists, patients harmfully delay in coming forward to receive treatment, and because psychiatrists' authority is less than other medical experts, patients often ignore their advice (Wilkinson and Daoud, 1998) and therefore they frequently appear ineffective (Sharf, 1986). They are then ignored by the media who are seeking other authority figures to discuss mental health problems (Rosenberg, 1983; Perr, 1983), which then places expertise on mental health issues, in the minds of the public and journalists, elsewhere than within psychiatry.

There are clearly a number of ways that mental health stigma can negatively impact an individual, his/her family, and even service providers. It is regrettable that there are not as many ways to de-stigmatise and reintegrate the person into a more 'normal' life (Goode, 1994) where they are free of the array of hampering consequences of stigma.

2.3 Stigma and attitudes to mental health problems in various cultures

2.3.1 China

Sevigny et al (1999: p42) state "that all observers of Chinese society would agree that there are still many forms of prejudice or stigma towards mental illness", including authoritarianism and fear. Song et al (2005) agree and provide an example of such stigma where a coffee shop run by people with mental health problems was forced to shut down due to the protests of the local community residents. Song et al argue that such stigma exists because the Chinese often view mental illness as directly related to moral judgment and supernatural factors. This links to the Chinese views of people with mental illness having a 'genetic taint' (Pearson, 1993) and being 'bad seed' (Sue and Morishima, 1982). Kwok (2000; 2004) states that part of the stigma problem is the Chinese cultural value of going to great lengths to ensure that family shame is kept inside the house and away from others. As mental health problems are conceived as a particularly strong phenomenon to be ashamed of for the whole family (Sue, 1994; Uba, 1994), due to its threat to family face and even marriage-ability (Kung, 2003), such problems often become hidden and go untreated (Lin, 1983). Kwok adds that the stigma problem is made worse by the Chinese in general possessing very little knowledge about the various degrees and types of mental health problems, and instead relating automatically with violence and fear. She argues that the media perpetuate such stereotypes, highlighting how newspaper editorials use sensational headlines such as 'A mentally ill man tried to kill a stranger', instead of objectively analysing the causes of mental illness which would help educate the public. Song et al (2005) agrees, describing that the media often report on negative events such as homicide, suicide and other disturbing behaviours committed by the mentally ill, who

the media have labelled 'the unpredictable bomb'. Chung and Wong (2004) found that such negative media portrayal causes Chinese inpatients to increase their feelings of hurt, rejection, and self-stigma, which can delay rehabilitation. Chou (1993) argues that even to receive mental health care is fortunate as it is generally unavailable, especially for the mildly or moderately ill. Consequently, to receive 'treatment' implies that you must be severely and persistently ill (such as chronically psychotic).

Thus, Kwok states that, under such a negative cultural environment towards mental health problems, it is understandable that many mentally ill people refuse to seek help and rather carefully guard the existence of any problem. She adds that this negativity and fear of accessing professional services carries over to Chinese living in other countries. Particularly for new Chinese immigrants, their problem is also often exasperated by their lack of language skills knowledge about their host countries' mental health services. Kwok also importantly highlights that Western psychiatrists tend to often overlook important aspects of the Chinese culture when dealing with Chinese patients, often failing to realise that the Chinese (and particularly females) confine their emotions and thoughts to close friends and not doctors. This is because the Chinese are not used to 'talk therapy' and are also raised to respect doctors, although not talk back at them.

Despite the existence of strong social stigma, Kung (2003) states that a person with mental illness is likely to receive care and involvement from their family members, given the centrality of family in traditional Chinese culture. Pearson (1993) agrees, stating that it is common practice for service providers to expect the close involvement of family members, including remaining with the individual in the

hospital to directly care for them. Mental health services also consider patient treatment and outcome from the perspective of the family (Chou, 1993). Yip (2005) further demonstrates the family's role in care by citing that in the USA and Canada approximately 65% of mental health clients who are discharged from hospital return to their families, whereas in China, over 90% do. Indeed, strong levels of family support and tolerance are central to why developing countries such as China are typically associated with comparatively positive prognosis and outcome in schizophrenia (WHO, 1979; Jablensky et al, 1992; Harrison et al, 2001). This is interesting as it suggests that if professional care is accessed, the strong levels of family support within collective cultures potentially improves outcome. If stigma is a barrier towards seeking professional help (Schomerus and Angermeyer, 2008), interventions that reduce stigma in collectivist cultures such as China could also improve patient prognosis and outcome.

The reviewed research literature paints a clear picture of there being a significant level of deep-rooted mental health stigma in the Chinese culture. It is apparent that this is causing an array of problems, such as perpetuating fear associated with mental illness, hiding a mental health problem within the family, and hampering the quick and effective treatment.

2.3.2 Greece/Cyprus

There is currently an extended national deinstitutionalisation project progressing in Greece, with a large number of psychiatric inpatients being discharged after a lengthy stay to be relocated in the community in small residential services (Ministry of Health

and Welfare, 2001). Economou et al (2005) state that the community relocation strategy is frequently being met a negative social reaction. However, Greece view views the deinstitutionalisation initiative as a necessary step towards challenging community stigmas even if they are initially with public negativity. Their motivation for proactively challenging stigma is in due to their participation in the World Psychiatric Association's 'Global Programme against Stigma and Discrimination Because of Schizophrenia' plan.

However, community-focused relocation initiatives in Greece have been argued to effectively erode stigma over time. For example, Madianos et al (1999) collected data on public attitudes to mental illness in 1979/1980 and again in 1994 from 360 people from two boroughs in Athens, in what is one of only a few studies that have accurately documented Greek public mental illness attitudes (Economou et al, 2005). They found that although Athenian attitudes were not positive in either time-frame, there were significantly less stigmatising attitudes in 1994. The authors conclude that was very likely due to the post-1980 introduction of a local community mental health centre that worked in both boroughs, which increased contact and knowledge about mental health problems.

Economou et al (2005) compared the results of their large-scale public opinion survey on schizophrenia in Greece with the same survey's results conducted in Germany (Gaebel et al, 2002) and Canada (Stuart and Arboleda-Florez, 2001), as part of Greece's involvement in the WPA anti-stigma programme. They found that social-distance levels were strikingly higher in Greece, particularly when considering social situations that involve higher degrees of intimacy. An especially stark contrast

between their samples' data regarded working with someone afflicted with schizophrenia: 50% Greeks reported that they would be 'disturbed' to do this, as compared to one every sixth Canadian and German. They also found that Greeks would rather form a friendship with a person with schizophrenia than work with them. Economou et al postulate that this rooted with the Greek public's perception of schizophrenia being directly associated with criminality. However, most Greeks were not rejecting of the idea of having mental health community group homes, so long as such homes were not in their own neighbourhoods. The main socio-demographic finding was that the older respondents held the most stigmatising views. Thus, it would appear that stigma towards schizophrenia is still highly prevalent, although mainly in the sense of social distance, particularly in employment situations and amongst older, more traditional Greeks.

Papadopoulos et al's (2002) comparison study of white-English and Greek/Greek Cypriots' attitudes to mental illness also found that Greeks were stigmatising of mental health problems. We found that compared to English people, Greek/Greek Cypriots were more authoritarian, more socially restricting of the mentally ill and more likely to view them as less intelligent – a view most strongly held by older, first generation Greek/Greek Cypriots. However, there were no ethnic differences between ethnic groups on measures of benevolence or aggression. These findings suggest that Greeks are sympathetic to people with mental health problems but still view them as inferior and potentially dangerous people to be kept away from local neighbourhoods and controlled for the safety of the community and themselves. Other research on UK-migrant Greeks indicates that Greek Cypriots are likely to strongly deny a family member having a mental health problem, will try to conceal it, and only access

psychiatric services if the symptoms were extremely severe (Dunk, 1989, Papadopoulos, 1999; Madianos et al, 1987). If a family member with mental illness does become hospitalised, they are deemed by the Greek community to be an individual incapable of normal social functioning and, therefore, the person and his/her family will face dire social consequences.

2.3.3 America

Mental illness is a substantial health problem in the United States. According to the American Psychological Association (APA) (2008), 18% of Americans suffer from a diagnosable mental disorder and close to 10 million are children. Even though mental health problems are widespread in the general population, according to the National Institute of Mental Health (NIMH) (2008), the main burden of illness is concentrated in a much smaller proportion - approximately 6%, or 1 in 17 - who suffer from a serious mental illness. In addition, the NIMH report that mental health problems are the leading cause of disability in the United States for people aged between 15 and 44 years. Further, nearly half (45%) of those meet the criteria for possessing two or more mental health problems, with severity strongly related to co-morbidity.

Despite their large-scale prevalence, mental health problems are still stigmatised in the United States (Duckworth et al, 2003; Hill, 2005). For example, in 1996, a 'General Social Survey' (GSS) was conducted in order to collect varied and detailed data on the demographic characteristics of United States residents. One integrated area of data collection, the 'MacArthur Mental Health Module', concerned how people perceive those afflicted with mental illness in order to evaluate Americans'

current attitudes toward mental disorders and those who experience them. Phelan et al (2000) compared this dataset with an equivalent 1950 national survey dataset and found little evidence that the stigma of mental health problems has been reduced in contemporary American society. This is demonstrated by the public's distressingly high social distance preferences and their unwillingness to accept the mentally ill as family members or co-workers. Socall and Holtgraves (1992) revealed similar findings when they found that the American public documented more unwillingness and social rejection towards people labelled mentally to a significantly higher degree than those labelled as physically ill, particularly when severity of mental illness symptoms increased. Phelan et al's (2000) analysis also revealed that many Americans believe that people who experience psychosis are dangerous. Link et al (1999), who also analysed the 1996 GSS dataset, argue that this is a key reason why Americans are more unwilling to interact with people experiencing symptoms of schizophrenia than with people experiencing symptoms of major depressive disorder. Link et al also found that Americans are aware of some the differences between such psychotic and mood disorders yet still make stigmatising assumptions such schizophrenia posing more danger, and being more dehabilitating and 'more of a mental illness' than major depressive disorder. Schnittker et al (2000)'s analysis of the same survey revealed several geographical and ethnic/cultural differences of mental health attitudes and knowledge in the United States. Specifically, they found that Southern Americans more frequently endorse the belief that a person's bad character is responsible for an occurrence of a mental health problem, although social distance preferences were very similar to the rest of America. They also found that African Americans are less likely than whites to believe that mental health problems can occur due to genetics or an unhealthy family upbringing. Further, they tended to

have more negative attitudes than towards how profession mental health services and treatment. Ayalon and Arean (2004) also revealed ethnic/cultural variances when they found that, from a sample of older adults recruited from primary-care clinics in San Francisco, Anglo-American participants were more knowledgeable about Alzheimer's disease and less stigmatising than African Americans, Asians, and Latinos.

However, there is also room for optimism. Pescosolido et al's (2000) analysis of the same dataset reveals that Americans are now much more knowledgeable and experienced about mental health problems than in 1950. For example, in the 1950s, when asked the meaning of mental illness, the largest proportion of the American public mentioned behaviours indicative of either psychoses or anxiety/depression. However, when asked this same question in 1996, large numbers of Americans broadened their definitions to also include less severe psychological problems such as mild anxiety and mood disorders. Further, in 1996, relatively large numbers of Americans had first-hand knowledge of people suffering from mental health problems, with over half of all Americans reporting that they personally know someone who had been hospitalised due to a mental health problem. An even larger percentage reported knowing others who have received outpatient mental health services. Further, research conducted in 2004 by the APA showed that stigma is less of an obstacle than ever before to seeking and obtaining mental health treatment in the United States. Their findings revealed that 48% of 1,000 randomly selected Americans aged 18 – 64 years reported a visit to a mental health professional by someone in their household this year. Furthermore, 91% agreed that they would likely consult or recommend a mental health professional if they or a family member experienced a problem in the future, while 97% regarded access to services as

important. Forty-seven percent of respondents agreed that the stigma surrounding mental health services has decreased in recent years, although a third of respondents also agreed that they would be concerned if other people found out if they sought mental health treatment, many of whom cited that stigma as "a very important reason not to seek help" from a mental health professional. The main obstacle to seeking treatment was instead a lack of confidence in treatment, cost, and lack of insurance. Faye (2005) also cites financial expense as significantly problem, stating that "in the United States, if an individual is poor and lacks health insurance, help is less likely to be attained. Significantly, if individuals are African American, American Indian or Alaska Native, Asian American and Pacific Islander, or Hispanic American, they have even fewer chances of receiving care than their more economically and socially privileged Caucasian counterparts" (p972). With regard to lack of confidence in treatment, this may be related with what Faye describes as services failing to deliver culturally competent care to non-Caucasian American populations. As Lim and Lu (2005) argue, the lack of professionals trained to identify and effectively treat the mental health problems manifested among ethnic minority populations is a significant barrier to the health and well-being of these individuals and their communities.

Interestingly, the APA (2004) also found that 35% of Americans give the media the most credit for reducing the stigma surrounding mental health services. The importance of the media's impact on public view is described by Duckworth et al (2003). They randomly selected 1,740 American newspaper articles between 1996 and 1997 that mentioned schizophrenia or cancer and found that only 1% of articles cited cancer in an inaccurate metaphorical sense, compared to 28% of articles that mentioned schizophrenia. The authors argue that such inaccurate metaphors

significantly add to public stigma of psychiatric illnesses: "Getting the word 'schizophrenia' almost right facilitates social unacceptability, contributing to reluctance on the part of persons with schizophrenia to seek help for the condition" (p1403). Although this research finding would appear to conflict with the APA's survey finding, it is important to note that Duckworth et al's enquiry only examined schizophrenia – a mental health problem known to be still highly stigmatised in American society. Henry et al (2004) provide more reason for optimism by comparing the mental health attitudes of community agency staff in the United States and Israel. After controlling for age, education, and agency type, they found that staff in the United States held generally more positive attitudes about mental illness than Israeli staff, although educational level was the main predictor of positive attitudes. Henry et al's work is one of a number of enquiries which indicate that Americans, and particularly Caucasian Americans, generally hold less stigmatising attitudes than many other cultures. For example, Whaley (1997) examined general population ethnic differences in stigma levels from a nationally representative sample of 1,468, finding that compared to Asian and Hispanic participants, Caucasian Americans were significantly less likely to view the mentally ill as dangerous. Shokoohi-Yekta and Retish (1991) compared Chinese and American male students attitudes towards mental illness and found that Americans held significantly less authoritarian and socially restrictive attitudes, and higher benevolent attitudes. Chen et al (2002a) compared American, Taiwanese and Singaporean university students' attitudes towards people with mental and physical disabilities. They too found that their American sample held less stigmatising attitudes. Specifically, their American respondents were significantly less likely to perceive people with disabilities as different, inferior, or disadvantaged to some degree. Further, the American

respondents were less likely to oppose dating or marrying a physically disabled or mentally ill individual. Interestingly, the Singaporean group were found to be less stigmatising than the Taiwanese group. The authors speculate that this may be due to the western influence because of its former status as a British colony. Another example comes from Suan and Taylor (1990) who used the Mental Health Values Questionnaire (MHVQ) to measure attitudes towards mental illness. They found that Japanese-American university students rated characteristics such as untrustworthiness, exhibiting poor interpersonal relations, and a negative personality, as stronger indicators of poor individual mental health than Caucasian-American university students. In a similar study, Gellis et al (2003) compared the attitudinal differences of 104 South Korean and 107 Caucasian-American counselling students, also using the MHVQ. They too found that the Korean students were significantly more likely to associate negative personality traits, low achievement and untrustworthiness to poor mental health than Caucasian-American students. They also found that the American students had significantly more experience of others with mental health problems than Korean students, as well as significantly being more likely to report personally having had a mental health problem. Further, significantly more Caucasian-American students expressed an interest in working in the mental health field upon graduation. Gellis et al (2003) speculate that Caucasian Americans hold more positive attitudes because of the progress made in American mental health services and advocacy during the past decade. This includes new forms of effective treatments, political support for parity of mental health coverage, and the proliferation of educational programs against the stigmatisation of the mental health problems. They also state that this has helped Americans' current knowledge of mental health problems to be greater now than it was in the 1950s (Pescosolido et al, 1999; Brown and Bradley,

2002). Mechanic (1999) also notes such positive progress, stating that there have been significant improvements in treatment, public attitudes, services organisation, growth in mental health insurance coverage, episodes of care, and research of all kinds. He cites both superior treatment technologies, and the deinstitutionalisation of people with mental health problems, lending to a trend of improved managed care arrangements, as primary reasons for mental health progress in modern American society.

The literature paints a picture of optimism tempered by the reality of perpetuating stigma. This is because while it can be argued that there is reason for sanguinity due to the American public's greater knowledge and experience levels of mental health problems, as well as very positive cultural comparison scores, a strong stereotype of dangerousness and desire for social distance persists, particularly in southern geographical regions and by non-Caucasian Americans.

2.3.4 United Kingdom

In the United Kingdom, 'Standard One' of the 'National Service Framework for Mental Health' (Department of Health, 1999) requires all health and social services departments to combat discrimination against mental illness and to promote the social inclusion of those afflicted. Actions to address stigma and discrimination are also found throughout service user movement, while professional organisations have also set up their own programmes, including the UK Royal College of Psychiatrists' 'Changing Minds' campaign that began in 1998.

According to Pinfold et al (2005), mental illness public stigma in the UK is relatively well researched compared to many other countries. For example, Crisp et al (2000) conducted a large-scale survey on a representative sample of the general population in the UK. They found that negative opinions of people with mental health problems were both widespread and prevalent across their sample. This included the stigmatising beliefs that such people are hard to talk to, feel different from the way 'normal' people do, and are unpredictable. The most negative opinions were held about schizophrenia and substance dependence, mainly due to the belief that people with these disorders are dangerous. As Crisp et al correctly state, this evaluation is in reality true of only a very small percentage of such sufferers, whereas their survey participants believed this to be true of most people. The authors state that these stereotyped beliefs align with the ideas that the media often portray of people with mental health problems. Johnson et al (2001) agrees, drawing attention to how during the 1990s, acts of violence by mentally ill individuals received extensive publicity, with media reports indicating that caring for such people in the community is dangerous. This is again highlighted by Ferriman (2000), who argues that in Britain, it is not uncommon to read the labels 'maniacs', 'schizos', 'psychos', and 'nutters' in the tabloid newspapers when stories are published about people with mental health problems. Even the traditionally more 'responsible' broadsheet newspapers in the UK overwhelmingly tend to portray people with mental illness as being potentially harmful to others, both in fictional and non-fictional representations (Philo et al, 1996). With such flagrant displays of prejudiced attitudes, it is easy to view the media as perpetuating stigmatising attitudes. Crisp et al's research also underlined the authoritarian belief that people who have eating disorders have self-inflicted this condition. They also consider that such people as very likely to recover – a view that

is consistent with the tendency to trivialise this condition. Crisp et al's findings also tentatively indicate that most British people have at least a basic knowledge about mental health problems, and that people who personally knew of someone with a mental health problem were no less likely than others to hold stigmatising ideas, such as the dangerousness of people with schizophrenia, alcoholism and drug addiction. This finding provides partial support for what James (1998) has previously claimed – that the effect of contact with a mentally ill person depends on both the nature of the contact and the nature of illness. A recent example of UK public stigma, reported by the media, was revealed in the Norwich area where a statue of Winston Churchill in a straitjacket was unveiled. Unveiled by the mental health charity 'Rethink' as an attempt to ironically stamp out mental illness stigma, the statue aimed to highlight that that despite dealing with the symptoms of manic depression throughout his life, he was able to become Prime Minister. However, the statue was instead interpreted by the public, former World War soldiers, and Churchill's family as insulting and their complaints eventually led to it being removed.

Papadopoulos et al (2002) also investigated the views, knowledge and contact levels of the British people, specifically white-English people, and compared them with those of Greek/Greek Cypriots. Although the large proportion of both samples held negative views about mental illness, the white-English participants held significantly less stigmatising views. They were also more significantly more knowledgeable, and reported significantly more previous contact with people afflicted with mental illness than their Greek/Greek Cypriot counterparts. We also found that the most significant predictor of negative attitudes was lack of knowledge, although previous contact was also found to be important. Another UK-based study was conducted by Wolff et al

(1996a; 1996b; 1996c). Their three-part enquiry revealed similar results; a relationship between lack of knowledge and negative attitudes, and that minority ethnic people are more likely than the white UK-born individuals to hold more stigmatising attitudes, be less knowledgeable about mental illness, and object to stigma-reducing intervention campaigns.

Another study that specifically examined the views of white-British people was conducted by Marwaha and Livingstone (2002). They qualitatively explored and compared the views of white-British and black African-Caribbean older people (aged 67-93 years) on depression, half of who had previously been depressed themselves. They found that the white-British participants were more likely to recommend that those with depression should consult a General Practitioner for treatment, whereas the black African-Caribbean group viewed spiritual care and the church as more appropriate treatment services for mental illness. The white participants were also considerably less likely to state that 'nothing can help' mental health problems.

Pinfold and colleagues have also examined mental illness stigma in the UK, however with specific attention on the effectiveness of various educational interventions aimed at reducing psychiatric stigma. For example, in 2003, Pinfold et al assessed the effectiveness of an anti-stigma intervention for young people in secondary schools. From their sample of 634 year-10 students, they found that young people possess an extensive vocabulary of 270 different words or phrases used to describe people afflicted with mental health problems, most of which are derogatory. The impact of their educational campaign was small but positive, particularly for females and those who had previously reported having personal contact with people with mental illness.

Two years later, Pinfold et al (2005) explored and compared the WPA's anti-stigma school programmes of both the UK and Canada. They found that, at baseline, the Canadian students were significantly more aware than their UK counterparts that schizophrenia is not a split personality, that mental illness is prevalent, and that people with schizophrenia are not more likely to be violent than others. Both educational campaigns had a positive impact, including increasing knowledge, decreasing social distance scores, and, overall, improving attitudes. Their findings also revealed a generally positive response from both students and school representatives, reflecting what Pinfold describes as a "growing commitment to promoting mental health and well-being in the classroom" (p50-51). They conclude that schools are a very important site for mental health education programmes. Pinfold et al (2003) evaluated an anti-stigma educational campaign on the English police force who the authors view as a particularly important target group due to their high levels of career-stress, and because of they are frequently engaging with members of the public afflicted with mental health problems. Their analysis of the educational campaign again revealed a positive and often significant impact on stigmatising mental illness attitudes.

The reviewed literature describes a complicated story for mental illness stigma in the United Kingdom. It appears that British people are relatively knowledgeable about mental illness, and, while stigmatising attitudes are still prevalent and widespread, there are emerging signs that this group's attitudes are improving, particularly in the case of white-British people.

2.4 Individualism-collectivism

This value paradigm has been examined more thoroughly than any other model in contemporary cross-cultural psychology, dominating areas of many fields, from social, developmental, and personality psychology to political science and management (Berry et al, 2003). Thus, even though it can be argued that the defining difference between individualism and collectivism is a primary concern for oneself in contrast to the groups(s) to which one belongs, it is not surprising that many other finer distinctions and conceptualisations have been proposed by authors. The following sections present a summary of three key authors who have conceptualised and researched the individualism-collectivism paradigm.

2.4.1 Geert Hofstede

It is argued by many that the concepts of individualism and collectivism were revived when Geert Hofstede, a Dutch cultural anthropologist, published his work 'Culture's Consequences' in 1980. Hofstede famously administered work goal questionnaires from 1967 until 1973 to 117,000 IBM employees from 50 national cultures and three regions in what remains one of the most comprehensive studies to date in cross-cultural psychology. Hofstede conceptualised culture in terms of meanings, and therefore studied it by assessing the values of people. Culture-level, rather than individual-level, factor analyses (using country mean scores) produced four factors: 'individualism', 'power distance', 'masculinity', and 'uncertainty avoidance'. In subsequent research, 'individualism-collectivism' far exceeded the other factors in popularity (Berry et al, 1997). The three work goal questionnaire items associated

with individualism stressed having a job that gives one sufficient time for personal or family life, having freedom to adapt one's own approach to the job, and having challenging work to do (providing a sense of personal accomplishment). The items associated with collectivism stressed having training opportunities, having good physical work conditions, and having the possibility using skills and abilities on the job. However, it is not clear how these six items, both in terms of number and content, assess individualism and collectivism, particularly in relation to collectivism, where the items do not appear to be conceptually similar to the definitions of the individualist and collectivist constructs. Hofstede, although acknowledges this problem, points out that the relative emphasis on individual freedom versus dependence in an organisation provides some valuable clues regarding individualism-collectivism.

The empirical validity of Hofstede's framework of cultural dimensions has also been extensively critiqued in the cross-cultural literature (Shackleton and Ali, 1990; Sondergaard, 1994; Yoo and Donthu, 1998). For example, the generalisability of his research findings has been questioned because of the sample being drawn from only one large multinational company (Yoo and Donthu, 1998). It has also been argued that country differences may be confounded by the homogenising influence of a corporate culture that traverses national boundaries (Shackleton and Ali, 1990; Schwartz, 1994). Furthermore, it has been suggested that Hofstede's dimensions of national culture may be a product of the period of the study (Yoo and Donthu, 1998). However, Hofstede's model is now generally accepted as the most comprehensive framework of national cultural values (Yoo and Donthu, 1998, Schimmack et al, 2005). It has a high level of generalisability and has significant correlations with

economic, social and geographic indicators (Kogut and Singh, 1988). Furthermore, Hofstede's dimensions have been found to be reliable and stable over time (Bond, 1988; Chinese Culture Connection, 1987; Kogut and Singh, 1988; Yoo and Donthu, 1998; Schimmack et al, 2005).

Hofstede later succinctly defined that "individualism stands for a society in which the ties between individuals are loose; everyone is expected to look after himself or herself and his or her immediate family only" and "collectivism stands for a society in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty" (Hofstede, 1991: p260-261). In a subsequent publication, Hofstede (1997) provided more detail for his conceptualisation of individualism-collectivism. He argued that individualistic cultures value personal time, freedom, challenge, and extrinsic motivators such as material rewards from work. Within the family, people from these cultures value honesty and truth, 'talking things through', using guilt to achieve behavioural goals, and maintaining self-respect. Their societies and governments place the individual's social-economic interests ahead of the group, maintain strong rights to privacy, restrain the power of the state in the economy, emphasise the political power of voters, maintain freedom of the press, while professing the ideologies of self-actualisation, self-realisation, self-government, and freedom. For people from collectivist cultures at work, Hofstede argues that people value training, physical conditions, skills, and the intrinsic rewards of mastery. Within the family, harmony is valued more than honesty and truth, silence more than speech, shame (not guilt) to achieve behavioural goals, while striving to maintain face and honour. Their societies and governments instead place the collective's laws, right and

social-economic interests ahead of the individual, they may invade private life to regulate opinions, dominate the economy, restrict the freedom of the press, while professing the ideologies of harmony, consensus, and equality. These and other differences between Hofstede's conceptualisations of individualistic and collectivist cultures are presented in table 2.1.

Table 2.1: Differences between collectivists and individualists (adapted from Hofstede, 1997)

Collectivists	Individualists
People are born into extended families or other in-groups which continue to protect them in exchange for loyalty	Everyone grows up to look after him/ herself and his/her immediate (nuclear) family only
Identity is based in the social network to which one belongs	Identity is based in the individual
Children learn to think in terms of 'we'	Children learn to think in terms of 'I'
Harmony should always be maintained and direct confrontations avoided	Speaking one's mind is a characteristic of an honest person
High-context communication	Low-context communication
Trespassing leads to shame and loss of face for self and group	Trespassing leads to guilt and loss of self-respect
Purpose of education is learning how to do	Purpose of education is learning how to learn
Diplomas provide entry to higher status groups	Diplomas increase economic worth and/or self-respect
Relationship employer-employee is perceived in moral terms, like a family link	Relationship employer-employee is a contract supposed to be based on mutual advantage
Hiring and promotion decisions take employees' in-group into account	Hiring and promotion decisions are supposed to be based on skills and rules only
Management is management of groups	Management is management of individuals
Collective interests prevail over individual interests	Individual interests prevail over collective interests
Private life is invaded by group(s)	Everyone has a right to privacy
Opinions are predetermined by group membership	Everyone is expected to have a private opinion
Laws and rights differ by group	Laws and rights are supposed to be the same for all
Low per capita GNP	High per capita GNP
Dominant role of the state in the economic system	Restrained role of the state in the economic system
Economy based on collective interests	Economy based on individual interests
Political power exercised by interest groups	Political power exercised by voters
Press controlled by the state	Press freedom
Imported economic theories largely irrelevant because unable to deal with collective and particularistic interests	Native economic theories based on pursuit of individual self-interests
Ideologies of equality prevail over ideologies of individual freedom	Ideologies of individual freedom prevail over ideologies of equality
Harmony and consensus in society are ultimate goals	Self-actualization by every individual is an ultimate goal

Hofstede (2008) has now re-measured the level of individualism across a number of

cultures, thus providing a valuable indication for which cultures are more

individualistic than others. Hofstede named this measurement the 'Individualism

Index'. The index score, which denotes the relative positions of 65 countries, ranges

from 0 for the most collectivist country to 100 for the more individualist (see table

2.2).

Table 2.2: Individualism (IDV) index values for 65 countries (Hofstede, 2008)

Score rank	Country or region	IDV score	Score rank	Country or region	IDV score
1	USA	91	34	Brazil	38
2	Australia	90	34	Arab countries	38
3	Great Britain	89	36	Turkey	37
4	Canada	80	37	Uruguay	36
4	Netherlands	80	38	Greece	35
4	Hungary	80	39	Philippines	32
7	New Zealand	79	40	Bulgaria	30
8	Italy	76	40	Romania	30
9	Belgium	75	40	Mexico	30
10	Denmark	74	43	East Africa	27
11	Sweden	71	43	Portugal	27
11	France	71	45	Malaysia	26
13	Norway	69	46	Hong Kong	25
14	Switzerland	68	47	Chile	23
15	Germany	67	48	Vietnam	20
16	South Africa	65	48	Singapore	20
17	Finland	63	48	Thailand	20
18	Luxembourg	60	48	China	20
18	Poland	60	48	Bangladesh	20
20	Malta	59	53	Salvador	19
21	Czech Republic	58	54	South Korea	18
22	Austria	55	55	Taiwan	17
23	Israel	54	56	Peru	16
24	Slovakia	52	56	Trinidad	16
25	Spain	51	58	Costa Rica	15
26	India	48	59	Pakistan	14
27	Surinam	47	59	Indonesia	14
28	Japan	46	61	Colombia	13
28	Argentina	46	62	Venezuela	12
28	Morocco	46	63	Panama	11
31	Iran	41	64	Ecuador	8
32	Jamaica	39	65	Guatemala	6
32	Russia	39			

2.4.2 Michael Bond

In 1984, Michael Bond reanalysed the findings of a study conducted by Ng et al (1982) who researched the value dimensions of nine Asian and Pacific countries. The re-analysis yielded five factors, four of which, including individualism-collectivism, corresponded to Hofstede's value dimensions across the six countries where both studies had been conducted (Hofstede and Bond, 1984). Schwartz (1994) has questioned this finding of correspondence, as only two values loaded into their factor analysis were considered to replicate individualism-collectivism, yet they do not fully nor adequately reflect the paradigm. Nevertheless, Hoftstede and Bond, claimed that the correspondence should be considered as "an example of synergy between two cross-cultural studies" (p432).

Bond subsequently worked with Chinese social scientists from Hong Kong and Taiwan to develop a non-Western instrument in an attempt to avoid any possible cultural bias that may have caused the correspondence found between Ng et al and Hofstede's work since both their measuring tools were developed in the West. This was constructed by asking Chinese scholars to nominate values of fundamental importance in the Chinese culture. The resultant 40-item instrument was named the 'Chinese Value Survey' (The Chinese Culture Connection, 1987). The survey, which was administered to 1,528 university students in 22 countries, revealed three factors which correlated with Hofstede's original dimensions, again including individualism-collectivism. Thus, the work provided additional validation of Hofstede's dimensions, including individualism-collectivism. It also revealed a new conceptual dimension, 'Confucian Work Dynamism', which was found to correlate to economic growth (.70)

and argued to be important to understanding Chinese value orientation. Hofstede and Bond (1998) examined this dimension and found that is links with the search for societal virtue, rather than a search for truth. They also argue that includes the sub-dimensions of persistence towards pursuing a goal, the hierarchical ordering of power relationships, a dislike of waste leading to creating products that are both economic in production and reliable in use, and a sense of shame if goals are not reached. Hofstede (1991) later adopted it as an added value dimension of cultural variation missing from his theory. Chinese cultural orientation is discussed in greater detail in chapter 2.5.2 and 5.4.2.

2.4.3 Triandis

Harry Triandis has popularised the individualism-collectivism paradigm in cross-cultural psychology with a research program that started in the early 1980s and currently continues. In 1986, Hui and Triandis conceptualised collectivism as 'concern for others'. They tested this by asking 81 psychologists and anthropologists of varying nationalities to indicate how individualists and collectivists would respond to questions tapping aspects of this concern (e.g. 'consider behaviours [e.g. fishing, singing] that the person enjoys doing very much. Would the person be likely to give up such activities to save time or money for the other, when the other has indicated that he or she needs such sacrifices?'). Their responses converged, showing some consensus in the construal of collectivism as the subordination of individual goals to the goals of the collective, in line with the author's existing conceptualisations.

Triandis et al (1986) also replicated some of Hofstede's results by sampling 15 different parts of the world. Four cultural value factors were obtained: 'family integrity' (e.g. 'children should live with their parents until they get married'); 'interdependence', representing collectivism (e.g. 'I like to live close to my good friends'); 'self-reliance' (e.g. 'it is best to work alone than in a group'), and 'distance from in-groups', representing individualism (e.g. 'if a family member is honoured, this honour is not shared by other family members'). However, and importantly, 'family integrity' and 'distance from in-groups' were found to explain more variance across cultures, whereas 'interdependence' and self-reliance explained more variance at the individual (or 'personality') level. Because this finding revealed the existence of an important distinction between the cultural and individual/personality level, Triandis coined the terms 'allocentrism' and 'idiocentrism' to replace collectivism and individualism, respectively, at the individual/personality level. As Triandis (2001: p910) states, "this allows us to discuss the behaviour of idiocentrics in collectivist cultures and allocentrics in individualistic cultures".

Triandis has also proposed several other indicators (antecedents and correlates) of individualism and collectivism (see table 2.3). One of these indicators is 'ecology' which Triandis argues can powerfully shape culture. For example, as Triandis states, "societies where fish is available in the environment are more likely to use fish as food, and to have fish-based economies. Societies that have experienced failures throughout their history are likely to be less optimistic than societies that have experienced mostly successes, and so on" (2001: p911). Ecology also includes geography. For example, societies that are relatively isolated, such as those on islands, are likely to score high on levels of 'tightness', where sanctions are present for even

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minor deviations from the norm. Triandis argues that tight cultures have very clear ideas about what behaviours are appropriate, and, due to their isolation, they are less likely to be influenced by neighbouring cultures, and are less likely to accept other norms. Triandis also highlights that such cultures tend to include members who are highly interdependent, and have a dense population which raises the level of surveillance. Therefore, when one does deviate, another will be likely to notice, which serves to protect the culture's members and their norms. Pelto (1968) agreed, stating that the tighter the culture, the more likely there is an agreement to what constitutes correct actions; one must also behave exactly according the norms of this culture, and suffer severe criticism for even slight deviations from established norms. As Carpenter's (2000) and Triandis' (1995, 2006) research reveals, tight cultures are more likely to be collectivist. For example, in Japan, which is a tight culture, people are sometimes criticized for minor deviations from norms, such as having too much sun tan, or having curly hair (Kidder, 1992), while Iwao (1993) argues that most Japanese live in fear that they will not act properly. The opposite to tightness, is 'looseness', and in these cultures Triandis states it is significantly more likely that deviance from the norm will be tolerated, where people depend less on each other, and where population density and opportunity for surveillance is lower. Cosmopolitan cities such London are generally loose, although ethnic enclaves and other relatively small communities that inhabit them can remain very tight. Like looseness, the more 'complex' a culture (where there are many available cultural choices and lifestyles available), the more likely it is to be individualistic. Triandis (1995, 2001) argues that indices of cultural complexity include gross national product per capita, personal computers per capita, the percent of population that is urban, the number of employment types and opportunities, and the size and number of cities. Iyengar and

Lepper's (1999) research concurs with this idea, and state that in complex cultures there are more likely to be more choices and lifestyles available for its members. Thus, it is understandable that people in individualistic cultures accept deviance from the norm and diversity, and desire and are motivated by personal choices more than people in collectivist cultures.

Other correlates of collectivism proposed by Triandis include sharp in-group-out-group distinctions, a small number of in-groups, in-groups being ascribed rather than achieved, hierarchy, corrupt governments, in-group harmony, low creativity, low stress, greater and better social support, low criminality, low social pathology (suicide, divorce, child abuse), and low modernity (traditionalism). These and other attributes, and their antecedents and consequents, are presented in table 2.3. A more detailed examination of correlates to collectivism and individualism is presented in section 2.7.

Triandis (1995, 2006) has also made it clear that pigeonholing cultures into a collectivist or individualist framework is the broadest and most basic categorisation. For example, there are many different types of individualism and collectivism. For instance, Korean collectivism is not identical to Israeli Kibbutz collectivism. Further, within cultural variations exist, as allocentrism can be found within traditionally labelled individualistic cultures, while idiocentrism can exist within collectivist cultures (Dutta-Bergman and Wells, 2002). Triandis also states that individualism and collectivism can also co-exist in individuals and groups at the same time and different situations. One example of this is provided by Kusdil (1991), who found that Bulgarian-Turkish teachers have higher allocentric values than Turkish teachers, but

were no different from each other in idiocentric values. If individualism-collectivism were a single dimension with two opposite poles, the above finding could not have been possible.

Table 2.3: Attributes defining individualism and collectivism and their antecedents and consequents (Triandis et al, 1990)

Antecedents	Attributes	Consequents
Individualism		
• Affluence • Cultural complexity • Hunting/food gathering • Upper social class • Migration • Urbanism	• Emotional detachment from in-group • Personal goals have primacy over in-group goals • Behaviour regulated by attitudes and cost-benefits analyses • Confrontation is ok	• Socialisation for self-reliance and independence • Good skills when entering new group • Loneliness
Collectivism		
• Unit of survival is food • In-group • Agriculture • Large families	• Family Integrity • Self defined in in-group terms • Behaviour regulated by in-group norms • Hierarchy and harmony within in-group • In-group is seen as homogeneous • Strong in-group/out-group distinctions	• Socialisation for obedience and duty • Sacrifice for in-group • Cognition: Focus on common elements with in-group members • Behaviour: intimate, saving face, reflects hierarchy, social support, interdependence

Another important contribution made by Triandis (2001, 2006) was the classification of 'horizontal and vertical' cultures. This is another cultural value paradigm that has links with individualism-collectivism. He states that in 'vertical' cultures, people accept that societal hierarchy is a natural state which members should strive to climb. Those at the top of society 'naturally' have more power and privileges than those of the bottom of the hierarchy. However, in horizontal cultures, people accept that

societal equality is a given, as if one is to divide any resource it should be done as equally as possible. Thus, in vertical individualist cultures (VI), such as in the United States, people want to be unique but also the 'best', whereas in horizontal individualist cultures (HI), such as Sweden, people also want to be unique but more strongly desire social equality. In vertical collectivist cultures (VC), such as China and India, people both submit and sacrifice themselves to the authorities of the in-group, whereas in horizontal collectivist cultures (HC), such as the Israeli Kibbutz, people merge themselves with their equal-standing in-groups. Table 2.4 presents more detail of the characteristics of vertical and horizontal individualism and collectivism. Triandis (2001) concludes that much future research needs to be done to identify new dimensions, and to define or refine existing ones.

Table 2.4: Characteristics of vertical and horizontal individualism and collectivism (Singelis et al, 1995)

	Vertical		Horizontal	
	Collectivism	**Individualism**	**Collectivism**	**Individualism**
	Interdependent Different from others	Independent Different from others	Interdependent Same as others	Independent Same as others
Orientation	Authority ranking	Authority ranking	Equality matching	Equality matching
Values	Low freedom	High freedom	Low freedom	High freedom
Political	Communalism	Market democracy	Communal living	Democratic Socialism
System	(e.g. rural village in India)	(e.g. USA, France)	(e.g. Israeli Kibbutz)	(e.g. Sweden, British Labour Party)

2.5 The history of individualism-collectivism

Individualism-collectivism has become a popular concept since Hofstede's 'Culture's Consequences' research publication in 1980. However, the awareness of the idea of individualism-collectivism can be found as far back as the writings of ancient Greeks. In the 'Republic', Plato emphasised the importance of community rather than the individual. He believed that uncontrolled, free individuals are by nature harmful. Hence, a population should consist of groups of people, societies and cultures, which are managed and controlled by external authorities. Aristotle, conversely, believed that a population should consist of free uncontrolled and distinct individuals, as this is by nature both good and beneficial to conscious life, and that the highest cause in the universe is the well-being and happiness of the conscious individual.

Greek Sophists during the 5th century BC were among the first philosophers to clearly support individualistic ideas. Sophists, who were almost exclusively non-Athenians, were radical sceptics who doubted the truth of anything. It is suggested that 'cynicism' as a philosophical movement began with the Sophists. Protogaras, a prominent Sophist teacher, argued that social truth is both relative and subjective and, as such, any argument can be attacked and defended with equal success. Sophists also declared that when "in Crete do as the Cretans" implying that the individual may choose how to behave without needing to follow his/her in-group. Their beliefs came under heavy criticism from philosophers Plato and Socrates, particularly for advocating free-thinking individualistic attitudes over "standards of what is good and proper". Sophists also proclaimed that any means to individual success was desirable (a key idea of generic individualism); a philosophy which again came under criticism

from Plato and Socrates for its immorality and its contradiction of their belief that one should stick to the 'truth' even if they do not succeed. The opposition and criticism of Sophists have led to a present day negative reputation, as indicated by the negative connotation of the word 'sophistry'.

The awareness of individualism is also notable in British history. Thomas Hobbes, a British political philosopher during the 17th century, believed that the only right an individual cannot give up is the right to protect oneself. He argued that all other rights have to be voluntarily transferred to the sovereign. Therefore, the sovereign's power and protection is not externally imposed on a society but rather authorised by the individuals of the society. If the sovereign failed in its obligation to protect the individual, the sovereign rule should terminate. He argued this as he believed if people voluntarily submit to sovereign rule, political and societal struggles would end, and all people could pursue peace, stability and the "satisfaction of the individual's appetite".

Adam Smith, a British economist during the 18th century, believed that the individual's self-interest in a free market economy leads to economic well-being. He argued that self-interest was fundamental for providing the essentials of living: "It is not from the benevolence of the butcher, the brewer, or the baker, that we can expect our dinner, but from their regard to their own interest." (I.2.2) Jeremy Bentham, an 18th century philosopher and one of the founders of 'utilitarianism', claimed that an individual's pleasure and the avoidance of pain is the sole motive for human action. The test of good or evil during human action is its utility, that is, the usefulness in bringing about pleasant results (utilitarianism). He believed that the free expression of

individuals' wills and interests would provide the best way to create effective utility. He also felt that it is reasonable for individuals to seek their own general happiness because the interests of others are inextricably bound up with their own interests, although he recognised that as something easy for individuals to ignore.

Epistemological individualism, a theory about the nature of knowledge, asserts that the source of knowledge lies solely within the individual. This philosophy can be traced to 17th and 18th century British empiricists such as John Locke, George Berkeley and David Hume. Such empiricists attempted to put science on a more solid footing by making knowledge inductive and reality-based, rather than 'a priori', deductive and theoretical. They believed that a person does not know anything beyond his/her own purely subjective experience, enclosed within the confines of the mind and the sensations it receives.

Predating British empiricists, Rene Descartes, during the 16th century, had indirectly approved epistemological individualism. Descartes set out to destroy Aristotelian philosophy which placed emphasis upon consensus as the basis of knowledge. He pointed to the individual as the key source of knowledge in his 'Cogito ergo sum' ('I think therefore I am') by supporting and validating his knowledge of the world by importing the certainty of mathematics. He did this by removing any doubt from the foundations from which he would build his knowledge of the world. He chose to reject popular opinions and the writings of previous philosophers, and even meticulously questioned and criticised his own beliefs, opinions and ideas by examining the foundations of which they were built – the perceptual experience. He recognised that his foundations may indeed be flawed due to the possibility of

perceptions of the world being influenced by misleading experiences such as dreams and hallucinations. To cast away the possibility of dubious beliefs, Descartes imagined that there was a powerful evil demon whose vocation it was to deceive us about what we see and believe in the world. This would throw into question the certainty of the objects around any person, even the knowledge of his/her own body, as the knowledge of these is based on sensation and sensation alone could not guarantee total certainty. Descartes questioned the existence of everything, and even doubted the possibility that he existed. It was the latter question where Descartes argued that doubting must cease as Descartes maintained that in the very act of doubting, he is existing: "I think therefore I am".

These strong philosophical trends in individualism continued in Western Europe and North America where during the 18th century the American Revolution took place which endorsed values such as the pursuit of individual happiness and that all people are equal. Alex de Tocqueville, a French intellectual during the 19th century, spent nine months travelling throughout the United States examining American prisons. In his book 'Democracy in America', he wrote about his observations of how individualism was permeating through this new society. Indeed, Tocqueville significantly changed the meaning of the term 'individualism', using the word in connection to American democracy which contrasted to the aristocratic European social structure. Tocqueville was believed to be the first philosopher to make a clear differentiation of the term 'individualism' from 'egoism': "individualism is a word recently coined to express a new idea. Our fathers only knew about egoism...[Individualism] is a calm and considered feeling which disposes each citizen to isolate himself from the mass of his fellows and withdraw into the circle of his

family and friends; with this little society formed to his taste, he gladly leaves the greater society to look after himself"…"Egoism springs from a blind instinct….[It] is a passionate and exaggerated love of self which leads a man to think of all things in terms of himself and to prefer himself to all…[which] sterilizes the seeds of every virtue". Unlike egoism, which Tocqueville viewed as "a vice as old as the world," he saw individualism as a new phenomenon "of democratic origin" that "threatens to grow as conditions get more equal" (II.II.II.477).

Individualistic ideas were further supported by the 19th century English philosopher Herbert Spencer and his belief in 'Social Darwinism'. Contrary to popular belief, it was Herbert Spencer, not Charles Darwin, who coined the phrase 'survival of the fittest' in his Principles of Biology book (1862). Spencer adapted Darwin's theory of evolution into a social system in which those individuals, species, or races with the best acquired characteristics would survive. The idea states that societies evolve over time, as organisms do, and where the parts of an organism exist to benefit the whole, a society exists merely for the benefit of the individual. Spencer maintained that the natural growth of an organism required liberty which enabled him, philosophically, to justify individualism and to defend the existence of individual human rights. He was committed to the 'law of equal freedom' and insisted on an extensive policy of laissez-faire. For Spencer, liberty "is to be measured, not by the nature of the government machinery he lives under [...] but by the relative paucity of the restraints it imposes on him". He argued that the only function of the government was to be the policing and protection of individual rights.

The laissez-faire doctrine (as described and advocated by Adam Smith in 'The Wealth of Nations'), which upholds the individual and emphasises the non-interference in the affairs of others, became especially popular in the United States. Its economic ideas contrasted with Marxist collectivist advocacy that the government should own the means of production.

In Europe, individualism perhaps reached its peak popularity in phenomenology and existential philosophy. Phenomenology, a research methodological doctrine, involves the description of an individual's consciousness and experience of a phenomenon so that the researcher can better understand the individual's personal view of life and the meanings constructed from their life experience. Thus, its emphasis is on the value of understanding an individual's view of life. Existential philosophers, such as Jean-Paul Sartre and Simone de Beauvoir, argue that people are only the sum of life that they have created and as such a person's existence is always particular, unique and individual. They reject the belief that a person's freedom or activity can be formulated because existing and 'being' is revealed to and felt by the individual through his/her own experience and his/her situation. They also state that all humans have free will and that this should be strongly protected. Such philosophical ideologies point a clear link between individualism and existentialism.

As previously stated, collectivistic themes have been apparent since Plato's 'Republic'. In the East, during approximately the same period, Confucius, revered by many as the China's greatest philosopher, was teaching a moral and political doctrine which included principles of virtue such as loving others, to honour one's parents, to do what is right instead of what is an advantage, to practice reciprocity, and to rule by

moral example instead of force and violence, as a ruler who resorted to violence had failed in his/her duty: "Your job is to govern, not to kill" (XII). Confucius thought that government by laws and punishments could keep people in line, but government by example of virtue and good manners would enable them to control themselves from individual greed: "The superior man understands what is right; the inferior man understands what will sell" (IV).

Such social morality, underpinning a collectivist ideology, is also implicit in other eastern religions and philosophies such as Hinduism, Taoism, Buddhism, and Shintoism. In these religions, one of the most important considerations is given to virtue - defined as traditionally 'proper' behaviour. In Buddhism, there is an emphasis on the need for community and 'the oneness of all things'. The ultimate goal of existence is 'Nirvana', that is, the liberation from the individual self. In Hinduism, it is said that that when in heaven the individual soul loses its unique identification which is dissolved like a drop into the great ocean of life.

Jean Jacques Rousseau, a French philosopher of the 18th century, was one of the first modern philosophers to attack the institution of private property, and therefore is considered a forbearer of modern Socialism and Communism. Rousseau's ideas were rooted in his antipathy towards the 'bourgeois' class. He instead envisioned a collectivist utopia, ideas which appeared again in the works of Hegel and Marx. In his work entitled 'Social Contract', he proposed the idea of the state limiting property holdings so that society would avoid the existence of classes. He believed that the state of human nature is 'brutish' and without law, and that there can only be good people if there is the presence of moral classless society. He added that when a state

fails to act in a moral fashion it ceases to function in the correct manner and ceases to exert genuine authority over the individual.

Georg Wilhelm Friedrich Hegel, of the late 18th and early 19th centuries also endorsed collectivistic ideologies. Hegel, a German philosopher with a predominantly theological background, is argued by Peikoff (1995) to be more explicitly supportive of collectivism and 'state-worship' than even Plato. Hegel argued that the collective group holds primacy over the individual, and that if each man suppresses his identity so to coalesce with his fellows, the resulting collective entity, the state, will be a truer reflection of identity. This entity is not merely an association of individuals, as it will have its own identity with a will and a purpose of its own due to the 'consumption' of each individual's spiritual essence. "A single person, I need hardly say, is something subordinate, and as such he must dedicate himself to the ethical whole. Hence if the state claims his life, the individual must surrender it" (1821: p241)…"All the worth which the human possesses, all spiritual reality, he possesses only through the State" (1830, p39).. Hegel believed that the state is a creature of god which demanded that both the obedience and worship of its citizens. "[The entity] has the supreme right against the individual, whose supreme duty is to be a member of the state" (1821: p258). Hegel added that "the state is the true self of the individual" (1821: p259), that is, what a man actually desires is what the state desires, even though he may not be aware of it. As such, Hegel did not attack the principles of liberty and freedom, as he argued that the state was an actualisation of freedom. It is argued by Peikoff that such political ideologies were at the forefront of the minds of both Fascists and Nazis.

Hegel, however, did not hold strong ethical positions as he was more interested in the great movements of history than the individual. He was perhaps the first philosopher to think of history in terms of a dialectic, that is, the process of arriving at a truth by stating a thesis, developing a contradictory anti-thesis, and combining and resolving them into a coherent synthesis. This method or arriving at a truth by exchange of logical arguments led to Hegel's understanding of the progression of history in determined stages, and also gave Karl Marx, a German 19th century philosopher inspired by Hegel, the idea for his doctrine of 'dialectical materialism', that is, a theory that history progresses in stages that are based on the supremacy of different economic classes (feudalism replaced aristocracy, capitalism replaced feudalism, and socialism or communism will replace capitalism). Marx also held that individuals do not fully exist separately from the group, but he felt the more relevant group was one's economic class, rather than merely the State. Marx, with his fellow German philosopher and colleague, Friedrich Engels, are said to be the founders of the economic movements of Socialism and Communism, philosophies which have inspired the foundation of many communist regimes in modern society.

It is clear from this short review that understanding the history of collectivism and individualism offers us an important insight into how and where the ideas of these differing paradigms have their roots in many of the most noted works of past philosophers. Today, as Berry et al suggest (2003), the majority of humanity shares at least some aspects of collectivism. The West, where individualism is believed to be more widespread, only comprises less than one third of humanity and, even there, there are many within-cultural collectivist groups, such as particular ethic and cultural minority enclaves, and people of lower socioeconomic status (Singelis et al, 1995).

Thus, it would appear that the tensions of differing philosophies from individualistic and collectivistic groups are commonplace in many societies.

2.6 The emergence of the individualism-collectivism paradigm

The individualism-collectivism paradigm has seen its popularity as a framework of at least partially understanding cross-cultural differences rise ever since the publication of Hofstede's Culture's Consequences (1980a) research study. As Suh (1999) states, almost 100 publications per year use this paradigm when discussing cultural psychological differences. Hofstede's work involved attempting to define and explain the main psychological differences between cultural groups by factor analysing 14 work goal items from questionnaires administered in 1968 and 1972 to 117,000 IBM employees from 50 national cultures and three regions. Hofstede conceptualised culture in terms of meanings, and therefore studied it by assessing the values of people. His results produced four factors of difference between cultures: 'individualism', 'power distance', 'masculinity' and 'uncertainty avoidance'. In subsequent research, 'individualism-collectivism' far exceeded the other factors in importance and popularity. The 3 work goal items associated with individualism emphasised having a job that gives one sufficient time for personal or family life, having freedom to adapt one's own approach to the job, and having challenging work to do (providing a personal sense of accomplishment). Those associated with collectivism emphasised having training opportunities, having good physical work conditions, and having the possibility of using skills and abilities on the job. It is not clear how these items, in terms of number and content, accurately assess individualism and collectivism, as they are not fully conceptually similar, or of similar

scope, to the various major definitions of this construct. Nevertheless, Hofstede's work saw the beginning in a revival of the interest of this construct which continues today.

The upsurge of interest in the construct following Hofstede's work, particularly in cross-cultural psychology, still needs an explanation, particularly when one considers that individualism-collectivism constitutes only one of the four dimensions described by Hofstede, and even then it is not a new discovery. Parsons and Shils (1951) demonstrate this as they were one of the first researchers to illustrate the construct when they differentiated between a "self-orientation, or focus on ego-integrative morals, and a collectivity-orientation, or a focus on the social system" (p248). Tönnies (1887), a German sociologist, also put forward the distinction when he wrote about 'Gesellschaft' and 'Gemeinschaft', roughly translated as society and community, respectively. These early ideas are key precursors of the individualism-collectivism paradigm.

One possible reason for such interest is its perceived potential in partly explaining economic development. Hofstede (1980a; 1980b), including many other writers (Epstein, 1996; Dana, 1997; Herbig and Dunphy, 1998), demonstrated this by showing a strong correlation (.82) between individualism (at a cultural level) and the level of national economic development, whereas collectivism has been found to hinder entrepreneurial development (Rakoto, 1975; Hailey, 1987, 1988; Ravuvu, 1988; Davies, 2000; Triandis, 2006). This is possibly because, as Herbig and Dunphy (1998) suggest, cultures that emphasise individualism and personal freedom are more likely to show creativity and innovation and thus entrepreneurship. They are

presumably also more likely to prioritise economic success as it is a means towards personal gain. However, Marsella and Choi (1993) challenge this assumption by demonstrating how many collectivist cultures in the Pacific Rim, such as Malaysia and Japan, are having successful economic growth. Triandis (2006) has also highlighted China's economic power as an exception to the individualism-affluence association. Hofstede and Bond (1988) have explained this aberration by suggesting that Confucian-collectivist values that reward hard work, thriftiness, obedience, benevolent leadership, and harmony can have a positive economic impact. This supports the idea that individualism-collectivism is more of a continuum than a dichotomy (Chen et al, 1998), as individualists and collectivists are capable of exhibiting both types of goals and values on an individual/personality level as reported by Triandis and his allocentricism vs. idiocentrism notions. For example, the Japanese are argued to be collectivists in a cultural sense, but also exhibit idiocentric traits in their entrepreneurial behaviour. This is similar to the Indo-Fijians, who are considered collective at home but individualistic in business.

Another possible reason could be that the simple explanations are usually better than the complicated ones (parsimony). Thus, the more we can explain by assuming less (or using less explanatory factors), the better. Although there is an obvious attraction for 'simpler' explanations, there is a danger that the individualism-collectivism paradigm could become an 'all-purpose' construct if it is too easily used to explain every variation in human behaviour between so-called individualistic and collectivistic cultures. Fijneman et al (1996) demonstrated this by studying the particular psychological differences of students from Hong Kong, Greece, Turkey, the Netherlands, and the United States. They argued that in theory, people from

individualistic cultures should be less willing to contribute resources to others in their groups than people from collectivist cultures. They proposed that if this is true, such a difference would also be matched by lower expectations of receiving from their groups, yet their findings did not reveal either of these correlations. This was because they found that 'emotional closeness', not the individualism-collectivism paradigm, was the most important explanatory factor in predicting the sharing of resources. Further, 'sharing resources', a presumed characteristic of collectivism (Hui and Triandis, 1986; Sinha and Verma, 1987), was not any greater in the collectivistic cultures.

2.7 Individualism-collectivism as an explanatory model

Despite the challenge of Fijneman et al (1996), there is accumulated evidence of the paradigm being a key explanatory model for many psychological and behavioural differences within and across cultures. Such evidence is another significant reason for its current popularity as an explanatory framework. A selection of this literature is presented below.

2.7.1 In-groups/out-groups

In 1998, Lee and Ward examined the individualism-collectivism paradigm in relation to ethnocentrism. They found that allocentrics were more often ethnocentric than idiocentrics, and held very strong, positive attitudes for their in-groups, and very negative attitudes about their out-groups. Triandis, who supports these associations, has defined clear in-groups as "groups of individuals about whose welfare a person is

concerned, with whom that person is willing to cooperate without demanding

equitable returns, and separation from whom leads to anxiety" (Triandis, 1995: p9).

The feeling of anxiety from separation is supported by Cheng and Kwan (2008) who

found statistical evidence that people from collectivist cultures are significantly more

likely to experience separation anxiety from their in-groups than people from

individualistic cultures. Triandis adds that although the family is usually an in-group,

each culture has its own types of important in-groups, such as friends, political

parties, public organisations, social classes, religious groups, and educational,

economic (e.g. the Mafia, corporations), athletic, artistic (e.g. an opera company),

racial, tribal, caste, language (e.g. Quebec), or location collectives may function as in-

groups. He defines clear out-groups as "groups with which one has something to

divide, perhaps unequally, or are harmful in some way, groups that disagree on valued

attributes, or groups with which one is in conflict" (Triandis, 1995: p9). Triandis

(1995) also reminds us that there are groups that are neither clearly in-groups nor out-

groups. He states that collectivists are more likely to view these ambiguous groups as

out-groups, whereas individualists would more likely view them as quasi-in-groups.

2.7.2 Self-definition

The paradigm has also helped us to understand how people from different cultures

differ when they define themselves. Most researchers see the primary influence of

individualism-collectivism on self-definition in terms of the 'autonomous-social

distinction'. This refers to whether concepts and definitions of the self are bounded

and separate from others, or whether they include others and are determined by one's

relationship to others (Parkes et al, 1999). People who use references to social entities

are likely to define themselves using 'group identity' techniques, that is, describing themselves in reference to a particular group that he/she belongs to and with whom they share a common fate (for example, "I am a doctorate student"). They may also use 'public' techniques which involves referring to a generalised other (for example, "others see me as a generous person") (Bochner, 1994; Dabul et al, 1995). Triandis (2001, 2006) argues that people from collectivist cultures are significantly more likely to define themselves in these ways, although evidence from Altrocchi and Altrocchi (1995) show that people who are originally from collectivist cultures and have acculturated to individualist cultures show this tendency considerably less. They examined both Cook Islanders, conventionally viewed as collectivists, who had recently migrated to New Zealand, and those of Cook Island descent born in New Zealand, conventionally viewed as individualists. The findings revealed that the least acculturated Cook Islanders used approximately 57% social entity content when describing themselves, whereas Cook Islanders born in New Zealand used 20% and native New Zealanders used 17% social content. Similarly, Ma and Schoeneman (1997) found 84% social entity content for Sumbaru Kenyans, 80% for Maasai Kenyans, but only 12% for American students, and 17% for Kenyan students living in America. More evidence comes from the work of Triandis et al (1990) who found in their samples that allocentrics used social content between 30% and 50% of the time when defining themselves, whereas their idiocentric samples used it between zero and 20% of the time. Parkes et al (1999) provided further support of this theory when they revealed, after surveying 581 adult employees in Australia and South-East Asia, that the allocentrics in their sample were significantly more likely to refer to social entities when self-defining than the idiocentrics.

Harb and Smith (2008) have found evidence that collectivists are significantly more likely to use 'contextual' self-definitions (for example, "I am a patient at a nursing home"), as opposed to 'abstract' self-definitions (for example, "I am a patient"). They state that "individuals with interdependent self-construals may have difficulty describing themselves in absolute terms without any contextual or situational references" (p179). Miller (1984) also demonstrated this by finding that Indians made significantly greater references to contextual factors when providing explanations for behaviour than Americans. She concluded that this was because the Indian participants viewed themselves collectively: "the openness and interdependence characterising the agent's relations with the surround", whereas her American participants viewed themselves individualistically: "the separation and independence of the agent from the context" (p963). This is supported by the work of Cousins (1989) who found that for the Japanese, situation had a greater impact on the characteristics of the self, than for the Americans. Choi et al (1999) further demonstrated evidence of cultural differences in sensitivity to context by revealing that East Asians tended to include more social, concrete, and situational responses to questions of self-concept and definition.

2.7.3 Emotions and emotional expression

Emotions have also been found to vary in individualistic and collectivistic cultures. Perhaps not surprisingly, as Markus and Kitayama (1991) explain, the emotions used by idiocentrics tend to be 'ego-focused' such as anger, frustration and pride. These emotions tend to be associated with an individual's internal state or attributes, and are consistent with the need for individual awareness, experience, and expression. As

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Markus and Kitayama argue, this helps such individuals "maintain their independence from others by attending to the self and discovering and expressing their unique inner attributes" (p1). Conversely, they argue that the emotions of allocentrics tend to be 'other-focused'. They demonstrated this by describing the vocabulary of the Japanese language for other-focused emotions, such as 'shitashimi' (the feeling of familiarity or intimacy with someone), 'oime' (the feeling of indebtedness), 'amae' (hopeful expectations of someone's indulgence and favour) and 'fureai' (the feeling of connection with someone). They concluded that allocentrics avoid expressing ego-focused emotions even though they may indeed be feeling them. This is because such emotions may pose a threat to the interdependent relations with others. This is interestingly illustrated by Ekman (1972), who studied American and Japanese students while watching stressful films, who were unknowingly being videotaped. They first watched the films alone, and then a second time in the presence of an experimenter. The video recordings revealed that when alone, both the American and Japanese participants displayed negative facial expressions, although when with the experimenter, the Japanese students masked their negative feelings with smiling, whereas the Americans continued to display their negative expressions. This study was partially replicated by Matsumoto and Kupperbusch (2001) who also found that allocentrics show significantly less negative and more positive emotions in the presence of an experimenter, even when ethnicity and gender is controlled for. Park and Kim (2008) argue that this is because collectivists are more likely to adhere to higher levels of emotional self-control and humility than individualists.

Further emotional differences were revealed by Matsumoto (1989) who studied emotions in 15 different countries. He found that allocentrics are more easily able to

identify someone else's sadness, whereas idiocentrics are more likely to identify happiness. His results also revealed that Americans are more likely than Japanese to seek 'fun' situations for personal gratification, whereas Japanese are more likely to look for situations that produce harmonious interpersonal atmospheres. Matsumoto et al (1997) also found that Americans are more likely to report more positive, disengaged emotions than Japanese (for example, feeling superior, proud, 'on top of the world'). Mesquita (2001) studied 86 Dutch individualists and 171 Surinamese and Turkish collectivists living in the Netherlands. He found that the collectivist participants' emotions were more grounded in social worth assessments, were to a large extent reflective of reality rather than the inner world of the individual, and belonged to a 'self-other' relationship rather than being confined to the subjectivity of the self.

Triandis (1995) also argues that the emotional expression of allocentrics lasts only while they are in the situation that is triggering the emotion, although this is less likely the case for idiocentrics, and consequently their emotional expression usually lasts longer.

2.8 Evaluation of the individualism-collectivism paradigm

It is clear that the individualism-collectivism paradigm has been thoroughly examined by many researchers and in many areas. Although the differences between researchers' conceptualisations have been highlighted, it is also clear that there are overlapping consensual views upon the paradigm, specifically that individualistic values are more focussed upon individual needs, desires and priorities, as opposed to

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collectivistic values that focus more upon the in-group needs, desires and priorities. However, there is a pervasive tendency for readers to treat individualism-collectivism as a dichotomy with one dimension and polar opposites. This is most likely due to the semantics of the terms coupled with lack of knowledge, and the historical-philosophical treatments of the paradigm. Nevertheless, this should be avoided as both theorising and empirical evidence suggest that these constructs do not necessarily form opposite poles, but instead have multidimensionality and may co-exist in both individuals and groups at the same time and in different situations, as demonstrated in the literature above.

The paradigm has been applied to areas other than cross-cultural psychology, such as economy and philosophy, most likely due to the strong utility of the paradigm, which have been highlighted by its powerful use as an explanatory model for many psychological and behavioural differences within and across cultures. However, the inherent danger of this is to use the paradigm to explain every variation in human behaviour between so-called individualistic and collectivistic cultures. Another danger is for researchers to presume and uncritically accept that some countries and/or cultures are individualist and others are collectivist, solely on the basis of Hofstede's cultural data or on the basis of stereotypical beliefs.

Another problem is that too many studies have sampled their data from specific population groups, such as university students, and generalised the resulting findings as support for national and/or cultural value orientation. Further, the large majority of studies have measured and examined individualism-collectivism from solely a quantitative methodology. There would thus appear to be a desperate need for more

work that samples the general population, particularly if the aim is to subsequently label an entire culture or nation as being individualistic or collectivist, and for research that provides a more detailed and qualitative perspective of individualistic collectivist ideas.

2.9 Culture

Over the years, there has been an outpouring of literature on the topic of culture and cultural studies, in which many authors have proposed their own ideas of what culture means. Some of these authors' ideas are briefly described in table 2.5, while others are described in greater detail within this text. Historically, the word 'culture' derives from the Latin word 'colere', which can be translated as 'to build', 'to care for', 'to plant' or 'to cultivate'. It was a term that first appeared in an English dictionary in the 1920s (Kroeber, 1949), but had its first use in an anthropological study by Edward B. Tylor in 1871 who defined culture as "that complex whole which includes knowledge, belief, art, morals, laws, customs and any other capabilities and habits acquired by man as a member of society" (p1). This definition, although old, is argued to be one of the most enduring (Moore, 1997). Another short but also now widely referred to definition was later proposed by Ralph Linton (1936: p78): "the total social heredity of mankind". Linton also proposed four elements that described the similarities and differences in behaviour within a culture (Linton, 1936: p272-5, cited in Herskovits 1964: p210):

1. 'Universals' - Beliefs and forms of behaviour that are expected of any normal member of a society (e.g. language, clothing, housing);

2. 'Specialties' - Particular aspects of behaviour that characterise the members of specific groups within the larger social whole (e.g. gendered activities, activities of different kinds of craftsmen);

3. 'Alternatives' - Forms of behaviour that are recognised by society as valid, but which cut across class or occupational or sex lines (e.g. colour choice in decorations, word choice, ways of playing a game, different forms of marriage) and;

4. 'Individual Peculiarities' - Experimental forms of behaviour contributed by individualists (e.g. sources of innovation in a culture).

As can be seen by the above, Linton believed that the universals of a culture explain the similarities in behaviour across all cultural members, while the specialties, alternatives and peculiarities (idiosyncrasies) account for cultural differences. Furthermore, he argued that all elements of culture possess four interrelated qualities - form, meaning, use and function.

In a classic survey of 164 definitions of culture, Kroeber and Kluckholn (1952) suggested that six major classes of definition were to be found in anthropological literature:

1. 'Descriptive' definitions – Those that attempt to list any and all aspects of human life and activity which are thought to be examples of what is meant by 'culture';

2. 'Historical' definitions – Those that emphasise the accumulation of tradition over time (the terms 'heritage' and 'heredity' are frequently used);

3. 'Normative' definitions – Those that the shared rules which govern the activity of a group of people. Unlike descriptive and historical definition types, normative

definitions require the examination of what lies behind overt activity (now often seen as the examination of implicit and explicit culture);

4. 'Psychological' definitions – Those that emphasise a variety of psychological features, such as notions of adjustment, problem-solving, learning, and habits. This category, most often used by cross-cultural psychologists, is broad and includes both implied (e.g. attitudes, values) and observable (e.g. habits, behaviours) cultural phenomena;

5. 'Structural' definitions – These emphasise the pattern and organisation of a culture. The central view is that culture is not a mere list of customs, but forms an integrated pattern of interrelated features. This type of definition also requires going beyond the overt/explicit features in order to understand and discover the arrangements that exist;

6. 'Genetic' definitions – The term 'genetic' has no reference to biology, but instead places emphasis on origin and the genesis of culture. These definitions usually either argue that culture arises as adaptive to the habitat of a group, out of social interaction, and/or out of a creative process that is characteristic of the human species. According to Kottak (1999), this is a dynamic and interactive view of how populations relate to their ecosystems, and treats culture as a constantly changing system, both adapting to, and impacting on, its habitat.

Kroeber and Kluckholn (1952: p181) concluded their review with the definition: "Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artefacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached

values; cultural systems may on the one hand be considered as products of action, on the other as conditional elements of future action". In this definition, there is an explicit acceptance that culture is comprised of both concrete, observable activities and artefacts, and of underlying symbols, values and meanings.

The definition of culture formulated by the famous anthropologist, Clifford Geertz (1973), suggested that we can truly understand another culture only when we are able to enter into it and to completely pass ourselves off as insiders. This can only be achieved by perfecting various facets of the cultures, such as the linguistic system, and the complex rules for nonverbal gestures. However, this approach, while unparalleled in its ability to provide insight into a cultural system, may represent an arduous undertaking.

Another concept of culture was put forward by Edward Hall in 1983. Hall viewed culture as often being subconscious, comparing it to an invisible control mechanism operating in our thoughts. We only become aware of this mechanism when it is severely challenged, such as through exposure of a different culture. He believes that people internalise society's cultural components and limits, and act within them so to be culturally acceptable: "Culture has always dictated where to draw the line separating one thing from another. These lines are arbitrary, but once learned and internalised they are treated as real. In the West a line is drawn between normal sex and rape, whereas in the Arab world it is much more difficult, for a variety of reasons, to separate these two events." (1983: p230).

An example of a Linton's 'psychological definition' of culture is proposed by Triandis, who uses the notion of cultural syndrome to refer to a "pattern of shared attitudes, beliefs, categorisations, self-definitions, norms, role definition and values that is organised around a theme" (1996: p408). He believes that culture functions "to improve the adaptation of members of the culture to a particular ecology, and it includes knowledge that people need to have in order to function effectively in their social environment" (2000: p146). He considers cultural differences as best conceptualised as different patterns of sampling information that is found in the cultural environment. He also argues that cultures can be examined and understood by use of both anthropological at the cultural and individual level: "The cultural and individual difference analyses are complimentary and allow us to describe cultures" (1996: p412).

Hofstede (1997) viewed culture as a set of 'mental programs', and distinguishes them at three levels. Hofstede argued that at the 'universal' level, mental programming is common to all human beings and includes behaviours (e.g. laughing and crying). The 'collective' mental programming, which takes place at a level above the 'universal', are behaviours common to a group of people in a society or a country. The 'individual' level of human programming, which takes place at a level above the 'collective', suggests that individual behaviour is different from others and that each person makes independent decisions. He concluded that universal mental programs are inherited, collective mental programs are entirely learnt, and that individual mental programs are partly inherited and partly learnt.

Despite the hundreds of cross-cultural journal articles published every year, a singular conclusive consensual definition of culture continues to remain elusive. This had led to the common criticism of investigators failing to provide a definition of culture as their focal construct of interest (House et al, 1997). The many variations and changes over time in the conceptualisations and definitions of culture have led to a crisis for anthropologists, to the point where even the very legitimacy of the concept has been questioned. As Abu-Lughod, (1991) highlights, anthropologists continue to struggle over the problem of culture. She identifies the main problem with culture as lying in the distinction between self and other, arguing that the very concept of culture is a way of distinguishing self from other: "Culture is the essential tool for making other…Culture essentialises and over-emphasises coherence" (p143-147). Because of such problems, Abu-Lughod suggests that "perhaps anthropologists should consider strategies for writing against culture" (p147). By this, she is asserting that during research enquiries, ethnographers should reorient themselves away from big, comprehensive studies which present a 'culture', and instead offer a focus on 'connections and interconnections' that involve particulars such as the place of the ethnographer in the community and in the study. She also states that researchers should present specific life stories and texts, while using terms such as practice and discourse, because these are useful as "they work against the assumption of boundedness, not to mention the idealism…of the culture concept" (p148). By presenting fieldwork based ethnographies and refusing to generalise, "one would necessarily subvert the most problematic connotations of culture: homogeneity, coherence, and timelessness" (p154).

Abu-Lughod's arguments imply that the culture concept is too static as it struggles to deal with worldwide changes, it ignores the individual agency in the construction of daily cultural interactions, and it places boundaries around phenomena that exhibit continuous variation over time. Such challenges to culture can be recognised as part of the deconstructionist or postmodernist challenge to positivism and empirical science. In defence of the concept, Bennett (1999: p954-955) states that "although the concept received bad press, and is a no-word in contemporary cultural anthropology, it remains on the whole the most profitable general way of handling multidimensional behavioural data. Whether we admit it or not, we are all still functionalists". Munroe and Munroe (1997) also accept the concept of culture as a set of knowable regularities that characterise human groups, arguing that "universals, generalisations and similarities across cultures could be expected due to our single-species heritage and necessity of adapting to environmental constraints" (p174).

In this study, the view that culture is indeed a useful notion is adopted. The concept will also be employed as if it has some objective existence that can be used to characterise the relatively stable 'ways of life of a group or people'. I believe that the latter can influence, and be influenced by, individuals and their actions, an idea developed by Segall et al (1999: p23): "to the cross cultural psychologist, cultures are seen as products of past human behaviour and as shapers of future human behaviour. Thus, humans are producers of culture and, at the same time, our behaviour is influenced by it. We have produced social environments that continually serve to bring about continuities and changes in lifestyles over time and uniformities and diversities in lifestyles over space. How human beings modify culture and how our cultures modify us is what cross-cultural psychology is all about". I also agree and

adopt the position of Fernando (2003: p11-12), who describes culture as not only a set

of distinct beliefs, traditions and practices that are passed through generations, but as

"something living, dynamic and changing – a flexible system of values and world

views that people live by and create and re-create continuously. It is a system by

which people define their identities and negotiate their lives".

Table 2.5. Various key authors' definitions of culture

Author	Key defining characteristics
Tylor (1871)	That complex whole which includes knowledge, belief, art, morals, laws, customs and any other capabilities and habits acquired by man as a member of society.
Linton (1936)	The total social heredity of mankind.
Parsons and Sils (1951)	The organised set rules or standards abstracted the actor who is committed to them by his own value orientations and in whom they exist as need dispositions to observe these rules.
Kroeber and Kluckholn (1952)	Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artefacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values.
Hoebel (1960)	The integrated sum total of learned behavioural traits that are shared by members of a society.
Triandis (1972)	The subjective perception of the human-made part of the environment. The subjective aspects of culture include the categories of social stimuli, associations, beliefs, attitudes, norms and values, and roles that individuals share.
Rokeach (1973)	An enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end state of existence.
Hofstede (1980b)	A set of mental programs that control an individual's responses in a given context.
Hall (1983)	A subconscious, invisible control mechanism operating in our thoughts, that we only become aware o when it is severely challenged, such as through exposure of a different culture.
Terpstra and David (1985)	A learned, shared, compelling, interrelated set of symbols whose meaning provides a set of orientations for members of a society. These orientations, taken together, provide solutions to problems that all societies must solve if they are to remain viable.

Schwartz (1994)	Desirable transitional goals, varying in importance, that serve as guiding principles in people's lives.
Fernando (2003)	A living, dynamic and changing flexible system of values and world views that people live by and create and re-create continuously. It is a system by which people define their identities and negotiate their lives

2.9.1 The Chinese cultural orientation

According to Triandis (1995), China is an interesting example of collectivism. It is a country that is approximately 80% rural, relatively poor and vastly collectivist, reflecting traces of Confucian selfhood that necessitates "the participation of the other…The reason for this desirable and necessary symbiosis of selfhood and others is the Confucian conception of the self as a dynamic process of spiritual development"…"one becomes fully human through continuous interaction with other human beings and one's dignity as a person depends as much on communal participation as on one's own sense of self-respect" (Tu, 1985: p113; p55). Fingarette (1972: p34) agrees, stating that in the Confucian sense, "man is not an ultimately autonomous being who has an inner and decisive power, intrinsic to him, a power to select among real alternatives and thereby to shape a life for himself. Instead he is born as 'raw material' who must be civilized by education and thus become a truly human being". Liang (1997: p9-24) made clear that "...in Chinese thinking, individuals are never recognised as separate entities; they are always regarded as part of a network, each with a specific role in relation to others". He proposed that the traditional Chinese is neither individual-based nor society-based, but relational-based. Fei (1992) agrees, describing the Chinese society as consisting of "webs woven out of countless personal relationships" (p78), and that to become a true adult, one must be

connected to others and uphold group obligations; failure to do so is "to be less than human" (p25).

Wang (1994) emphasised the fact this culture is collectivist, highlighting that values such as the group approach, harmony, equality, and social commitment are desirable in contemporary China. Yang and Kleinman (2008) agree, adding that upholding family honour remains a significant modern-day collectivist Chinese cultural value. Ho and Chiu (1994) explain that for the Chinese, individualism connotes selfishness, a lack of concern for others, and an aversion to group discipline, whereas collectivism is understood to affirm the solidarity of the group. Triandis (1995; 2001) elaborates, stating that the Chinese focus their trust and solidarity toward the norms of the members of their collectives, and are often distrustful of out-groups. Triandis also believes that the Chinese culture is slightly more of a vertical-collectivist one than a horizontal-collectivist one, even though the political authorities advocate horizontal themes. Vertical-collectivism includes a sense of serving one's in-groups by sacrificing and doing one's duty for the groups' benefit. Inequality and rank are an integral part of a vertical-collectivist culture, as well as ethnocentric and prejudiced views that are used to distinguish themselves from out-groups. Although both facets of horizontal and vertical-collectivism may be present in Chinese society, several studies suggest that, overall, the Chinese do indeed lean towards vertical-collectivism (Chen et al, 1997; 2002b; Pye and Lew, 1998 and; Matsumoto, 2001), thus supporting Triandis' beliefs. For instance, the results reported by the Chinese Culture Connection (1987) revealed that people from the Taiwan and Hong Kong are low on social integration, a value that emphasises tolerance of others, harmony, non-competitiveness, and solidarity. Therefore, both of these Chinese cultural groups

could be classified as low on the horizontal collectivism scale. Furthermore, as Triandis highlights, vertical collectivism can be seen to be manifested by the Chinese preference for an orderly and hierarchical society based on rank and obedience.

However, both Zhou (2002) and Triandis (1995; 2001) have also argued that there are nuances of individualism emerging, particularly in the younger generation. This is because traditions of Confucius, Taoism, and Buddhism have been knotted into new ideas in order to emphasise not only egalitarianism but also individual and team responsibility and competition. Triandis uses the example of teams now being rewarded according to productivity and their superiority relative to other teams. Before the 1980s, only the individual's 'social contribution' was considered in the distribution of rewards, whereas more recently it is not enough to hold a socially contributing job – one must also do it well. They are also encouraged to find a job that is enjoyable. Furthermore, to the extent to which they are able, Triandis explains that the Chinese engage themselves in continuous learning and self-cultivation with the aim of becoming more loyal, filial, brotherly, and friendly to in-group members and to be good followers of the in-group authorities. Ho and Chiu (1994) explain that to be 'filial', one must regularly worship their ancestors (although only on the proper occasions), for children to repay the debts of their parents, accept the spouse chosen by the family. As Tu (1985: p234) elaborates, "For the son to cultivate himself, in this view, he must learn to suppress his own desires, anticipate the wishes of his father, and take his father's commands as sacred edicts". Evidence for loyalty to authority in-groups came from a study by Bond et al (1985) who found that compared to Americans, Hong Kong Chinese are more willing to accept insulting criticism from a high status in-group person. However, no cultural difference was found when the

insult originated from a low status individual, or from a high status individual who is not from the in-group.

An example of research evidence that highlights collectivist traits in the Chinese culture is provided by Leung (1987) who compared the procedural preferences of resolving conflicts between Chinese and American participants. It was found that the Chinese preferred mediation and negotiation to a larger extent than Americans – two important aspects of interpersonal harmony and cooperation. The difference was not so much in their values as their beliefs as both the Chinese and Americans greatly valued obtaining a harmonious outcome. The difference instead lied in the contrasting expectations about the procedures that would be most conducive to the restoration of harmony. Morris et al (1999) later replicated this finding of a greater Chinese preference for bargaining and found that this was because, in part, that the Chinese were less likely to ascribe negative dispositions to their opponent. Another interesting study that documents Chinese and American cultural differences came from Leung et al (2001) who put American and Hong Kong university students in the role of an employee whose suggestions would be criticised by managers in a way that violated 'interactional' justice, that is, the manager interrupting, failing to listen closely, and being unfairly dismissive. As expected, compared to the Americans, the Chinese perceived the manager's actions as less unjust, and were less likely to subsequently reduce their loyalty towards their manager. These findings not only demonstrate high vertical-collectivism, but also high 'power distance'. For cultures that score high on power distance, the legitimate authorities can treat their subordinates more harshly before this behaviour is challenged as being unfair. Such cultures have a tendency to prefer to obey without question those who are in authority positions, and also have

clearly defined role differentiation of a hierarchical nature. In the Chinese cultural context, these preferences can be understood through the indigenous concept of filial piety - a guiding principle for socialisation and intergenerational conduct in the Chinese culture. Although this refers to a hierarchical relationship of social roles and behaviour toward one's parents and ancestors, such as father to son, or husband to wife, whereby the senior in age has authority over the younger person, Yeh and Yan (1989) have stated that filial piety can also be generalised to all authority relationships.

The finding of high collectivism and high power distance scores has been supported by Hofstede's work (1980b; 1997; 2008) who also examined the cultural orientations of the Chinese. Although his study did not include a sample from mainland-China, it did sample ethnic Chinese groups from Taiwan, Hong Kong, and Singapore. His analyses for China revealed scores that were lower than any other Asian country in the individualism ranking. Hofstede partly attributes this to the high level of emphasis on a collectivist society by the current communist rule. He also found very high 'long-term orientation' scores, a cultural orientation that Hofstede states is true for all Asian cultures. Scores high on this dimension indicate that the country prescribes to the values of long-term commitments and respect for tradition. Hofstede writes that this lends to a strong work ethic where long-term rewards are expected as a result of today's hard work. As stated earlier, work by the Chinese Culture Connection (1987) added to Hofstede's value dimensions when they found the presence of the conceptual dimension, 'Confucian Work Dynamism' in the Chinese culture. This value dimension is linked with the search for societal virtue, rather than a search for truth. It includes the sub-dimensions of persistence towards pursuing a goal, the hierarchical

ordering of power relationships, a dislike of waste leading to creating products that are both economic in production and reliable in use, and a sense of shame if goals are not reached (Hofstede and Bond, 1998).

Overall, the Chinese cultural orientation is one that mainly appears to encompass notions of collectivism (mainly vertical), high power distance, and an array of Confucian values, including selflessness and a hard-working ethic. Authority, hierarchy, distinct ideas for social roles and behaviour, and societal order are also emphasised, perhaps most notably highlighted by the concept of filial piety.

2.9.2 The Greek/Greek Cypriot cultural orientation

Ninety-eight percent of people in Greece and Cyprus follow the Greek Orthodox religion which is philosophically similar to Catholicism. According to Hofstede (1997), in countries that have over 50% of their populations practicing the Greek Orthodox or Catholic religions, one will find a high correlating score for 'uncertainty avoidance'. Hofstede (2008) describes this cultural dimension as focusing "on the level of tolerance for uncertainty and ambiguity within the society - i.e. unstructured situations. A high 'uncertainty avoidance' ranking indicates the country has a low tolerance for uncertainty and ambiguity. This creates a rule-oriented society that institutes laws, rules, regulations, and controls in order to reduce the amount of uncertainty". Of all the cultures sampled in Hofstede's research, Greece was found to be the highest scorer for uncertainty avoidance, therefore strongly indicating that in Greece, a clearly structured rule-orientated cultural and societal structure exists. People from low uncertainty avoidance cultures like (such as, according to Hofstede,

the UK, Denmark, Jamaica, and Ireland) distrust too many rules and regulations, but for Greeks such rules are essential. Hofstede also states that for strong uncertainty avoidance cultures, there is also an intolerance of alternative ideas, an urge to work hard, an emotional need for rules (and taboos), a fear of what is different, and experts are considered very important. Holden (1972, p23) agrees that Greeks have an urge to work hard, and states in his book on Greece: "The dream of most Greeks is to work for themselves something which explains the fact that half of the workforce is self-employed". Furthermore, according Broome (1996), Greeks are not intimidated by status or hierarchy. They instead believe that they have the solution to all company or state problems. Every individual has a strong opinion about how things should be done and does not hesitate to let that opinion be known.

Greece also scored low on Hofstede's individualism cultural dimension, which conversely indicates high collectivism. Triandis (1995) also argues that the Greek culture is a largely collectivist one. Triandis and Vassiliou (1972a) provided evidence of this when they examined the traditional Greek culture in great depth. They found a number of interesting cultural values, including that traditional Greeks show more positive affection and intimacy within the family than Americans, although one exception was the husband-wife role, where the opposite is the case. They state that in traditional Greek culture, emotions are channelled into the parent-child relationships (especially the mother-son relationship), which is characterised by extreme interdependence of which carries on through life. However, this was found to often be detrimental to levels of personal achievement, as the Greek subjects showed considerable apprehension to self-initiated action, even though they also stated as being comfortable with their dependence on their parents. It was also found that

Greeks perceived more intimacy in 'vertical' (e.g. father-son) than 'horizontal' (e.g. friend-friend) relationships than Americans, for who the opposite was found. Greeks also showed higher intimacy levels towards extended family members. Rose et al (2003) more recently examined the parental styles of the Greek culture and agreed that the high level of family loyalty, lack of control, obedience, and dependence found in Greek children is strongly indicative of a collectivist culture. Triandis and Vassiliou also found that when Greeks complete sentences, they associate 'good conduct' with love, trust and respect significantly more than American subjects. This is consistent with the collectivist emphasis on virtuous and honourable action. There was also much evidence of traditional Greeks having a low self-esteem. This is similar to other collective cultures, such as the Japanese (Markus and Kitayama, 1991b). Their low self-esteem was manifested into oversensitivity to personal criticism and blaming others for their own mistakes. With regard to power relationships, they found a submission to in-group authorities – a finding consistent with Hofstede's (1980a, 2008) reporting of a fairly high 'power distance' cultural dimension score in Greece (although not as high as in China). As previously stated, cultures high in power distance are more likely to allow without resistance for inequalities of power and wealth to grow within the society. This links with Triandis and Vassiliou's (1972b) conclusion that the Greek culture is a vertically collectivist one.

These authors add that the Greek cultural aim of being 'philotimos' provides a further clue of collectivist cultural values. This because to reach this desirable label, a Greek must behave towards members of his/her in-group in a way that is respectful, proud, truthful, generous, self-sacrificing, tactful, virtuous, reliable, and, grateful, and doing

what the in-group expects of the person. Once inside an in-group, the member enjoys substantial advantages of cooperation, generosity, protection, and help. However, the member must always show concern and self-sacrifice for the in-group, while also viewing out-groups as competitive and suspicious.

In summary, research thus far points to a religious culture which is collectivist (as seen by their strong family and in-group loyalty), value hierarchy (as seen by their vertical orientation and high power distance scores), and hold a low tolerance for uncertainty and ambiguity.

2.9.3 The American cultural orientation

According the The World Factbook (2008), the USA currently holds a population of approximately 304,000,000 people, of whom 80% are white, 12.9% are black, and 4.4% are Asian. The most prominent religions are Protestant (51%), Roman Catholic (24%), Mormon (2%), other Christian (2%), Jewish (2%), Buddhist (1%), Muslim (1%), and about 4% are Atheist.

Both Hofstede and Triandis have closely examined the cultural orientation of American society. Hofstede (2008) scores the USA extremely highly on the individualism index (91); it is their strongest cultural dimension and they also score higher individualism than any other country or region. Hispanic-American countries were in the opposite extreme ranking 28 or lower, (see table 2.2). Therefore, the differences between the United States and Hispanic-American countries along the individualism-collectivism dimension should be noted. It should also be noted that the

scores are only relative positions of the different countries along the index, and therefore do not form a universally-valid construct. Hofstede states that the high individualism score indicates that the populace is strongly self-reliant and looks out mainly for themselves but also their close family members. The next highest Hofstede dimension was found to be 'masculinity' According to Hofstede (2008), "this indicates the country experiences a higher degree of gender differentiation of roles. The male dominates a significant portion of the society and power structure. This situation generates a female population that becomes more assertive and competitive, with women shifting toward the male role model and away from their female role". The lowest Hofstede cultural dimension was that of 'long-term orientation', otherwise known as 'Confucian work dynamism'. Hofstede states that this indicates that America is more allowing for societal and cultural change to occur more rapidly as long-term traditions and commitments do not become impediments to change.

As with many other researchers (Holt, 1997; Li, 1999; McCrae et al, 2004, Neuliep, 2005), Triandis (1995) agrees that the American culture is highly individualistic, and that it is generally a vertical and loose individualistic culture. Being a vertical-individualistic culture is consistent with the notion of 'being the best'; an idea linked with societal competition that is present in American culture (Holt, 1997). Triandis argues that the vertical aspect of American culture may derive from the fact that the early American settlers included many members of the upper classes. He uses the nature of horizontal-individualism in Australia to support this argument, as the Australian early settlers were from lower classes. Triandis add that the past British influence, affluence, the open frontier, and social and geographical mobility are other factors possibly responsible for the American current level of high individualism.

Triandis also notes that the early American immigrants were likely to be to have been more individualistic than other members from their in-groups anyway, since moving to America most likely required breaking with traditional behaviours.

One interesting example of research evidence that highlights American individualism comes from studies by Markus and Kitayama (1991b) and Kitayama and Uchida (2003). According to Triandis, collectivists frequently have realistic self-perceptions about their abilities, whereas individualists frequently have more flattering self-perceptions. Using this idea, Markus and Kitayama asked both Japanese and American participants to respond to questions such as "what percent of this population is higher than you are on X?", with 'X' referring to an ability. Americans, especially males, were found to be significantly more likely to hold a self-enhancement bias, as they stated that on average only a third of the population was higher than them on any particular socially desirable ability. Conversely, the Japanese, especially the females, showed a modesty bias as on average they indicated that they were below average in ability. Furthermore, for the trait of 'independence', only 33% of Americans saw others as more likely to be independent than them, whereas the Japanese stated that approximately 50% of other people in the same population would be more likely to be more independent than them. This led Markus and Kitayama to conclude that Americans have a strong sense of 'false uniqueness'. This links with another finding by Kitayama and Uchida (2003) who found that the frequency of saying "yes, they do apply" to a list of positive personal attributes was significantly higher for an American sample than a Japanese sample, who were conversely significantly more likely to state that negative personal attributes apply to them. This led to the conclusion that in relation to the Japanese, Americans see

themselves more positively and hold higher levels of self-esteem. Another study by Snibbe et al (2003) involved presenting 200 successful situations and 200 failure situations to American and Japanese participants. Both groups were asked whether their self-esteem would be affected if they were in either type of situation. They found that the Americans rated the successful situations as more likely to affect them (thus boosting their self-esteem) significantly more often than the Japanese, who instead decreased their self-esteem because of failure. It leads to the conclusion that Americans focus more on success and Japanese on failure. Triandis argues that this difference is related to the 'looseness-tightness' dimension. In loose cultures, for any given situation a person is allowed more freedom to choose different behaviours. If the behaviours are unsuccessful, the person begins a trial and error sequence of behaviour application until a set of behaviours are successful. When this happens, people praise the performance and note the success, ignoring the previous failures. However, in tight cultures, in any situation a person is not allowed so many choices and must react to situations with successfully appropriate behaviour more quickly, as failure to do the correct thing results in criticism. An example of the United States being a loose culture comes from Naito (1994) who examined the acceptability of chewing gum in a classroom setting. He found that in America, 12% of second-grade children (6-8 year olds) and 0% of fourth grade children (8-10 year olds) indicated that it was unacceptable to chew gum in class, whereas in Japan 92% of children from both grades stated it was unacceptable behaviour, leading Naito to conclude that in tighter cultures there are much fewer appropriate ways to respond to a particular situation.

A study by Harewood et al (1999) substantiated American individualism when they examined the cultural differences in maternal beliefs and behaviours in samples of middle-class Anglo (white-Americans) and Puerto Rican mother-infant pairs. Their results showed that Anglo mothers place greater emphasis on the socialisation of goals and childrearing strategies that are associated with an individualistic orientation (such as independence), whereas Puerto Rican mothers placed greater focus on goals and strategies that reflected a collectivist orientation (such as structured guidance). The finding of child-rearing differences in individualistic and collectivist cultures has also been strongly supported elsewhere (Bronfenbrenner, 1970; Triandis and Vassiliou, 1972a; Wu, 1985; Triandis, 2001; Rohner and Britner, 2002)

Overall, research on American cultural orientation paints a picture of a culture that is highly individualistic. This is not surprising since values of individual freedom, rights and independence are strongly emphasised. Americans also embrace societal hierarchy and competition, perhaps most suitably demonstrated by the 'American Dream' of financial prosperity. It is also a culturally loose, diverse, and complex nation, which allows for societal and cultural change to occur more rapidly than many other nations.

2.9.4 The British cultural orientation

The UK includes four distinct territories: England, Wales, Scotland, and Northern Ireland. According to The World Factbook (2008), the current total population of the UK is approximately 61 million people – the third largest in the European Union (behind Germany and France) and the 21st-largest in the world. Most people are

ethnically white (92.1%, of which 83.6% are English, 8.6% are Scottish, 4.9% are Welsh, and 2.9% are Northern Irish). Two percent are black, 1.8% are Indian, 1.3% are Pakistani, 1.2% are mixed, and 1.6% are 'other'. Seventy two percent of the UK's population affiliates to the Christian religion (Anglican, Roman Catholic, Presbyterian, Methodist), while 2.7% are Muslims, 1% are Hindus, 1.6% are 'other', and 23.1% are unspecified or of no religion.

Hofstede's scores of cultural dimensions for the UK were found to be very similar to the scores of the United States. For example, the highest rating cultural dimension was found to be individualism (UK: 89, US: 91). Only two other countries, the United States and Australia, scored higher on Individualism than the UK in Hofstede's research. Hofstede links the high score of individualism with the high level of Christianity found in the UK. He also revealed a relatively high score for 'masculinity' (66), and a low 'long-term orientation' score (25), which are again similar scores to the United States (masculinity: 62; long-term orientation: 29). The main difference in scores between the United States and the United Kingdom was for the 'uncertainty avoidance' cultural dimension, for which the UK scored 35 compared to America's score of 46. This means, according to Hofstede, that the UK may in general be even more tolerant of ambiguity, uncertainty, and diversity than the United States.

Ryckman and Houston (2003) examined the value priority differences of American and British female and male university students. Participants responded anonymously to 'Schwartz's Value Survey' (1992, 1994) which consisted of various individualistic and collectivistic values. They found that both samples scored highly for

individualism, but the American students scored slightly higher for the individualistic values of achievement, hedonism, self-direction, and stimulation. Women from both countries were more likely to assign greater value priorities to the collectivistic values of benevolence, universalism, security, and subordination of self to others, although they too scored highly in individualism, and, in fact, placed greater importance on achievement than their male counterparts. Further evidence of individualistic behaviour from English (usually white) samples was found in the coping styles and the health of relatives facing drug and alcohol problems (Orford et al, 2001), in the ways that young children work together in school settings (Lewis et al, 2000), and in the management of conflict between adolescent children and their parents (Gilani, 1999)

Another important strong cultural value of the British, and in particular, the English, is that of social distance. According to Paxman (1999), social distance in the English culture involves the zone of privacy, and is applicable to every person despite his/her age or status. It is one of the most important cultural values which regulates social relationships in the English culture. Paxman states (p117-118) that it is "one of the defining characteristics of the English", and "one of the country's [most] informing principles", adding that "the importance of privacy informs the entire organisation of the country, from the assumptions on which laws are based, to the buildings in which the English live". Wierzbicka (1985: p145) agrees, stating that "in Anglo-Saxon culture, distance is a positive cultural value, associated with respect for autonomy of the individual. By contrast, in Poland [a collectivist country] it is associated with hostility and alienation".

The research above suggests that the British culture is similar to the United States in the sense that it is highly complex and individualistic, and tolerates and accepts diversity and ambiguity. It too places great emphasis on individual freedom which includes the value of social privacy and distance. There is also a clear societal hierarchy mostly based on wealth, but, as Grendstad (1999) reminds us, given that in British history there has always been a segmented and top-down society in which the nobility and ruling class kept society in place, the presence of societal hierarchy today is perhaps not altogether surprising.

Chapter 3: Methodology

3.1 Study design

In order to address research questions, Bryman (2001) argues that researchers must devise a methodological strategy as it is "a general orientation to the conduct of social research" (p20). A key strategy of this study was combining quantitative and qualitative data collection and analysis techniques. This approach is not uncommon: as Bryman (2006: p97) argues, "the integrating of quantitative and qualitative research has become increasingly common in recent years". One of the main reasons why a mixed-method approach was adopted was due to my belief that utilising techniques and methods from both approaches would most appropriately facilitate the exploration of my original research aims. I felt that some of the research aims should be addressed using techniques from both approaches; where as for other questions, a quantitative approach alone was more suited. Specifically, I believed that exploring the individualism-collectivism paradigm in relation to mental health stigma, my first outlined aim, could be most fully and best addressed by combining the findings that both perspectives can provide. This is also true for my second and fifth outlined aims; to explore the underlying cultural reasons for stigmatisation, and to explore whether and how acculturation affects the individualism-collectivism paradigm. For my third and fourth aims, to investigate where the four cultures to be studied fit within the individualism-collectivism paradigm, and to explore the levels of stigmatising attitudes present in the four cultures, I decided that the application of quantitative methods alone would be both appropriate and sufficient.

3.1.1 Epistemology

The epistemological stance that I subscribe to in this study is critical realism. This dualistic philosophical subscription accommodates different knowledge claims, including the views that there exists both a mental, subjective world as well as an objective, outside world. Thus, critical realism offers a useful and pragmatic interface to the opposing notions of positivism and interpretivism. It also affords the inquirer the philosophical justification of combining quantitative and qualitative methodological techniques; the former to measure and quantify knowledge in the objective world, and the latter to tap into the knowledge of the mental, subjective, social world. An examination of the epistemological underpinnings of quantitative and qualitative methodologies, followed by an explanation of critical realism and justification for its use in this study follows.

Quantitative approaches that employ measurement instruments and statistical techniques are usually associated with a positivist paradigm that is linked with the natural sciences. Positivism, founded by August Comte, attempts to provide an empirical, scientific stance to social research enquiry. Comte believed that social investigators should seek explanation of social enquiries by examining the structure of social relations and systems. For instance, he argued that it is not god who makes people poor or rich, but rather the social forces at work in society. Therefore, he argued that methods should be scientific, as these provide would the most appropriate tools for understanding society, rather than what he described as metaphysical, theological and speculative methods of social enquiry. Positivism defines reality as objective, orderable, measurable and empirically testable. It views research as a tool

for studying social events, specifically learning about the latter and their interconnections, so that generalisable causal laws can be discovered, explained and used to predict occurrences of particular social phenomena.

Qualitative approaches based on non-numerical narratives are typically associated with the interpretivist paradigm. Interpretivism strongly contrasts to positivism and forms a basis of criticism towards positivist ideology. It is an ideology that relates back to the works of Giovanni Batista Vico (1668-1744), Dilthey (1833-1911), and Weber (1864-1920). A significant contributor to interpretivism is the school of thought that is symbolic interactionism. Interpretivist theorists, unlike positivists, do not believe that there is one reality 'out there' that is objectifiable and measurable. Rather, they believe that there are an unlimited number of realities, and that these realities can differ and change across time and place. This is because reality is made up from the minds of the people; reality is internally experienced, created through the interactions of people ('social actors'), and interpreted by the social actors. They therefore view reality not as objective but as subjective, since reality is simply what people view it to be. For interpretivists, it is the human beings who occupy the most important position for understanding the social world, as reality is created by the people's subjective meanings which afford them an understanding of social interactions that take place around them. Again contrary to positivism, interpretivists do not believe in generalisable laws of truth, as their understanding of social reality dictates that people are not quantifiable, rational individuals that will produce the same behaviours due to certain causes every time. Thus, for interpretivists, the purpose of social research is not to learn about casual laws, but rather to search for the systems of meaning that social actors use to make sense of their world. To do this,

they attempt to interpret and understand people's reasons for social behaviour, and the way they construct their lives through meanings.

The question of whether or not to combine quantitative and qualitative methods is a controversial and long-debated topic. Methodological purists take the view that these methods are incommensurable as they are based on mutually exclusive philosophical assumptions (for example, positivism vs. interpretivism) with almost no common ground between them (Guba and Lincoln, 1989). For example, Leininger (1994) has cautioned against the use of a mixture of quantitative and qualitative research methods as the differences in their paradigms, which as so radically different, cannot be reconciled. Conversely, methodological pragmatists, such as Tashakkori and Teddlie (1998) and Johnson and Onwuegbuzie (2004), argue that researchers should switch between alternative paradigms if this results in an optimum level of understanding and a more complete analysis. They also assert that the differences between quantitative and qualitative methods are not always as extreme as they are made out to be, and can be used to effectively complement each other. For example, qualitative methods are often used in the preparatory stages of quantitative research. However, as Perlesz and Linsay (2003) and Johnstone (2004) argue, this may result in 'dissonant data' being obtained due to their conflicting epistemological assumptions with, for example, highly contextualised interpretative findings not linking meaningfully with quantitative findings that establish empirical generalisations.

The approach of critical realism offers a useful alternative to the established paradigms of positivism and interpretivism (Houston, 2001; McEvoy and Richards, 2003) and a theoretical basis for mixed-method justification. According to Bhaskar

(1978) (a significant proponent of this philosophical paradigm), and Delorme (1999),

critical realism distinguishes between three different modes of reality: (1) the

empirical (the facets of reality that can be experienced either directly or indirectly);

(2) the actual (the facets of reality that occur but are not necessarily experienced); and

(3) the real or 'deep' structures and mechanisms that generate phenomena. The latter

are not open to direct observation, but they can be inferred through a combination of

empirical investigation and theory construction. Therefore, for critical realists, the

goal of research is not to identify generalisable patterns (positivism) or to identify the

experiences or beliefs of social actors (interpretivism) but to develop explanations that

result in our understanding what structures and/or mechanisms underpin phenomena.

In short, as Olsen and Morgan (2004) state, "it means asking why events have

happened in the way they did" (p25).

Critical realism criticises positivism as an epistemology that focuses exclusively on

observable events, therefore failing to take full account of the extent to which these

observations are influenced by prior theoretical frameworks (Olsen, 2002). Further,

positivism, deals with relationships between the various elements of social systems in

isolation, instead of taking into account the interactions between mechanisms and the

contexts in which they occur (Collier, 1994). In terms of interpretivism, Bhaksar

(1989) asserts that critical realism acknowledges the value of focusing upon

motivation, discourse, and human perception as these human mechanisms can serve

as causal explanations. However, it importantly fails to relate these mechanisms to

their underlying social structures, which may enable or restrict the actions of

individuals or to the social networks in which social actors belong (Granovetter, 1985;

Williams, 2003).

According to Sayer (2002), from a critical realist standpoint, the best explanations are those that are identified as having the greatest explanatory power. In order to ascertain maximum explanatory power, the use of both quantitative and qualitative methodologies is encouraged (Olsen, 2002), as long as they can together identify patterns and associations that may otherwise be masked and illuminate complex concepts and relationships that underpin the observed phenomena. According to McEvoy and Richards (2006), this can be particularly well achieved if the different methodologies are employed to triangulate findings, as this can increase the level of detail in the data extracted, and strengthen the confirmation of the researchers' overall theoretical deductions.

The strengths and uses of critical realism outlined above form the basis of my justification in choosing this philosophical paradigm as my epistemological stance. As I hold the pragmatic belief that the choice of methods should be dictated by the nature of the research problem(s), and that using them together provides a research inquiry a greater sense of balance and perspective, I will employ a mixed-methodology design. Governed by critical realism's philosophical notions, I will aim to use these methods to critically examine the knowledge that exists within both empirical and actual realities. I will triangulate my methods and use them to, as effectively as possible, tap into and provide explanations for the structures and mechanisms that generate the phenomena of interest present in the latter realities.

3.1.2 Methods

Under the umbrella of quantitative and qualitative methodologies come a number of specific methodological techniques, each with a different purpose and style. The most common quantitative methods of data collection are questionnaire based surveys, documentary methods, observation, sociometry and experiments (Sarantakos, 2004). Some of the most common qualitative methods of data collection include interviews (open, semi or structured), observation (participant or non-participant), case study analysis, and textual analysis. Decisions on which methodological techniques to use are key and should be carefully chosen, as these techniques play a major role in the type of data that is collected, which in-turn influences the general findings and understanding of the phenomena under the research microscope.

3.1.2.1 Quantitative method

In this study, for the research aims that require a quantitative approach, I chose to use a face-to-face questionnaire survey approach. This decision was due to a number of reasons. All of my research aims require a statistical measurement of particular phenomena, including socio-demographic and cultural background, mental health stigma, the individualism-collectivism paradigm, and acculturation. Questionnaires are able to incorporate measurement tools, whether standardised or not, and thus affords me the opportunity to explore my research aims in this way. I shall discuss the specific measurement tools used for the study later in section 3.4. In order to measure something effectively, not only should the tool be have strong level of internal validity, but the researcher should aim to collect a large sample size. Sample sizes can

be calculated if a population-representative randomised sampling method is chosen (sampling methods are detailed in section 3.2), but for those that are not calculated, the general rule is that the bigger the sample, the more likely ones results will be stronger in terms of generalisability. Questionnaires are regarded as a quick means to obtaining large sample sizes, and therefore provide another reason for its selection in this study. They are also generally less expensive method, and, if designed well, user-friendly and convenient, as questionnaires can be completed at the participants' pace and convenience. There are of course a number of other advantages and also disadvantages towards using questionnaires, but for the purpose of addressing my research aims, and my epistemological stance, I decided that they would be meet both purposes more than adequately.

3.1.2.1.1 Questionnaire data collection style

As previously stated, I also aimed to conduct all questionnaire data-collection in a face-to-face manner. This was also due to two main reasons. Firstly, as I decided to use previously developed and standardised tools of measurement, it was important to carry out the application of these tools in the manner that they were constructed for, specifically face-to-face questionnaire interviewing. Secondly, I wanted to meet with each participant because I had previously already decided that for the subsequent qualitative data collection component, I would be selecting interviewees from the participants who had taken part in the quantitative component. I believed that by meeting the individuals, they may be more willing to take part in the qualitative interviews, thus forming a more diverse and stronger sample base from which to later select interviewees. Furthermore, being in a face-to-face situation affords the

participant to ask any me any questions that need clarification. This is a particularly useful benefit if the participant needs explaining regarding the specific meanings of each question. Finally, it is my opinion that data collection in this manner also helps to alleviate concerns of anonymity and confidentiality, since the establishment of trust is more likely to happen if they have met the researcher. I also decided that during the questionnaire process, I would offer the participant the choice of completing the questionnaire themselves, or for me to read each question out and write their responses. I made this choice because I wanted to provide the participant the setting that would be most comfortable for him/her, so that they may understand and answer each question as accurately and truthfully as possible. Furthermore, neither of the questionnaires' standardised tools prohibited this, and I doubted that such a minor deviation in data collection procedure across participants would influence the results. This variation was naturally unavoidable with the Chinese participants that preferred to complete a Chinese-translated questionnaire, as I was not able to read each question to them.

3.1.2.1.2 Questionnaire translation

As stated above, I provided participants with the choice of completing a questionnaire that was written in English or their native language. The main reason that I translated the questionnaires into Chinese and Greek was because I strongly desired to sample Chinese and Greek participants who primarily use their native language. This is because I envisaged that such participants may be those who are less acculturated to English society, and/or those who are older and first generation Chinese/Greek people. As I wanted to capture a socio-demographically balanced as possible sample,

by not translating the questionnaires, certain participants of the previously described nature may not have been included, consequently detrimentally skewing my sample.

There a number of issues to consider when translating questionnaires from language to another, particularly in cross-cultural research, and it is by no means a simple process. As Munet-Vilar'o and Egan (1990) correctly state, in order to study the people from diverse cultural backgrounds, research instruments must be reliable and valid in each culture studied. Thus, the quality of translation and validation of the translated research tools plays an important role in ensuring that the results obtained in cross-cultural research are not due to errors in translation, but rather are due to real differences or similarities between cultures in the phenomena being measured. As stated previously, sections of the questionnaire used in this study have been previously validated (see section 3.4), although not for use in a non-English language. This means that ideally the researcher who translates a questionnaire should test for internal validity. However, as shall be later seen, the amount of participants who opted to complete a translated version of my questionnaire was too small to conduct validity tests, since they would not deliver results of any real meaning. Readers may deem this to be a criticism of my study. However, I tried to minimise any potential damage this may have caused to the results by following a number of techniques used to ensure translation rigour. These techniques included two that Brislin et al (1973) famously recommended: 'committee approach' and 'pretest'. The committee approach is the use of a team of bilingual people to translate from the source to the target language. For both the Chinese and Greek questionnaires, I was able to obtain the services of a professional who was paid to translate the questionnaire. I subsequently asked one other fluent Chinese speaking individual, and

two other fluent Greek speaking individuals to view the translated document and make recommendations for any possible amendments. Although the committee approach is ideally performed when the team conducts the translation together and at the same time, in this case such an option not a practical possibility. In pretest procedures, a pilot study is carried out after instrument translation is completed in order to ensure that future users of the target language version can understand all of the questions and procedures. This was performed accordingly, as after I had completed translation of the questionnaires, I conducted a pilot study in order to examine the effectiveness of the translation, as well as other issues (see section 3.5). Although these and other techniques have been criticised for various reasons, they nonetheless form an imperative step to ensuring that research instruments are as accurately as possible measuring what they were originally supposed to measure (Maneesriwongul and Dixon, 2004)

3.1.2.2 Qualitative method

For the research aims that required a qualitative approach, I chose to conduct a series of one-to-one semi-structured interviews on participants from each cultural group. This qualitative method was selected as it can effectively facilitate the phenomenological exploration of the mental, subjective, and social worlds.. Further, as Lamnek (1989) states, it is a method that places the interviewees as experts who provide valuable information, while allowing for researcher to ascertain important aspects of the interviewees' mental and subjective experience – two important elements that are applicable for the purposes of my study.

I preferred one-to-one interviewing over group interviewing as I wished to avoid the problems associated with the latter method. Sarantakos (2004) highlights these, including the possible influence of particular participants in a group influencing others' ideas; the possibility of some participants being fearful of expressing their honest ideas and thoughts in front of a group; and keeping the discussion on track and accurately recording data. Although group interviewing would have been less time-restraining, avoiding the previously described possible problems was more important. In addition, semi-structured interviews were deemed more appropriate for this study than unstructured interviews because they are more specifically geared for qualitative research that has specific research questions and aims already explicitly outlined, such as in the case of this study. This is because the structure of the questioning affords the interviewer to focus the interview on the ideas that are related (directly or indirectly) to their original research questions and aims, rather than for the content of interview to digress in other less related areas. However, it is also my belief that some digressing into conversation areas that are seemingly less relevant during the interview, may not be an ineffectual or worthless exercise. This is because the researcher may later, upon reflection and/or analysis, discover some indirect yet important meaning from such discussion. This is the main reason why I selected the semi-structured interview approach over the structured interview approach, as for the former, a level of open discussion for each question that may lead to some digression is encouraged, whereas for the latter, the rigidity of the interview questioning allows very little or no freedom for the interviewee to elaborate into areas not directly related to the original question. Furthermore, in structured interviews, the interviewer can not ask new questions related to any open discussion that may take place, since strict adherence to the questioning schedule is of paramount importance. This was

something I aimed to avoid as I was interested in pursuing any discussion that was at least loosely related to the original question. Hard-line positivists and quantitativists may argue that this approach invokes researcher bias into which topics of conversation are important or not, and therefore weaken the legitimacy of the results. However, the theoretical underpinnings of qualitative research and its relation to critical realism (and other) epistemology justify such procedures, since they are (debatably) less concerned about researcher bias, and view the meaning of validity in a very different, yet equally compelling, way.

In summary, this study has a design that incorporates both quantitative and qualitative methods which were used to address the original research aims, and which link my own epistemological stance. Specifically, face-to-face questionnaires were used for the quantitative component of the study, and one-to-one semi-structured interviews were used for the qualitative component.

3.2 Sampling methods

One of the most important aspects of any research study are the sampling procedures as these determine the type and number of participants that are recruited, and have an overall impact on the meaning of a research study's findings. Chosen sampling procedures and the rationale for their selection need to be clearly stated. As Fade (2003, p16) states, "sampling techniques should be clear and details should be given of any relevant characteristics of the population so that readers can interpret the findings…making the rationale clear behind a sampling strategy enhances credibility". There are many types of sampling strategies, each with its own

usefulness, levels of appropriateness and associated problems. Sampling is most commonly associated with quantitative methodology, although to state that qualitative research cannot involve sampling is incorrect as there are also various techniques available in qualitative methodology. They are generally less strict, structured and quantitative than the techniques found in quantitative research, simply because their methods correspond to a different type of epistemology and philosophy. With regard to the quantitative component of this study, a key starting question was whether or not a randomised sampling procedure was possible, practical, and appropriate, as sampling procedures are generally either randomised or non-randomised. Although time consuming, expensive and sometimes complicated, randomised sampling methods offer a high degree of population representativeness, and therefore produce stronger, more robust results. However, there are three main reasons why this study did not employ a randomised sampling technique for its quantitative arm. Firstly, to conduct a statistically powerful and accurate randomised (probability) sample, a researcher usually needs sampling frames of the highest-level clusters he/she are aiming to sample in order to calculate minimum sample size requirements. For this study, these would have to be sampling frames of UK-resident individuals of a primarily (1) white-English cultural subscription; (2) American cultural subscription; (3) Greek/Greek/Greek Cypriot cultural subscription and; (4) Chinese cultural subscription. However, obtaining sampling frames for each of these groups was unfortunately not possible and this is a partial explanation for why a power calculation was not carried out in this study. Secondly, as it was deemed that recruiting particular sample clusters would be practically very difficult and time-consuming (specifically, first-generation Chinese and American migrants), a 'snowballing' sampling method was specifically chosen due to ability to recruit 'hard-

to-reach' groups. This is a non-randomised, purposive method, which does not rely on sampling frames and makes no claims of representativeness (Bernard, 1994). Thus, this study's findings make no claims of external generalisability, and therefore a power calculation is not necessary. Finally, non-randomised sampling is a practically useful option as they are usually cheaper, easier, and quicker to implement. Therefore, any conclusions drawn from the sample can only be fully applied to the sample collected, rather than the population of which the sample represents. This may appear as a disadvantage, particularly in terms of generalisability, but, when performed rigorously, non-randomisation can still provide reliable indications about the population that the sample represents. For this study, this involved using strongly validated questionnaires to augment the confidence of the quantitative findings (see section 3.4). Furthermore, triangulation was implemented which is an effective method that tests the quality of study's findings by triangulating them with findings obtained from different methodological approaches as well as other researchers. This was a key reason why a mixed methods approach was employed in this study, and why the multiple coding technique was later utilised (see section 3.7.2).

There are a number of specific non-randomised sampling methods available. As stated earlier, for the purposes of this study, it was decided that 'snowballing' method (sometimes referred to as the 'chain-referral' or 'network sampling' method) would be employed. I selected this method because it is useful for locating 'hard to reach' participants, which I foresaw as being the American and Chinese participants in particular – the former because of the relatively small number of UK-migrant Americans, and the latter because they are traditionally viewed as a fairly closed-community, particularly the first generation Chinese migrants. If used effectively, it

can allow researchers to obtain balanced and high numbers of participants from varying backgrounds, (particularly when used in conjunction with quota-sampling) thus reducing the likelihood and level of sample bias. Another reason for its selection is that it is often used in community studies (Merrell et al, 2006; Steel et al, 2006; Ochoa et al, 2005). Vogt (1999) defined snowball sampling as a technique for finding research subjects that involves initially locating types of individuals that fit into a researcher's sampling criteria, and then asking these 'primary' participants to direct the researcher to other individuals of a similar background to themselves, and who might be willing to participate. The researcher then approaches these individuals, and asks them to recommend individuals that they know of who fit the sampling criteria (in this case, adults, having an English, American, Greek/Greek Cypriot or Chinese cultural background, and who are living in the United Kingdom). The same process continues until a desirable sampling size has reached, or until no more participants can be discovered. Berg (1988) argues that this process works best when a 'bond' or 'link' exists between the initial sample and others in the same target population, allowing a series of referrals to be made within a circle of acquaintance. However, as with any technique, snowballing comes with a number of possible problems. Firstly, it is inevitable that only participants who are volunteer will be selected. By volunteering to take part in this study, they may already have an interest in mental health, and therefore possibly hold 'strong' attitudes about the issue. Furthermore, as selected individuals were asked to recommend others to participate in the study, they may inevitably have recommended friends and family members who may hold similar views with them. This may cause bias towards the inclusion of individuals with interrelationships, and miss 'isolates' who are not connected to any network that the researcher has tapped into (Van Meter, 1990). As previously stated, the main cost of

non-randomised sampling methods is its low level of generalisability (Griffiths et al, 1993). As probability sampling is sometimes not an available option, researchers must simply accept that this is a possible criticism to the overall study, particularly if inferences are applied to the general population of the sample group.

For the qualitative component of this study, participants were purposively selected from the list of individuals who had been previously recruited for the quantitative survey and who had given their consent and permission to be contacted about the possible involvement of a subsequent in-depth recorded interview about mental health in their culture. This method was used to ensure the representation of participants from differing personal and socio-economic backgrounds for each cultural group. If participants who had previously agreed to be involved were approached but then declined to take part, other individuals from the list of consenters would be approached. I used the method of saturation to inform me when the sample size of interviews was satisfactory and appropriate. According to Sarantakos (2004), the saturation technique involves the researcher continuing to add new units to the sample (in this case, units refer to individuals from particular cultural backgrounds) until the study has reached a point where no new meaningful data is being collected. This is only possible if the qualitative researcher analyses their data throughout their study, as it is the analysis that informs the researcher if new and meaningful data is being collected. However, I was aware that no matter the approach, in qualitative research samples, because of the type of questions that it explores, and the related purposes that it pursues them for, there will always inevitably be smaller samples than in quantitative research.

3.3 Ethical considerations

Raiborn and Payne (1990) defined ethics as "a system of value principles or practices and a definition of right and wrong" (p879). According to McCabe and Rabil (2002), ethics is the "study of what is good and bad, right and wrong, just and unjust" (p18). Ethical issues by their very nature are complex; philosophers have for a long time debated their differences in opinion about the manner in which they should be addressed, and which are the most important for researchers to consider (Jowell, 1986; Nelson et al, 2006; Slowther, 2005). There is therefore an array of ethical considerations that a researcher can consider, although the key considerations usually depend on the specific dynamics of the particular research study. What were deemed key in this study were issues of informed consent, anonymity and confidentiality and interview ethics. Ethical approval for this study was obtained from the University's School of Health and Social Science's ethics committee who reported no concerns (see appendix 3).

3.3.1 Informed consent

In general, participants who provide consent to their involvement of a research study should do so freely and fully informed. The procedure of obtaining consent must therefore primarily centre on the person from whom consent is requested. By doing so, the researcher can more accurately find out if the potential participant truly wishes to be involved in this study. This may sometimes place the potential participants' interests in opposition to the researcher; however, this is necessary process to establish their true feelings about possible involvement. The researcher seeking

consent must therefore be aware of their own behaviour, so to ensure that they are providing a clear explanation of the scope of consent being sought, what involvement fully entails, and an honest answer to all questions. Further, as Oliver (2003) highlights, some participants may be impressed by the status of the researcher, or by the word 'research', and agree to involvement without actually having a good idea about what their involvement or the study entails. This is another reason why any participation must be fully and accurately informed. There are a number of methods and strategies that a researcher can use to obtain informed consent (Steinemann et al, 2006; Shalowitz and Wendler, 2006). For this study, the method chosen was a written document that provided key summarised information on what the study is about, what participation involves, and what happens after their involvement such as the possible use of their responses in publication (see appendix 1). This document, called the 'participant information sheet' was made using short words, sentences, and paragraphs, and without the use of misleading and technical terms. One of the main reasons for choosing this method was that it ensured that each potential participant was being provided with the same information and in the same manner. A separate consent form was also provided for the participant to sign and date, so to establish that they have indeed provided their informed consent to being involved in the study (see appendix 2). Participants who refused involvement were not pressurised to change their stance in any manner, nor were they asked to provide reasons for their refusal. Participants who took part in the study were also told in advance that they may choose to cease involvement at any time and for any or no reason. This was offered to avoid the possibility of the participant regretting their involvement (perhaps because they were not in fact fully informed), and in case they began to suffer from stress or anxiety during participation.

3.3.2 Anonymity and confidentiality

Participant anonymity and data confidentiality are two other and inter-related important ethical issues that have undergone serious consideration in this study. The consideration of mechanisms to protect the identity of research participants appears has become central to the design and practice of ethical research. They are also not only important elements of research, but a legal requirement of the Data Protection Act (1998). The fundamental principle of the Act is the protection of individuals' personal data held about them by data controllers which includes academic researchers. It is an importance that is also stressed by the British Psychological Society as their ethics code states that "participants in psychological research have a right to expect that information they provide will be treated confidentially and, if published, will not be identifiable as theirs" (Robson 1995: p43). According to Barnes (1979), a general but important rule of thumb is that collected research data should be presented in such a way that participants should be able to recognise themselves, whereas the reader should not. Grbich (1999) goes as far as saying that participants should be told explicitly how confidentiality and anonymity will be maintained, including any pseudonyms (fictitious names) that are used in the reporting of participants' responses. This type of detail was implemented during this study. Participants that took part in the quantitative survey were explicitly verbally told before their involvement began that their names would not written on their questionnaire, nor would they be stated on any other document, or on the database that stores each questionnaire's data. Participants that agreed to be interviewed for the qualitative component either agreed that I may write their name and contact details on

their questionnaire, or instead on a separate document which was not in any way linked with their completed questionnaire. For the former, I explicitly explained that this would not fully conceal their personal data, and made sure that they understood would be agreeing to this. I also asked each consenting participant which mode of initial contact they would primarily prefer (email, telephone, postal letter, or other). These participants were also informed that their interview would be one-on-one, face-to-face, semi-structured, conducted in a quiet and private area of their choosing, of indeterminate length, and audio recorded. These procedures were also explained in the participant information sheet. During the qualitative interviews, participants were asked if they would prefer that I use pseudonyms during the analysis and the presentation of my findings. I provided them this choice as work by Grinyer (2002a) highlighted how participants in qualitative interviews sometimes prefer their real names to be used in the presentation of findings, and that participants of this preference who subsequently view the pseudonyms use in published work may feel high degrees of distress. For example, Grinyer's work (2002b) highlighted one participant who talked about her son who had died from cancer. When the participant read the published work, she informed the researcher that she was disappointed not to see the real names of both her son she discussed and herself, as, even though her words were there, she felt that she had lost ownership of them and betrayed her son. She also stated that this caused confusion and sadness among her family and friends. This was a scenario and provides the main reason for why I provided all interviewees with the choice of real or fictitious names for any published work.

3.3.3 Interview ethics

There are also a number of other ethical principles that I adhered to during the interview process for both the quantitative and qualitative components. One principle of providing qualitative interview participants the choice of data anonymity has already discussed above. Further, qualitative interviewees were provided with the option of choosing to stop the audio recording at any time and for any reason, or for part of the interview. These interviewees were also informed that the tape recordings would be stored in a secure and private area, that only I would have access to them, and that they would be destroyed after they have been analysed. Another simple method of putting the participant at ease was to arrange a time and place that they felt comfortable to be interviewed, and which offered privacy and a pleasant and relaxing atmosphere. This was a strategy employed for every qualitative interview participant as it was possible that these participants could view the interview process as daunting and fearful – a prospect that could consequently inhibit the discussion. However, for many of the participants during the quantitative component, the preference of speed replaced comfort as rather than arrange a separate meeting for conducting the survey, many participants understandably preferred to complete it at that moment.

3.4 Data collection tools

As stated earlier, this study has used both quantitative and qualitative data collection procedures. The quantitative component employed a questionnaire tool to collect data, whereas the qualitative component employed a semi-structured interview with a schedule of pre-determined open-ended questions. Choosing these methods have previously been discussed and highlighted as crucially important. However, equally as important are the choices a researcher makes on the specific instruments that are used,

and the types of questions that are explored, as this ensures that the collection of relevant information that pertains to the original research aims.

3.4.1 The questionnaire

The purpose of the quantitative component of this study was to collect information that partially or fully addresses every original research aim (see section 3.1). Therefore, a questionnaire was constructed that consisted of subsections that collected an array of participant data, including socio-demographics, attitudes towards mental health problems, personal knowledge and experience levels of mental health problems, and individual scores of individualism and collectivism (see appendix 5). For the beginning socio-demographic subsection, data was collected on age, gender, ethnicity, place of birth, educational levels, marital status, occupation and religion. These questions were included because they are research-standard socio-demographic enquiries. Furthermore, a number of these questions have been previously found to be important associative factors in determining stigma (Wolff et al, 1996a), and may also bear relation to an individual's level of individualism-collectivism (Triandis, 1995). I also included the questions of generation, first language, place of education, and length of stay in England, as these are not only variables individually worth exploring but collectively provide a rudimentary yet useful indication of the level of acculturation to the English culture. This subsection was chosen to begin the questionnaire as it is common practice for questionnaires to begin by asking participants more simple and neutral types of questions.

The following subsection utilised the 'Community Attitudes to Mental Illness scale' (CAMI) (Taylor and Dear, 1981) in order to measure the attitudes and stigma levels towards people with mental health problems. This tool was selected as it has been shown to be both valid and reliable (Sevigny et al, 1999; Byrne, 2001; Song et al, 2005) relatively brief (a 40 statement inventory each with a 5 point Likert-scale response option of strongly agree, agree, neutral, disagree, and strongly disagree), and, importantly, focuses on community rather than professional attitudes toward the mentally ill. The tool measures levels of 'authoritarianism', 'benevolence', 'social restrictiveness' and 'community mental health ideology', each of which consist of 10 unique statements. According to Taylor et al (1979), authoritarianism refers to a view of the mentally ill person as someone who is inferior and requires coercive handling; benevolence corresponds to a paternalistic and sympathetic view of the mentally ill; social restrictiveness refers to the belief that the mentally ill patients are a threat to society and should be avoided and; community mental health ideology concerns the acceptance of mental health services and mentally ill patients in the community. The 40 statements were randomised so that order effects were eliminated.

For the following subsection, I added the questions used by Wolff et al (1996c). These items related to participants' knowledge of mental health problems and their personal beliefs about aggression and intelligence in people with mental health problems. I also enquired about their possible previous contact with mentally ill people. These questions asked whether the participants personally had experienced a mental health problem, and if they have a family member and/or a non-family member who has had a mental health problem.

For the final subsection, I utilised Triandis' (1995) 'vertical-horizontal individualism-collectivism scale' (VHIC) in order to measure each participant's level and type of individualism and collectivism. This scale was selected as it has been validated in a number of cross-cultural studies and found to be rigorous across samples (Strunk and Chang, 1999; Lee and Choi, 2005). It also offers the opportunity to measure more than the traditional uni-dimensional conceptualisation of individualism and collectivism, but also a more sophisticated multidimensional classification of vertical and horizontal aspects. The scale is a 32 item measure of horizontal collectivism (HC, e.g. "If a co-worker gets a prize, I would feel proud"), vertical collectivism (VC, e.g. "I would do what would please my family, even if I detested that activity"), horizontal individualism (HI, e.g. "One should live one's life independently of others") and vertical individualism (VI, e.g. "It is important to me that I do my job better than others"). Each dimension consists of eight unique statements which participants are asked to rate the extent of their agreement to these items across a 9 point Likert-scale ranging from 0 (strongly disagree) to 9 (strongly agree). The 32 statements were randomised to avoid ordering effects.

The final page of the questionnaire thanked the participant for involvement and also enquired about whether they would be interested in taking part in a follow-up semi-structured interview at a later date in a place and time of their choosing. Participants were not required to provide a reason for not wanting take part in this. For participants that agreed to this, their names and contact details were noted down on a separate document so to ensure questionnaire anonymity. Furthermore, participants were asked if they knew of anyone with a similar cultural background to themselves that they considered as being interested in also taking part in the survey. If they did, space was

provided for the potential participants' name and contact details. Finally, participants were provided with my contact details, as well as the opportunity to write down any miscellaneous thoughts that they had about any aspect of the survey

When constructing the questionnaire, I tried to follow the presentation rules stated by Sarantakos (2004). These included that all questions should be easy to read, use a clear font size and font type, that there is sufficient space for answers, clear instructions are provided, only relevant and necessary questions are asked, that questions are checked for bias and ethical adequacy, that subsections flow in a logical progressive manner, and that the questionnaire has an overall professional appearance.

3.4.2 Semi-structured interviews

As previously stated, one-to-one audio recorded semi-structured interviews were used in order to collect data that explored three of my five original research aims, namely, an exploration of the individualism-collectivism paradigm in relation to mental health stigma, an exploration of the underlying cultural reasons for stigmatisation, and an exploration of whether and how acculturation affects the individualism-collectivism paradigm. Consequently, a schedule of open-ended questions was created that was specifically geared to focus interview discussion on these themes. Additional key themes that were identified after the analysis of the quantitative survey data were also explored. The complete schedule of questions can be found in appendix 4. Each interview question was asked in the same manner and with the same wording for each participant. During the interview, I adopted the 'reflexive' approach which involved formulating new questions intuitively and succinctly with a view of extending the

discussion if I believed I was obtaining information that at least loosely related to either the original question, or to another original research aim. This is because the question structure was not strictly fixed or fully rigid, as I wanted to allow for changing in question order, or the addition of new questions, if and when it became necessary. As Lamnek (1989) argues, qualitative interviews should not use a strictly standardised approach, as they should be ready and flexible enough for change during which interviewers should engage in the open discussions although in a passive and stimulating, but not dominating, role. Eisenhardt (1989) also recommends such a strategy, labelling it 'controlled opportunism'. I also avoided using 'leading questions', that is, questions that through specific wording can motivate the interviewee to give answers that conform with the view and the biases of the interviewer, as such questions have been shown to influence results (Maguire, 2002). The problem of researcher bias is further compounded by another associated problem, 'demand characteristics'. This phenomenon refers to when participants provide answers that they think the researcher wants, and that the researcher "acts like a sieve which selectively collects and analyses non representative data" (Bogdan and Taylor, 1975: p12). In order to minimise this occurring, I made myself aware of my own possible pre-assumptions and biases about the data being collected so to avoid directing discussion in any manner that suited these assumptions. I also explicitly instructed all participants to respond to questions in as truthfully as possible, and not to provide statements that they believe I may wish to hear.

However, 'non-directive' and 'summary' probes were sometimes used during interview discussions, but only when a partial, seemingly irrelevant, or inaccurate response was provided to a question. Non-directive probes offer brief but neutral

assertions of understanding and interest, so that responses are not influenced in any way, but rather extended and exemplified so that in-depth discussion can continue. Summary probes consist of summarising the participant's last statement and motivating him/her to say more about the issue in question without leading the discussion into a particular direction. According to Sarantakos (2004), probing is a common and useful technique that helps interviewees to offer accurate information and/or refine and complete their answers. I also found probing useful as it helped to clarify possible misunderstandings of the meaning of participant statements – an important process as I aimed to avoid the assumption that the participant and I have shared meanings.

3.5 Pilot

A small-scale pilot study was undertaken in order to specifically identify any potential problems with the questionnaire. Pilot studies are a crucial element of a good study design, and, although it does not guarantee success in the main study, it does increase the likelihood. According to Sarantakos (1993: p277), a pilot study is "a small-scale replica and a rehearsal of the main study". As van Teijlingen and Hundley (2001) highlight, a pilot study can be used in two different ways in social science research: to test the feasibility of the study by trialling the administrative and organisational procedures related to the whole study and the participants, or to test the mechanical problems of particular research instruments. It was mainly for the latter reason that I decided to conduct a small-scale pilot; specifically to test the mechanics of the questionnaire instrument employed for the quantitative survey. In order to approach this examination systematically, I accorded to the areas of instrument testing that

Moser and Kalton's (1971) and Sproull's (1988) work identify. These included testing the duration of the questionnaire, the effectiveness of its layout and presentation, the administering process, the level of question response, the difficulties of understanding particular questions, the sensitivity of the questions, the snowball recruitment process, and to identify and resolve any other procedural bugs to that may not have been expected.

The pilot study involved 8 participants from different backgrounds who were selected from purposive means. This was an acceptable method of locating pilot participants as the snowball-sampling method was not being tested, rather only the instrument itself. These participants included 2 Greek Cypriots, 2 white English participants, 2 Americans and 2 Chinese participants. One Greek Cypriot participant, a friend, is a second generation 25 year old male who is single, well educated and from a working class background. The other Greek Cypriot, a relative, is a 55 year old male and is a first generation married migrant with little formal education and from a middle class background. The 2 white English participants were neighbours; one is an 18 year old working class single female, and the other is a 43 year old working class cohabiting female with very little education. One of the Americans, a colleague, is a middle class and very well educated divorced female. She refused to disclose her age, although did make it known that she was in her 50s. The other American, a friend, is a 29 year old single middle class female with a good educational background. One of the Chinese participants, also a colleague, is a 35 year old married female, who is well educated, and a first generation migrant of middle class background. The other Chinese participant, a salesman, is a 39 year married male with a low level of education and of working class background.

Each participant conducted the questionnaire in a quiet place of their choice. I began by thanking them for agreeing to take part, before reading to them the opening paragraphs of the questionnaire which describe the aims and themes of the questionnaire, and that they will remain anonymous, their answers will be treated confidentially and that it is not a test. I reminded them to take as much time as they wanted, and to ask me any questions or make any comments about the questionnaire at any time. I also stated that they may choose to stop or refuse to continue at any time with or without reason. The 55 year old Greek relative and the 39 year old Chinese salesman chose to complete the Greek and Chinese translated questionnaire respectively.

Although each participant successfully completed the questionnaire on their own, answering every question without too much difficulty, there were some questions that the piloting process revealed the need for improvements. One such question was '*If yes* (to knowing the names of any types of mental illness)*, please name as many as possible*'. This question, taken from Wolff et al (1996b), is one of the questions aimed at obtaining an idea of the level of knowledge that the participant possesses on mental health. However, I found that the participants who did possess a good level of mental health knowledge were unsure how many they should write to indicate their good level of knowledge. One participant wrote out 4 names, whereas another wrote out 13 names, although it was made clear to me that both participants had approximately an equal level of knowledge on mental health. It was therefore decided that the question would be improved if there was a stated maximum limit of names they could give, so the question was changed to '*If yes, please state a maximum of 3 names*', which

yielded a quicker and clearer response from the participants, and also removed the strain of trying to think of as many names as possible.

The following question, '*Can you tell somebody has a mental illness? Yes/No'*, which was also taken from Wolff et al (1996b)'s work as part of the mental health knowledge related questions, also led to some difficulty among some participants. According to Wolff et al, the correct answer in the question is 'no' as it is not always possible to assume that one can know if someone has a mental health problem. However, a few participants argued that they personally believe that it depends on the particular mental health problem. For example, one participant reasoned that he could sometimes distinguish whether someone was suffering from anorexia due to them looking unusually thin, whereas it might be much more difficult to know whether someone was suffering from depression. Therefore, I decided to change the answer choices to 'Yes/No/Sometimes' which successfully yielded a clearer response from the participants.

Another question that needed tweaking was '*If yes* (to knowing somebody with a mental illness), *what was/is the problem?'* This question, also taken from Wolff et al's (1996b) work, is a question aimed at understanding participants' level of experience. However, some participants responded with answers such as 'compulsive lying' and 'extreme unhappiness', which are the symptoms of particular mental health problems, rather than the name of the health problem. Therefore, the question was modified to '*If yes, what was/is the problem? (Please try to state the name of the illness, not the symptoms'*.

I also found it useful to add the following question: '*How close to you would you consider this person?* (A person who they have stated to know who has/had mental illness) *Extremely close/Quite close/Not very close/Distant/Very distant*'. This helps to estimate what level of contact the participant may have had with the person who has/had mental health problems, and as such those people who state that they are close to the person would score higher experience points.

Another question that was subsequently added which also aimed to gauge participants' level of experience with mental health problems was '*Have you ever worked with people with mental health problems?*' and '*If yes, please state the type of work*'. This was because some participants informed me during the questionnaire process that many of their experiences of mental health came from their work in the mental health sector. I decided that such participants that successfully stated work that related to mental health should score an extra point for experience as this was an important facet of experience that I had previously not thought about including in the questionnaire.

Answering the questionnaire took the participants between 20 and 45 minutes, and on average approximately 35 minutes, which the participants felt was not too tiring. There were no reported problems regarding the socio-demographic background information section, the CAMI section, or the VHIC section. The participants were all also happy with the presentation and organisation of the questionnaire, the clearness of the various scales, the sensitivity level of the questions, and the vocabulary level of the questions. This was pleasing because I feel that it is important to word questions in a manner that is simple to understand without being condescending. Further, I was

worried that some participants may feel frustrated with understanding some of the questions on the CAMI questionnaire and the VHIC scale, as I had decided against changing the wording in case of affecting the validity of instruments. However, the piloting process did not flag any concerns related to this. Furthermore, the two participants who completed the translated versions of the questionnaire did not have any difficulties or concerns to note about the quality of the translation.

Each participant also stated that the researcher administration of the questionnaire was good as they did not feel that I was influencing them or being intrusive despite being close by. This was pleasing as, according to Bernard (1994), two disadvantages of administering a questionnaire in a face-to-face manner is that participants can feel that the researcher is intrusive, and that they may feel influenced or obliged to answer in a certain way to please the researcher. All participants also stated that they would be happy to take part in a follow-up interview, and most participants also provided names and contact details of people who are of a similar cultural background to them to contact.

3.6 Data collection procedure

Research data was collected using a snowballing sampling method for the quantitative survey, and a purposive sampling method for the qualitative semi-structured interviews. The survey was conducted first so that its analysis could partly inform the construction of the schedule of questions used for the qualitative interview process. Specific procedural details for both components are provided below.

3.6.1 Quantitative survey

As already stated, the quantitative survey employed a snowball sampling technique. For each cultural group, primary participants from varying socio-demographic backgrounds were contacted. This was performed so that the collected samples were as balanced and representative of the general population as possible so that criticisms of low generalisability could be minimised. Primary participants who met the sampling criteria (associating themselves with of the four cultural groups) were approached in any place that they could be found, although most were found in London community centres, social clubs, expatriate groups, personal contacts, universities, schools, and places of work, and random door-stopping in economically diverse areas of London. The questionnaires were mostly completed at that moment, although occasionally some participants completed the questionnaire in their own time and later returned it to me either directly, or by post, fax or email. On other occasions, such as on visits to community centres and social clubs, it was more suitable for a group of participants to complete the questionnaire at the same time. Participants who were found on expatriate meet-up websites or other meeting forums were contacted by email, informed of the study, and meetings were arranged in quiet venues of their preference and convenience. Phone numbers and appearance information were exchanged prior to any meeting. To further ensure participant safety, they were requested not to approach anyone and instead wait until I had made direct contact with him/her. Greek or Chinese translations of the questionnaire were provided for those who preferred it. Following questionnaire completion, participants were thanked and invited to take part in an audio-recorded semi-structured interview at a later time to discuss in greater depth the issues of mental health stigma in their

culture. They were also asked to nominate other people of a similar cultural background who might agree to participate. Participants provided the contact details of prospective secondary participants, or stated that they would contact the prospective participant and ask him/her to contact me. Others provided details of places where I am likely to sample other participants such as names of websites, community centres and cultural organisations. The secondary participants who took part in the survey were also asked to nominate other prospective participants. This process continued until a balanced and desirable sampling size was reached, or until no more participants could be discovered.

3.6.2 Qualitative interviews

Interviewees from each cultural group were recruited from the list of survey participants who had provided their consent and permission to be contacted for involvement. The decision to recruit interviewees in this opportunistic manner was primarily based on pragmatism, as a number of appropriate potential interviewees had already been identified and provided informed consent. This technique had the added advantage of affording a degree of systematic interviewee selection so that a balanced sample of interviewees was constructed, particularly in terms of age, gender, and socio-economic status. Potential interviewees were initially contacted via their primary choice of contact type (this was usually by email). Individuals were not asked to provide reasons if they declined involvement, and were not contacted again at a later date. Those who agreed to take part were provided with the choice of venue and time of interview that would be convenient, private and generally preferable for them. For participants that preferred to speak in their native language, a professional

translator was arranged. Each interview was always one-to-one (besides the translator), face-to-face and audio-recorded for transcription. Interviewees were also provided with the option of choosing to stop the audio recording or end the interview at any time and for any reason. The same schedule of pre-determined open-ended questions was used in each interview so that themes related to the original research aims were explored (see appendix 4 for schedule of questions). Non-directive probes were used when needed to exemplify and extended statements. Any new important themes that emerged during conversation were explored further. If participants used inconcrete words, concepts or ideas, clarification was sought so that any assumptions of meaning was confirmed or rejected. If permitted, written notes were taken on non-verbal communication, such interviewee feelings and body language. The number of interviews completed primarily depended on the amount of time that was available to organise, conduct, reflect and analyse each interview.

3.7 Data Analysis

Selecting appropriate data analysis methods is a key step in any research study. The analytical selections are based on a number of criteria that relate to the researcher's epistemology and thus the type of data that has been collected. As this study incorporated positivist and interpretivist epistemologies, and as such quantitative and qualitative data collection methods, it was important to utilise analytical techniques that are appropriate for these differing approaches. This subsequently yields an understanding of the data that affords the researcher to effectively address the original research aims.

3.7.1 Quantitative data analysis

The data collected from the questionnaire-based survey was analysed using the analytical software 'Statistical Package for Social Scientists' (SPSS) (Version 13). Frequencies and descriptives were calculated for all levels of data. Extensive data cleaning was conducted which consisted of rigorously checking for errors in data inputting. Further, for any missing data, missing value analysis was used which replaced missing data with analysed estimates. The CAMI questionnaire and Triandis' vertical-horizontal individualism-collectivism scale were analysed for scale reliability using Cronbach's alpha coefficient. As the data collected is not representative of the general population, non-parametric tests for significance were used. Nonparametric tests have less power than the appropriate parametric tests, but are more robust when the assumptions underlying the parametric test are not satisfied, such as in this study. Specifically, Mann-Whitney U-tests were carried out for tests of significant relationships between two independent variables and one dependent variable (e.g. gender [male/female] vs. social restrictiveness score). Kruskal Wallis H-tests were carried out for tests of significant relationships between three or more independent variables and one dependent variable (e.g. cultural group [English/Greek/American/Chinese] vs. social restrictiveness score). Spearman's rho was used to test for correlations between two of more dependent variables (e.g. mental health knowledge score vs. authoritarianism score). Pearson's chi-square (x^2) test was used to test for significant relationships between two or more categorical variables (e.g. gender [male/female] vs. knowledge level [low/high]). When transformation of linear, non-categorical variables (e.g. social restrictiveness) was deemed necessary for specific tests, they were recorded into categorical type variables (e.g. age = young/older age group, restrictiveness score = low/medium/high score)

using the median (for splitting into two categories) and median-based percentiles (for splitting into three or more categories). Social class was determined by the 'Occupation Groupings' (MRS, 2003). The score for 'knowledge of mental health problems' was calculated by aggregating 4 binary items (correct = 1, incorrect = 0) and 3 multiple items (possible score = 0–3). The maximum possible score was therefore 13. The score for 'experience of mental health problems' was calculated by aggregating 3 binary items (correct = 1, incorrect = 0) and 2 multiple items (possible score = 0–3). The maximum possible score was therefore 9. Stepwise binary logistic regression tests were used to identify the existence of any independent predictors within each CAMI stigma construct across the complete dataset, and within cultural groups that were deemed necessary (for which culture-specific medians for each CAMI construct were constructed and used). Model strength was evaluated using Nagelkerke R^2, and model goodness of fit level was evaluated using the Hosmer-Lemshow statistic. Odds ratios were determined using the 'Exp(B)' statistic. Unexplained model variance was measured using the '-2 Log likelihood' (2LL) statistic.

3.7.2 Qualitative data analysis

My analysis involved a five-stage iterative content analysis: (1) development of a coding schedule; (2) coding of the data; (3) description of the main themes; (4) linking of the themes; (5) development of explanations for the relationships between themes. This is a standard qualitative analysis technique (Richards et al, 2002) which I have prior experience with. To help strengthen this analytical process, I employed a three-stage cyclical process described by Sarantakos (2004). This process is based on

the idea of an analysis being a cyclical continuous process that goes through three stages: 'data reduction', 'data organisation' and 'data interpretation'. Data reduction refers to the researcher's manipulation and transformation of the data by the process of summarising, coding and categorising data. It is a method used to primarily aid the researcher to carefully focus on the collection and identification of important aspects of the issues in question. Data organisation is the process of assembling information around certain themes and points. Data interpretation involves making decisions and drawing conclusions that relate to the research aims by identifying patterns, themes, trends and explanations. This approach emphasises the 'constant comparison' method of continuously comparing and contrasting themes and concepts as they emerge within and between different interviews in order to understand when, why and under what conditions particular themes occur in the text. According to Dunn and Johnson (2001, p3), this helps to serve two purposes: "Promoting the testing of hypotheses as they are being formulated, and guiding the researcher to search for evidence in the data to support or refute concepts on the basis of emerging theory". After this process, the findings revealed from the data can be linked and tested against previous substantive and formal theories.

A number of steps were also taken to maximise the credibility of my findings. This included continuously considering my personal biases on what the data might entail before, during and after the analysis of data. This was carried out so that the influence and affect of such biases could be minimised. These included my personal beliefs of the Chinese and Greek cultural groups being more likely to hold stigmatising attitudes to people with mental health problems. I also believed the Chinese and Greek groups would be more culturally orientated towards collectivism, whereas the white-English

and American groups would be more orientated towards individualism. This is also discussed in section 6.5.

To further increase the credibility of my analysis, I utilised the multiple coding technique. This involved the cross-checking of coding strategies and interpretation of data with other researchers, in this case, my supervisors. Barbour (2001) argues that multiple coding of entire datasets may not always be necessary (due to time and cost), and does not demand the perfect replication of results, but a second researcher should at least look over segments of the dataset. Of particular interest was the examination of the differences in data interpretation between my supervisors and I, as this ultimately served to produce the final refinement of the codes and analysis. I also employed the 'deviant case analysis method'. This is another method agreed to be useful in ensuring the quality of analysis (Barbour, 2001). This method was useful as it warranted the attention of 'negative cases' in the dataset. This involved searching for elements in the dataset that contradicted, or seemed to contradict, the emerging explanations of the phenomena under study. Analysis continued until no new meaningful information was being obtained (analysis saturation).

Chapter 4: Results

4.1 Quantitative survey data

4.1.1 Socio-demographic details

Three hundred and five people completed the questionnaire. Of these, 75 described themselves as primarily belonging to the white-English cultural group, 77 to the Greek/Greek Cypriot group, 78 to the American group, and 75 to the Chinese group. One hundred and forty four participants were male, and 161 were female. The distribution of numbers is reasonably evenly balanced across cultural groups, gender and age, although the Chinese and American groups are made up of slightly younger people (a median age of 27 and 31 years respectively, compared to 35 and 39 years for the white-English and Greek/Greek Cypriot group). A complete socio-demographic breakdown of the survey dataset can be seen in table 4.1.

An examination of the American survey group reveals that it is essentially comprised of first generation individuals, most of whom are in their 20s and 30s (see figure 4.1), have recently migrated ('lifetime living in UK' median percentage = 4), and most hold a university degree (70.5%). The majority (66.7%) are classified as belonging in the 'C1/C2' social class grouping which refers to people who are in moderately paid non-manual or skilled manual employment, or who are students. It should also be noted that this group holds the lowest percentage in the 'D/E' social class grouping (10.3%) which refers to those unskilled manual labour or at least six months of unemployment. Compared to the other cultural groups, the Americans are comprised

Table 4.1: Socio-demographic details of survey participants

Socio-demographic variable		Cultural Group				
		Total	American	White-English	Greek/Greek Cypriot	Chinese
n		305	78	75	77	75
Gender	Male	144 (47.2%)	35 (44.9%)	41 (54.7%)	35 (45.5%)	33 (44%)
	Female	161 (52.8%)	43 (55.1%)	34 (45.3%)	42 (54.5%)	42 (56%)
Age	Median	30	31	35	39	27
	Range	18 - 82	18 - 65	18 - 79	18 - 82	18 - 69
Generation+	1st	176 (76.9%)	77 (98.7%)	N/A	42 (54.5%)	57 (76%)
	2nd	45 (19.2%)	1 (1.3%)	N/A	31 (40.3%)	13 (17.3%)
	3rd	9 (3%)	0 (0%)	N/A	4 (5.2%)	5 (6.7%)
Migrants*	n	178 (58.4)	77 (98.7%)	0 (0%)	44 (57.1%)	58 (77.3%)
Lifetime living in UK	Median	57.5%	4%	100%	77%	22%
Educational Level	Higher**	154 (50.5%)	55 (70.5%)	30 (40%)	34 (44.2%)	35 (46.7%)
	Lower**	151 (49.5%)	23 (29.5%)	45 (60%)	43 (55.8%)	40 (53.3%)
Social Class	A/B	58 (19%)	18 (23.1%)	20 (26.7%)	8 (10.4%)	12 (16%)
	C1/C2	180 (59%)	52 (66.7%)	37 (49.3%)	41 (53.2%)	50 (66.7%)
	D/E	67 (22%)	8 (10.3%)	18 (24%)	28 (36.4%)	13 (17.3%)
First language	English	203 (66.6%)	76 (97.4%)	100 (100%)	35 (45.5%)	17 (22.7%)
	Other	102 (33.4%)	2 (2.6%)	0 (0%)	42 (54.5%)	58 (77.3%)
Religiousness	High***	81 (26.6%)	20 (25.6%)	23 (30.7%)	34 (44.2%)	4 (5.3%)
	Medium***	112 (36.7%)	35 (44.9%)	30 (40%)	36 (46.8%)	11 (14.7%)
	Not***	112 (36.7%)	23 (29.5%)	22 (29.3%)	7 (9.1%)	60 (80%)
Marital Status	Single	161 (52.8%)	47 (60.3%)	39 (52%)	34 (44.2%)	41 (54.7%)
	Married/Cohab	122 (40%)	27 (34.6%)	30 (40%)	34 (44.2%)	31 (41.3%)
	Other****	22 (7.2%)	4 (5.1%)	6 (8%)	9 (11.7%)	3 (4%)

+ = 1st generation: Someone born in their native country and subsequently moved to live in England; 2nd generation: Someone who was born and grew up in England and whose parents are 1st generation; 3rd generation: Someone who was born and grew up in England and whose parents are 2nd generation.

* = All migrants were born in their native country except for one American participant who was born in India

** = Higher (a grouping of 'university degree' and 'post-graduate degree' responses); Lower (a grouping of 'primary school', 'secondary school', 'A level', and 'college level' responses).

*** = High (a grouping of 'quite religious' and 'extremely religious' responses); Medium ('not very religious' responses); Not (a grouping of 'agnostic' and 'atheist' responses).

**** = Other (a grouping of 'divorced', 'separated' and 'widowed' responses).

Figure 4.1: Age distribution of American survey participants
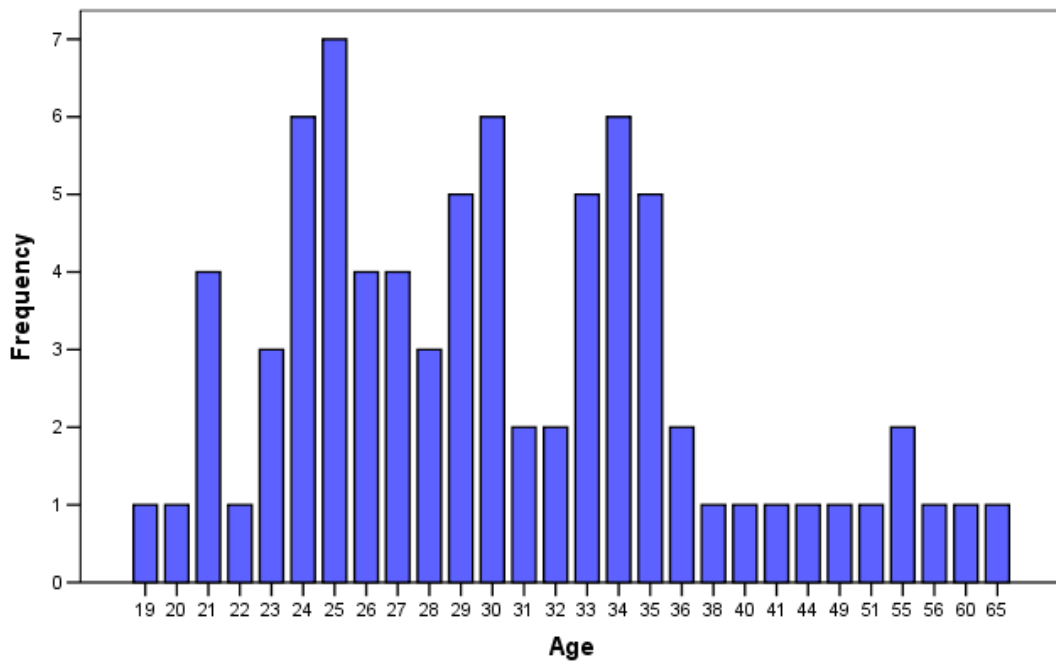
of a high percentage of people from the A/B social class grouping (23.1%, compared

to 26.7%, 10.4% and 16% for the white-English, Greek/Greek Cypriots and Chinese

respectively). This grouping refers to people who are employed in high-income

employment, such as very senior business managers or top-level civil servants. This

highlights that despite the majority of this group having only lived in the UK for a

relatively short period of time, the American participants are prospering in UK

society. This is most likely linked to the fact that, as previously stated, the majority of

the study participants are highly educated, and also because every participant spoke

the English language fluently (for 97.4% it was their first language).

As can be seen in figure 4.2, the Chinese group is also mainly comprised of first

generation people, of whom the majority are also in their 20s or 30s. This may be due

Figure 4.2: Age distribution of Chinese survey participants
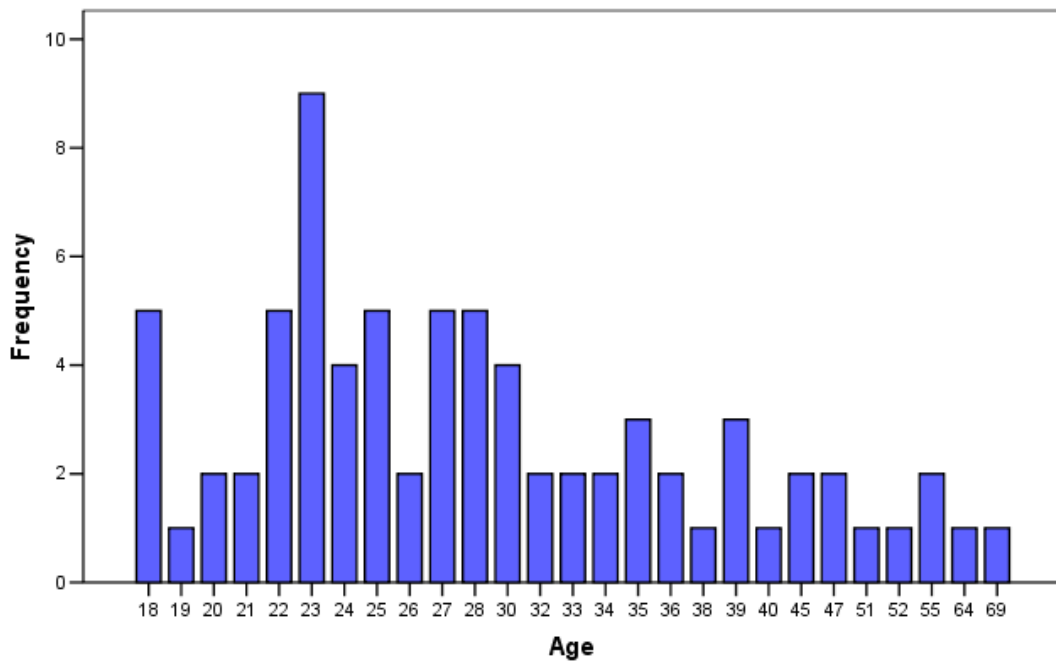
to the fact that many older first generation Chinese migrants declined to participate in the study. Although the median percentage of life lived in the UK by this group is considerably higher than American group (22%), fewer people fell into the A/B social class groupings whereas comparatively more were classified in the D/E social class groupings (A/B = 16% vs. 23.1%; D/E = 17.3% vs. 10.3% - Chinese and Americans respectively). This may be due to this group being the youngest in median age (27 years) and consisting of considerably fewer people with English as their first language (22.7%).

Similarly to the Chinese group, less than half of the Greek/Greek Cypriot group stated that English was their first language (45.5%). Their A/B class grouping was also low compared to the American and white-English groups (10.5%), whereas no other group had as many participants who fell into the D/E social class grouping (36.4%). As

older, first generation Greek/Greek Cypriots did not resist participating in the survey, the median age for this group (35 years) is higher than the Chinese (27 years) and American groups (31 years) and more similar to the white-English group (39 years). Figure 4.3 highlights the age spread of the Greek/Greek Cypriot group.

Figure 4.3: Age distribution of Greek/Greek Cypriot survey participants
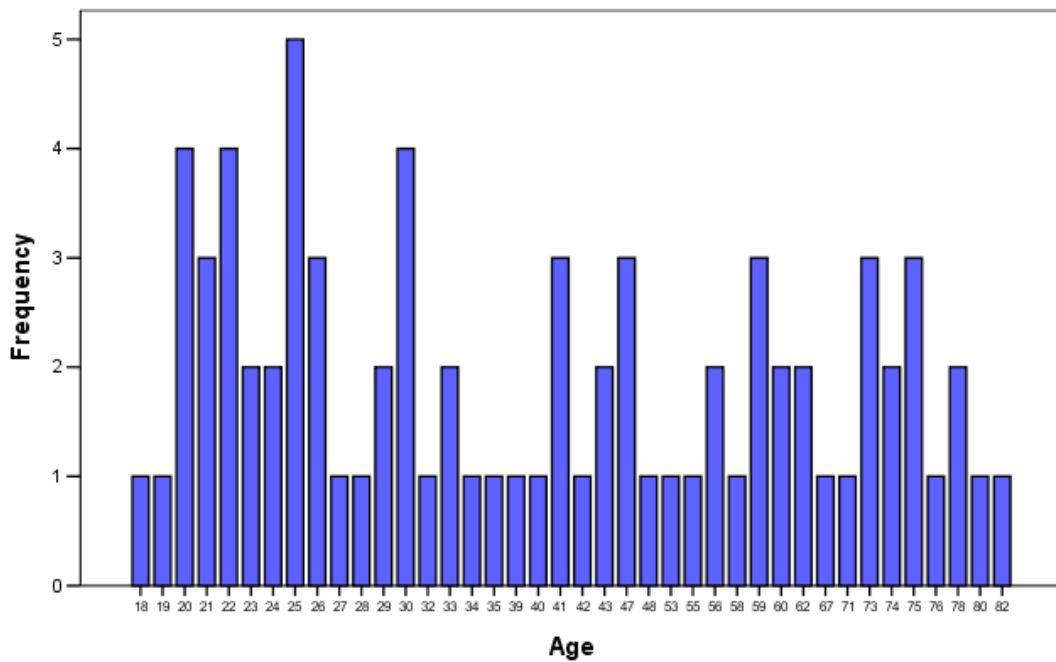
Greek/Greek Cypriots also scored the highest on the religiousness level variable (44.2% = high religiousness; 9.1% = Atheist/Agnostic), a finding also consistent amongst both older and younger Greek/Greek Cypriots compared to the other cultural groups (see table 4.2). The Greek Orthodox religion dominated the Greek/Greek Cypriot group (89.6%), whereas atheism and agnosticism were the main ideologies held by the Chinese group (80%). The predominant religious affiliation for both the white-English and American groups was Protestantism (56% and 34.6% respectively). The white-English group were quite similar to the American group in religiousness

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level – 30.7% of the white-English group were classified into the 'high' religiousness group (Americans = 25.6%), and 29.3% in the 'atheist/agnostic' group (Americans = 29.5%). A full breakdown of religious affiliations by cultural group can be seen in table 4.3.

Table 4.2: Survey participants' religiousness level across cultural groups by age groups

Cultural Group	Age (split by median)	Extremely Religious	Not Very Religious	Atheist/ Agnostic
American	19-31 years	12 (25.5%)	21 (44.7%)	14 (29.8%)
	32-65 years	8 (25.8%)	14 (45.2%)	9 (29%)
White-English	18-35 years	9 (22.5%)	15 (37.5%)	16 (40%)
	36-79 years	14 (40%)	15 (42.9%)	6 (17.1%)
Greek/Greek Cypriot	18-39 years	14 (35.9%)	18 (46.2%)	7 (17.9%)
	40-82 years	20 (52.6%)	18 (47.4%)	0 (0%)
Chinese	18-27 years	3 (7.5%)	4 (10%)	33 (82.5%)
	28-69 years	1 (2.9%)	7 (20%)	27 (77.1%)

Table 4.3: Religious affiliation breakdown of survey participants

	Cultural Group			
Religion	American	White-English	Greek/Greek Cypriot	Chinese
No Religion/Atheism/Agnosticism	22 (28.2%)	22 (29.3%)	8 (10.4%)	60 (80%)
Protestant	27 (34.6%)	42 (56%)	-	11 (14.7%)
Catholic	14 (17.9%)	7 (9.3%)	-	-
Greek Orthodox	-	-	69 (89.6%)	-
Islam	1 (1.3%)	-	-	-
Buddhism	1 (%)	-	-	4 (5.3%)
Episcopalian	5 (6.4%)	-	-	-
United Church of Christ	1 (1.3%)	-	-	-
Jewish	7 (9%)	-	-	-
Pagan	-	3 (4%)	-	-
Hindu	-	1 (1.3%)	-	-

Compared to the Chinese and Greek/Greek Cypriot groups, there is less age skew in the white-English group (see figure 4.4). As 100% of the participant was born in England, and 92% had lived their entire life in England, the questions of generation and migration are not applicable. Forty percent of the group are educated to at least university degree level, and 26.7% of participants were classified as belonging in the A/B social class grouping. This is a higher figure than any other cultural group, although only slightly higher than the American group.

Figure 4.4: Age distribution of white-English survey participants
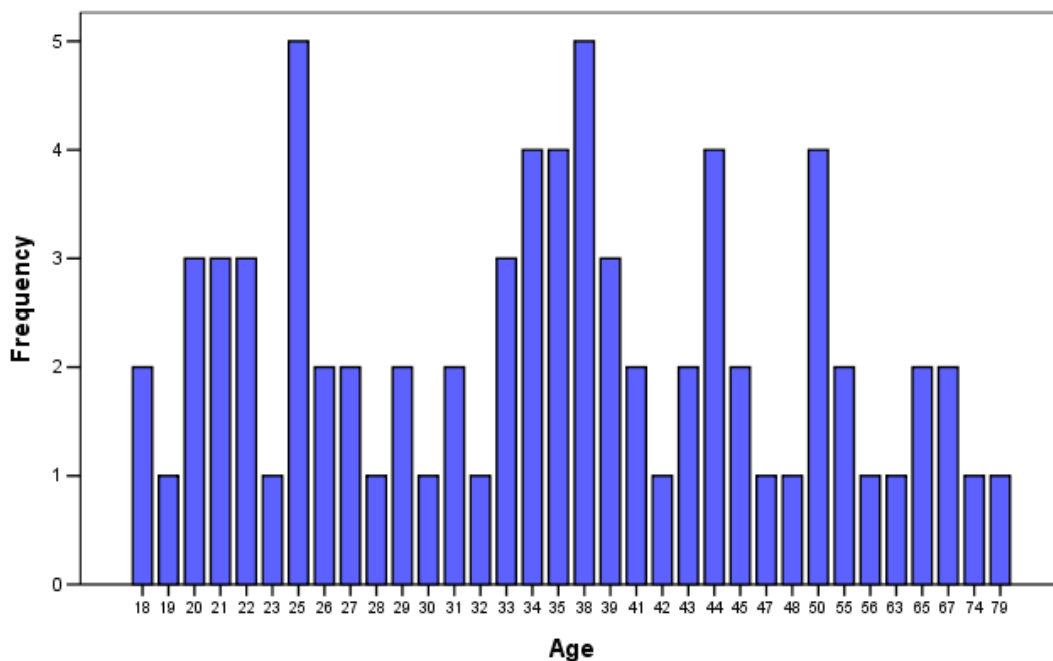
As can be seen in table 4.4, all white-English and Chinese participants described their ethnicity as 'white-English' and 'Chinese respectively'. Sixty-four (83.1%) Greek/Greek Cypriots described their ethnicity as 'Greek Cypriot' and 13 (16.9%) as 'Greek'. For the American group, 57 (73.1%) participants described their ethnicity as 'American', 7 (95%) people stated 'white', 5 (6.4%) stated 'white American', and 4 (5.1%) stated 'African American'.

Table 4.4: Ethnic breakdown of survey participants

Cultural Group	Ethnicity	Frequency	Percentage
American	American	57	73.1
	White	7	9
	White American	5	6.4
	African American	4	5.1
	Pakistani American	1	1.3
	Tibetan American	1	1.3
	Indian American	1	1.3
	Colombian American	1	1.3
	Japanese American	1	1.3
White-English	White English	100	100
Greek/Greek Cypriot	Greek Cypriot	64	83.1
	Greek	13	16.9
Chinese	Chinese	100	100

4.1.2 Stigmatisation levels within cultural groups

Alpha-coefficient reliability tests of the CAMI inventory showed strong reliability on each attitudinal scale. The results were as follows: authoritarianism = 0.8; benevolence = 0.83; social restrictiveness = 0.85 and; community mental health ideology (CMHI) = 0.84. As can be seen in table 4.5 and figure 4.5, there were significant differences in stigma levels in each of the four cultural groups. The American group scored significantly lower on each of the four stigmatising measures than the other cultural groups. The white-English group scored the next lowest on each measure, followed by the Greek/Greek Cypriot group, and finally the Chinese group, who held the most stigmatising views. It should be noted however that although the Chinese group held the least positive attitudes on mental health

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Table 4.5: Cultural group CAMI construct scores

Cultural Group	CAMI Measure (Median, 1 - 5)							
	Authoritarianism		Benevolence		Social Restrictiveness		CMHI	
	MR	Median	MR	Median	MR	Median	MR	Median
American	73	1.75	221	4.4	81	1.8	199	3.8
White-English	141	2.3	162	3.9	150	2.3	156	3.5
Greek/Greek Cypriot	182	2.6	133	3.8	180	2.5	136	3.3
Chinese	218	3.0	94	3.6	203	2.7	119	3.2
H	**115****		**85****		**84****		**35****	

* P = < 0.05; ** P = < 0.001; H = Kruskal-Wallis H Test; CAMI= 'Community Attitudes to Mental Illness'

Figure 4.5: Cultural group CAMI median construct scores
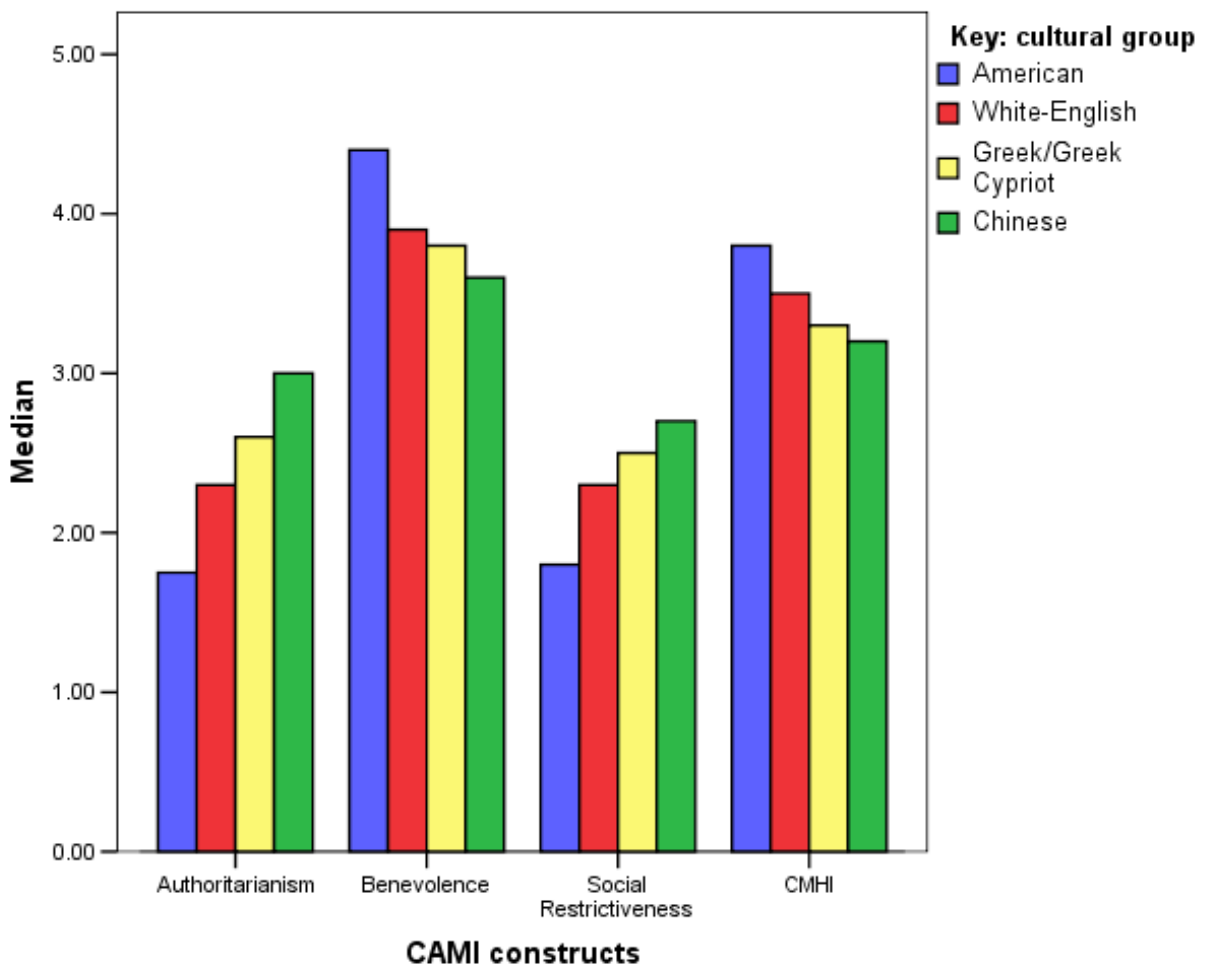
problems, this does not necessarily mean that their attitudes should be labelled as stigmatising. Moreover, the median scores for this group were either neutral (authoritarianism = 3.0) or mildly positive (social restrictiveness = 2.7; CMHI = 3.6 and; benevolence = 3.6). However, the Chinese and Greek/Greek Cypriots participants who had migrated to the UK were significantly more stigmatising than their UK-born, counterparts (table 4.6) who, it could be argued, are more acculturated to English culture. Thus, the non-stigmatising results of the Chinese and Greek/Greek Cypriots can be partly attributed to the impact of the less stigmatising UK-born and acculturated participants in these groups. This is discussed in detail in section 5.2.

Table 4.6: Non-UK-born Greek/Greek Cypriots and Chinese vs. UK-born Greek/Greek Cypriots and Chinese vs. CAMI construct scores

Group Type	CAMI Constructs							
	Authoritarianism		Benevolence		Social Restrictiveness		CMHI	
	MR	Median	MR	Median	MR	Median	MR	Median
Chinese: Non-UK-born (n=58)	44	3.1	34	3.4	41	2.7	36	3.1
Chinese: UK-born (n=17)	18	2.2	53	4	27	2.3	44	3.5
U	160**		233.5**		308.5*		392.5	
Greek/Greek Cypriot: Non-UK-born (n=44)	45	2.9	40	3.8	44	2.7	40	3.25
Greek/Greek Cypriot: UK-born (n=33)	30	2.5	37	3.8	32	2.4	37	3.3
U	443*		668		493.5*		671	

* P = < 0.05; ** P = < 0.001; U = Mann Whitney U Test; CAMI= 'Community Attitudes to Mental Illness'; MR = Mean Rank

4.1.2.1 Main stigmatisation explanatory factors within white-English culture (excluding individualism-collectivism)

Non-parametric Mann Whitney U, Kruskal Wallis H, and Spearman's rho statistical tests were run on each cultural group to reveal which participant background factors associate with high or lower levels of stigma on the CAMI inventory. The established explanatory factors for each CAMI construct would then be included within stepwise binary logistic regression tests. For the white-English cultural group (see table 4.7), no significant associations between the CAMI constructs and age, social class level, gender, and marital status were revealed. However, more previous experience with mental health problems was found to significantly correlate with having lower stigmatising scores on all four CAMI constructs. This was also the case with possessing a stronger educational background and more mental health knowledge. These two factors also significantly correlated with each other (rho = .360, $p < 0.01$). Therefore, the three aforementioned variables were selected for inclusion for the subsequent logistic regression analysis. Also chosen for inclusion was 'religiousness level' at a higher level was found to correlate with higher social restrictiveness (rho = .299, $p < 0.01$) and less regard for CMHI (rho = -.306, $p < 0.01$). Testing for differences in generation or first language was not applicable as both these variables were constructed to examine migration which is not applicable to this group. Furthermore, all English participants' first language was English.

Table 4.7: Factors associated with CAMI constructs within the white-English cultural group

Socio-demographic variable		n (%)	CAMI							
			Authoritarianism		Benevolence		Social Restrictiveness		CMHI	
			MR	Median	MR	Median	MR	Median	MR	Median
Gender	Male	41 (55)	42	2.4	36	3.9	40	2.5	39	3.5
	Female	34 (45)	33	2.15	41	3.95	36	2.3	37	3.35
	U		540.5		604		614.5		670.5	
Generation+	1st	n/a	n/a		n/a		n/a		n/a	
	2nd & 3rd									
	U									
First language	English	n/a	n/a		n/a		n/a		n/a	
	Other									
	U									
Marital status	Single	39 (52)	40	2.4	37	3.9	36	2.3	39	3.5
	Married/Cohab	30 (40)	34	2.15	42	3.95	38	2.35	37	3.3
	Other	6 (8)	45	2.45	29	3.9	48	2.5	38	3.6
	H		1.9		2.2		1.6		0.1	

	n	CAMI			
		Authoritarianism	Benevolence	Social Restrictiveness	CMHI
		rho	rho	rho	rho
Age	75	-.100	.089	.045	-.034
% of lifetime spent in UK+	n/a	n/a	n/a	n/a	n/a
Highest educational level (1-6)++	75	-.382**	.278**	-.374**	.358**
Social class (1-6)+++	75	.211	-.125	.188	.109
Religiousness level (1-3)++++	75	.145	-.132	.299**	-.306**
MH knowledge score (0-13)	75	-.534**	.472**	-.561**	.378**
MH experience score (0-9)	75	-.405**	.415**	-.444**	.342**

+ = excludes White-English participants; ++ = 1 = Primary/equivalent, 2 = Secondary/equivalent, 3 = A Level/equivalent, 4 = College/equivalent, 5 = Degree/equivalent, 6 = Postgraduate/equivalent; +++ = 1 = Class group A, 2 = B, 3 = C1, 4 = C2, 5 = D, 6 = E; ++++ = 1 = Atheist/agnostic; 2 = Not very religious; 3 = Extremely/quite religious
* P = < 0.05; ** P = < 0.01; H = Kruskal-Wallis H Test; U = Mann Whitney U test; rho = Spearman's bivariate correlation test; CAMI= 'Community Attitudes to Mental Illness'

As seen in table 4.8, the regression analyses for this cultural group revealed that possessing greater knowledge of mental health is the strongest and most consistent predictor of lower CAMI stigma scores. It alone was able to predict authoritarianism (Wald = 5.081, $p < 0.05$), social restrictiveness (Wald = 4.311, $p < 0.05$) and, in particular, benevolence levels (Wald = 6.961, $p < = .001$) for which participants were 1.316 times more likely to be within the higher benevolence group (high/low median divide = 3.9). No factor was deemed sufficiently powerful and reliable enough to independently predict CMHI scores; this is reflected further by CMHI scoring the highest unexplained variable between each factor (2LL = 91.205). Overall model strength ranged from .204 (for the social restrictiveness construct) to a higher .353 (authoritarianism). Further, all regression models fit the data to an acceptable level as no significant Hosmer and Lemeshow statistics were revealed.

Table 4.8: Logistic regression statistics of significant independent predictors associated with CAMI constructs within the white-English cultural group

Predictors	CAMI Authoritarianism									
	Variable statistics						Overall model statistics			
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
Religiousness level							80.604	.353	6.314	.504
MH knowledge	-.244	.108	.783	.634 - .969	5.081	.024				
MH experience										

Predictors	CAMI Benevolence									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
Religiousness level							81.938	.325	8.082	.325
MH knowledge	-.274	.104	1.316	1.073 – 1.613	6.961	.008				
MH experience										

Predictors	CAMI Social Restrictiveness									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
Religiousness level							87.839	.204	1.034	.994
MH knowledge	-.212	.102	.809	.662 – .988	4.311	.038				
MH experience										

Predictors	CAMI Community Mental Health Ideology									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
Religiousness level							91.205	.209	4.576	.712
MH knowledge										
MH experience										

B = Regression coefficient, Exp(B) = Odds change per unit, S.E = Standard error, CI = Confidence intervals for Exp(B), Wald = Wald statistic, -2LL = -2 Log Likelihood, N R² = Nagelkerke R Square statistic, HL X² = Hosmer-Lemshow Goodness of Fit Chi Square statistic, HL Sig. = Hosmer-Lemshow Goodness of Fit significance statistic

4.1.2.2 Main stigmatisation explanatory factors within American culture (excluding individualism-collectivism)

Similarly to the English cultural group, the variables 'generation' and 'first language' were excluded because all but one Americans were categorised as 'first generation' and all but one stated that their first language was English. Therefore any tests of difference were not statistically possible or appropriate. No significant associations were found between the CAMI constructs and social class, gender and age, although for the latter, a moderate numerical relationship between being younger and having higher regard for CMHI existed (table 4.9).

Being single was found to significantly associate with higher CMHI scores. This is likely connected to the fact that being single in this group significantly associated with being a younger age ($\chi^2 = 29$, $p < 0.01$). As a strong relationship between marital status and CMHI was found ($H = 11.4$, $p < 0.01$), marital status was included in the regression analysis. 'Mental health knowledge score' was also included as this correlated with lower stigma scores on all four CAMI constructs, while 'mental health experience score' was also incorporated as this correlated with lower stigma scores on three of CAMI constructs (the exception being the CMHI construct). Further, as significant correlations between more lifetime spent in the UK and higher authoritarianism, social restrictiveness, and lower regard for CMHI were revealed, the variable 'percentage of lifetime spent in UK' was also selected for inclusion. A closer inspection of this finding shows that Americans who have lived an average group median of 4% of their life or more in the UK were still much less stigmatising than

Table 4.9: Factors associated with CAMI constructs within the American cultural group

Socio-demographic variable		n (%)	CAMI							
			Authoritarianism		Benevolence		Social Restrictiveness		CMHI	
			MR	Median	MR	Median	MR	Median	MR	Median
Gender	Male	35 (45)	44	1.8	37	4.3	43	1.8	38	3.8
	Female	43 (55)	36	1.6	42	4.4	37	1.8	41	3.8
	U		583.5		652.5		624.5		706.5	
Generation+	1st	n/a	n/a		n/a		n/a		n/a	
	2nd & 3rd									
	U									
First language	English	n/a	n/a		n/a		n/a		n/a	
	Other									
	U									
Marital status	Single	47 (60)	38	1.7	38	4.4	38	1.7	47	4
	Married/Cohab	27 (35)	41	1.8	43	4.4	42	1.8	29	3.5
	Other	4 (5)	43	1.8	31	4.4	43	1.95	26	3.45
	H		0.4		1.3		0.8		11.4**	

	n	CAMI			
		Authoritarianism	Benevolence	Social Restrictiveness	Community Mental Health Ideology
		rho	rho	rho	rho
Age	78	.099	-.116	.181	-.203
% of lifetime spent in UK+	78	.321**	-.106	.290**	-.226*
Highest educational level (1-6)++	78	-.269*	.212	-.211	.111
Social class (1-6)+++	78	-.016	-.107	.089	.071
Religiousness level (1-3)++++	78	.056	-.076	.144	-.205
MH knowledge score (0-13)	78	-.398**	.305**	-270*	.325**
MH experience score (0-9)	78	-.218*	.248*	-.245*	.204

+ = excludes White-English participants; ++ = 1 = Primary/equivalent, 2 = Secondary/equivalent, 3 = A Level/equivalent, 4 = College/equivalent, 5 = Degree/equivalent, 6 = Postgraduate/equivalent; +++ = 1 = Class group A, 2 = B, 3 = C1, 4 = C2, 5 = D, 6 = E; ++++ = 1 = Atheist/agnostic; 2 = Not very religious; 3 = Extremely/quite religious, * P = < 0.05; ** P = < 0.01; H = Kruskal-Wallis H Test; U = Mann Whitney U test; rho = Spearman's bivariate correlation test; CAMI= 'Community Attitudes to Mental Illness'

any of the other cultural groups (table 4.10). Finally, having a stronger educational

background significantly correlated with higher knowledge scores (rho = .398, p <

.001), lower authoritarianism (rho = -.269, p < 0.05), and numerically correlated with

more benevolence and lower social restrictiveness levels. Thus, the 'education level'

variable was also selected for logistic regression inclusion.

Table 4.10: Higher and lower UK-living lifetime percentage in American group vs other cultural groups vs. CAMI median scores

Cultural Group		n	%	CAMI constructs (1-5)			
				Authoritarianism	Benevolence	Social Restrictiveness	CMHI
Americans	Lower: 0-3% of life lived in UK	29	37.2	1.5	4.5	1.6	3.9
	Higher: 4-100% of life lived in UK	49	62.8	1.9	4.3	1.8	3.7
White-English		75	100	2.3	3.9	2.3	3.5
Greek/Greek Cypriot		77	100	2.6	3.8	2.5	3.3
Chinese		75	100	3	3.6	2.7	3.2

As can be seen in table 4.11, regression analyses for this group revealed no

independent predictors for the benevolence and CMHI constructs. A higher

percentage of lifetime spent in the UK predicted higher social restrictiveness scores

(Wald = 4.794, p < 0.05), although the odds of being in the higher social

restrictiveness category (high/low median divide = 1.8) were only 1.109 greater for

such people. Higher UK lifetime also independently predicted higher authoritarianism

(Wald = 6.901, p < 0.01), as did a weaker educational background (Wald = 4.269, p <

0.05) and lower mental health knowledge; the latter being a stronger predictor of this

CAMI construct (Wald = 9.267, p < 0.01). Model strengths ranged from a low .121

(benevolence) to a higher .500 (authoritarianism). All models fit the data to an

acceptable level as revealed by no significant Hosmer and Lemeshow statistics.

Table 4.11: Logistic regression statistics of significant independent predictors associated with CAMI constructs within the American cultural group

Predictors	CAMI Authoritarianism									
	Variable statistics						Overall model statistics			
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level	-.863	.418	.422	.186 - .957	4.269	.039				
% life spent in UK	.116	.044	1.123	1.030 – 1.225	6.901	.009				
Marital status							71.446	.500	7.576	.476
MH knowledge	-.575	.189	.563	.389 -.815	9.267	.002				
MH experience										

Predictors	CAMI Benevolence									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
% life spent in UK										
Marital status							100.638	.121	6.823	.556
MH knowledge										
MH experience										

Predictors	CAMI Social Restrictiveness									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
% life spent in UK	.097	.044	1.102	1.010 – 1.203	4.794	.029				
Marital status							86.440	.309	10.576	.227
MH knowledge										
MH experience										

Predictors	CAMI Community Mental Health Ideology									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
% life spent in UK										
Marital status							85.329	.337	5.798	.670
MH knowledge										
MH experience										

B = Regression coefficient, Exp(B) = Odds change per unit, S.E = Standard error, CI = Confidence intervals for Exp(B), Wald = Wald statistic, -2LL = -2 Log Likelihood, N R² = Nagelkerke R Square statistic, HL X² = Hosmer-Lemshow Goodness of Fit Chi Square statistic, HL Sig. = Hosmer-Lemshow Goodness of Fit significance statistic

4.1.2.3 Main stigmatisation explanatory factors within the Greek/Greek Cypriot culture (excluding individualism-collectivism)

An examination of table 4.12 reveals the findings from the tests of association between background variables and the CAMI constructs within the Greek/Greek Cypriot cultural group. As can be seen, a number of significant relationships were found between the CAMI measures and collected background factors, although no one factor associated with more than two CAMI constructs. Being younger, single, of second and third generation, better educated, holding more mental health knowledge, having English as one's first language, and being from a higher social class are all factors which were found to significantly associate with lower authoritarianism and social restrictiveness scores. Higher knowledge scores were found to strongly correlate with being in a higher social class (rho = -.442, p < 0.001) and holding higher qualifications (rho = .423, p < 0.001). Having more previous experience with mental health problems significantly correlated with being less authoritarian (rho = .407, p < 0.001) and more benevolent (rho = .259, p < 0.05) towards people with mental illness. Females were also found to be significantly more benevolent towards mental illness than males (U = 523, p < 0.05). Therefore, gender, and the other aforementioned significantly associated variables, were selected for logistic regression inclusion.

Table 4.12: Factors associated with CAMI constructs within the Greek/Greek Cypriot cultural group

Socio-demographic variable		n (%)	CAMI							
			Authoritarianism		Benevolence		Social Restrictiveness		CMHI	
			MR	Median	MR	Median	MR	Median	MR	Median
Gender	Male	35 (45)	39	2.6	33	3.7	42	2.6	36	3.2
	Female	42 (55)	39	2.7	44	3.85	36	2.5	41	3.3
	U		730		523*		628		632.5	
Generation+	1st	42 (55)	45	2.9	43	3.8	44	2.7	41	3.25
	2nd & 3rd	35 (45)	32	2.5	35	3.8	33	2.4	37	3.3
	U		494*		585		520*		663	
First language	English	35 (45)	30	2.5	39	3.8	31	2.4	40	3.3
	Other	42 (55)	47	2.9	39	3.8	45	2.7	39	3.2
	U		411**		726		467.5**		717	
Marital status	Single	34 (44)	32	2.5	37	3.75	33	2.4	39	3.3
	Married/Cohab	34 (44)	41	2.7	42	3.85	42	2.6	40	3.3
	Other	9 (12)	57	3.1	34	3.7	52	2.8	34	3.0
	H		9.3**		1.2		6.3*		0.6	

	n	CAMI			
		Authoritarianism	Benevolence	Social Restrictiveness	CMHI
		rho	rho	rho	rho
Age	77	.358**	.058	.310**	-.011
% of lifetime spent in UK +	77	-.159	-.160	-.155	-.149
Highest educational level (1-6)++	77	-.587**	.201	-.428**	.216
Social class (1-6)+++	77	.526**	-.191	.399**	-.204
Religiousness level (1-3)++++	77	.198	-.179	.017	.118
MH knowledge score (0-13)	77	-.536**	.143	-.273	.142
MH experience score (0-9)	77	-.407**	.259*	-.182	.058

+ = excludes White-English participants; ++ = 1 = Primary/equivalent, 2 = Secondary/equivalent, 3 = A Level/equivalent, 4 = College/equivalent, 5 = Degree/equivalent, 6 = Postgraduate/equivalent; +++ = 1 = Class group A, 2 = B, 3 = C1, 4 = C2, 5 = D, 6 = E; ++++ = 1 = Atheist/agnostic; 2 = Not very religious; 3 = Extremely/quite religious
* P = < 0.05; ** P = < 0.01; H = Kruskal-Wallis H Test; U = Mann Whitney U test; rho = Spearman's bivariate correlation test; CAMI= 'Community Attitudes to Mental Illness'

Despite many significantly associated variables, the regression analyses in this cultural group could only find two significant predictors. One of these was 'mental health experience' which, scoring higher in, significantly predicted lower levels of authoritarianism. This was a strong predictor as demonstrated high significance was revealed (Wald = 10.037, p < 0.01), a strong regression co-efficient curve with low standard error (B = -.848, S.E. = .268), and a moderate odds ratio factor of .428 with reasonable confidence intervals (.253 - .724). The other predictive relationship was found between gender and benevolence, in which being female increased the participants' odds of being in the 'high' benevolence group (high/low median divide = 3.8) by a factor of just under 0.29. This statistic, however, together with its poor confidence intervals (.084 - .985), and modest regression coefficient (B = -1.245, S.E. = .627), point to this being a weak predictor. This is corroborated by its predictive power only just entering significant levels (Wald = 3.938, p < 0.05). Overall model power ranged from a low .094 (CMHI) to a high .724 (authoritarianism). All four models were also determined to fit the data to an acceptable level as revealed by no significant Hosmer and Lemeshow statistics.

4.1.2.4 Main stigmatisation explanatory factors within the Chinese culture (excluding individualism-collectivism)

As can be viewed in table 4.13, the most consistent and significant explanatory factors revealed in the Chinese cultural group analysis were 'mental health knowledge score', 'mental health experience score', and 'highest educational level'. This is because a higher score in these variables strongly correlated with significantly lower stigma levels on each of the CAMI constructs. With regard to the former two variables, the

Table 4.13: Factors associated with CAMI constructs within the Chinese cultural group

Socio-demographic variable		n (%)	CAMI							
			Authoritarianism		Benevolence		Social Restrictiveness		CMHI	
			MR	Median	MR	Median	MR	Median	MR	Median
Gender	Male	33 (44)	38	2.9	36	3.6	39	2.8	36	3.0
	Female	42 (56)	38	3	40	3.55	37	2.6	39	3.4
	U		683		619.5		639		640.5	
Generation+	1st	57 (76)	44	3.1	33	3.4	41	2.7	36	3.1
	2nd & 3rd	18 (24)	18	2.3	54	4.1	27	2.35	45	3.5
	U		156.5**		225**		313*		391.5	
First language	English	17 (23)	21	2.4	51	3.8	30	2.4	43	3.5
	Other	58 (77)	43	3.05	34	3.4	40	2.7	37	3.1
	U		207**		269.5**		353		414.5	
Marital status	Single	41 (55)	36	2.9	39	3.6	37	2.7	39	3.2
	Married/Cohab	31 (41)	38	3	40	3.6	36	2.6	39	3.2
	Other	3 (4)	59	3.7	9	2.9	65	3.8	15	2.3
	H		3.1		5.5		4.7		3.4	

Socio-demographic variable	n	CAMI			
		Authoritarianism	Benevolence	Social Restrictiveness	CMHI
		rho	rho	rho	rho
Age	75	.164	-.171	.222	-.285
% of lifetime spent in UK+	75	-.319**	.252**	-.137	.084
Highest educational level (1-6)++	75	-.323**	.405**	-421**	.310**
Social class (1-6)+++	75	.173	-.168	.224	-.203
Religiousness level (1-3)++++	75	-.029	.077	.049	-.084
MH knowledge score (0-13)	75	-.512**	.597**	.409**	.295*
MH experience score (0-9)	75	-.391**	.527**	-.404**	.357**

+ = excludes White-English participants; ++ = 1 = Primary/equivalent, 2 = Secondary/equivalent, 3 = A Level/equivalent, 4 = College/equivalent, 5 = Degree/equivalent, 6 = Postgraduate/equivalent; +++ = 1 = Class group A, 2 = B, 3 = C1, 4 = C2, 5 = D, 6 = E; ++++ = 1 = Atheist/agnostic; 2 = Not very religious; 3 = Extremely/quite religious
* P = < 0.05; ** P = < 0.01; H = Kruskal-Wallis H Test; U = Mann Whitney U test; rho = Spearman's bivariate correlation test; CAMI= 'Community Attitudes to Mental Illness'

Chinese cultural group was found to score the lowest mental health knowledge and experience scores compared to the other cultural group (see tables 4.14 and 4.15) (these factors are also highly inter-correlated in each cultural group – see table 4.16).

Table 4.14: Mental health knowledge scores vs. cultural group

Cultural Group	Knowledge Score (0-13)		Knowledge category (low = 0-7; high = 8-13)				Reported any mental health knowledge?	
	Mean	Median	Low		High		Yes	No
			n	%	N	%	n (%)	n (%)
White-English (n=75)	7.51	8	31	41.3	44	58.7	73 (97.3)	2 (2.7)
American (n=78)	9.94	10	13	16.7	65	83.3	78 (100)	0 (0)
Greek/Greek Cypriot (n=77)	6.19	5	49	63.6	28	36.4	76 (98.7)	1 (1.3)
Chinese (n=75)	5.19	4	58	77.3	17	22.7	75 (100)	0 (0)

Table 4.15: Mental health experience scores vs. cultural group

Cultural Group	Experience Score (0-7)		Experience category (low = 0-1; high = 2-7)				Reported any mental health experience?	
	Mean	Median	Low		High		Yes	No
			n	%	n	%	n (%)	n (%)
White-English (n=75)	2.75	3	27	36	48	64	54 (72)	21 (28)
American (n=78)	3.05	3.5	28	35.9	58	64.1	56 (71.8)	22 (28.2)
Greek/Greek Cypriot (n=77)	2.60	3	30	39	47	61	51 (66.2)	26 (33.8)
Chinese (n=75)	1	0	57	76	18	24	22 (29.3)	53 (70.7)

Table 4.16: Mental health experience and knowledge bivariate correlation test vs. cultural group

Cultural Group		Knowledge Score (0-13)
White-English (n=75)	Experience Score (0-7)	.600**
American (n=78)	Experience Score (0-7)	.492**
Greek/Greek Cypriot (n=77)	Experience Score (0-7)	.434**
Chinese (n=75)	Experience Score (0-7)	.392**

* P = < 0.05; ** P = < 0.01

Being a first generation Chinese participant and having Chinese as a first language associated with higher authoritarianism, lower benevolence, and higher social restrictiveness (although the language and social restrictiveness relationship was only numerically associated). Younger participants were numerically less socially restrictive of mental illness and also significantly more likely to be in favour of CMHI. Participants who had spent a higher percentage of their life living in the UK were found to correlate with significantly lower levels of authoritarianism and higher levels of benevolence (rho = -.319, p < 0.01; rho = .252, p <0.01 respectively). Despite some small-to-moderate numerical differences between the CAMI inventory and the social class, religiousness, gender and marital status variables, these were not deemed explanatorily powerful enough to be included in the stepwise binary logistic regression analyses.

The results of the regression analyses can be viewed in table 4.17. They show that a higher educational level in this group was able to significantly and independently predict lower authoritarianism (Wald = 6.151, p < 0.05) and social restrictiveness

Table 4.17: Logistic regression statistics of significant independent predictors associated with CAMI measures within the Chinese cultural group

	CAMI Authoritarianism									
Predictors	**Variable statistics**						**Overall model statistics**			
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language							73.585	.444	5.752	.569
% life spent in UK										
Educational level	-.735	.296	.480	.268 - .857	6.151	.013				
MH knowledge										
MH experience										

	CAMI Benevolence									
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language							51.264	.673	4.852	.678
% life spent in UK										
Educational level	1.489	.476	4.432	1.745 – 11.256	9.800	.002				
MH knowledge										
MH experience	.758	.281	2.133	1.229 – 3.702	7.258	.007				

	CAMI Social Restrictiveness									
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language							74.959	.428	8.161	.319
% life spent in UK										
Educational level	-.608	.261	.544	.327 - .907	5.440	.020				
MH knowledge										
MH experience										

	CAMI Community Mental Health Ideology									
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language							78.444	.383	10.410	.166
% life spent in UK										
Educational level										
MH knowledge										
MH experience										

B = Regression coefficient, Exp(B) = Odds change per unit, S.E = Standard error, CI = Confidence intervals for Exp(B), Wald = Wald statistic, -2LL = -2 Log Likelihood, N R² = Nagelkerke R Square statistic, HL X² = Hosmer-Lemshow Goodness of Fit Chi Square statistic, HL Sig. = Hosmer-Lemshow Goodness of Fit significance statistic

(Wald = 5.440, p < = 0.05), and higher benevolence (Wald = 9.800, p < 0.01). More

mental health experience also independently predicted higher benevolence (Wald =

7.258, p < 0.01). No factors were independently powerful enough to predict CMHI.

The factors included in the regression test of the latter CAMI construct produced the

lowest collective model strength (.383). Model strength was highest for the

benevolence construct (.673), of which also produced the least unaccounted variance

(-2LL = 51.264). All models also passed the Hosmer and Lemeshow goodness-to-fit

statistic.

4.1.3 Individualism-collectivism scores: association with cultural groups and CAMI constructs

'Total collectivism' and 'total individualism' scales were created and tested for alpha-

coefficient reliability for which both scales scored highly (α = .913 and .850

respectively). An overall individualism-collectivism score was then constructed for

each participant. This was calculated by subtracting the 'total collectivism' score for

each participant from their 'total individualism' score. This created a negative-

positive measure where 0 = evenly individualistic and collectivistic, >0 =

individualistic, and <0 = collectivistic. The maximum collectivistic score recorded

was -75, whereas the highest individualistic score was 104.

As can be seen in table 4.18 and figure 4.6, the Americans were the most

individualistic (median = 28), followed by the English (19), Chinese (-8) and

Greek/Greek Cypriots who conversely scored the highest in collectivism (-10). These

were significant differences (H = 94.238, p < 0.01). A visual inspection of figure 4.6

Table 4.18: Individualism-collectivism scores vs. cultural group

Cultural Group	Individualism-collectivism measure (<0 = collectivistic; 0 = balanced; >0 = individualistic)	
	Median	**Range**
American (n=78)	28	-19 to 104
White-English (n=75)	19	-40 to 87
Greek/Greek Cypriot (n=77)	-10	-75 to 67
Chinese (n=75)	-8	-58 to 35
H	**94.238***	

* P = < 0.01; H = Kruskal-Wallis H Test;

Figure 4.6: Bar chart of median individualism-collectivism scores vs. cultural group
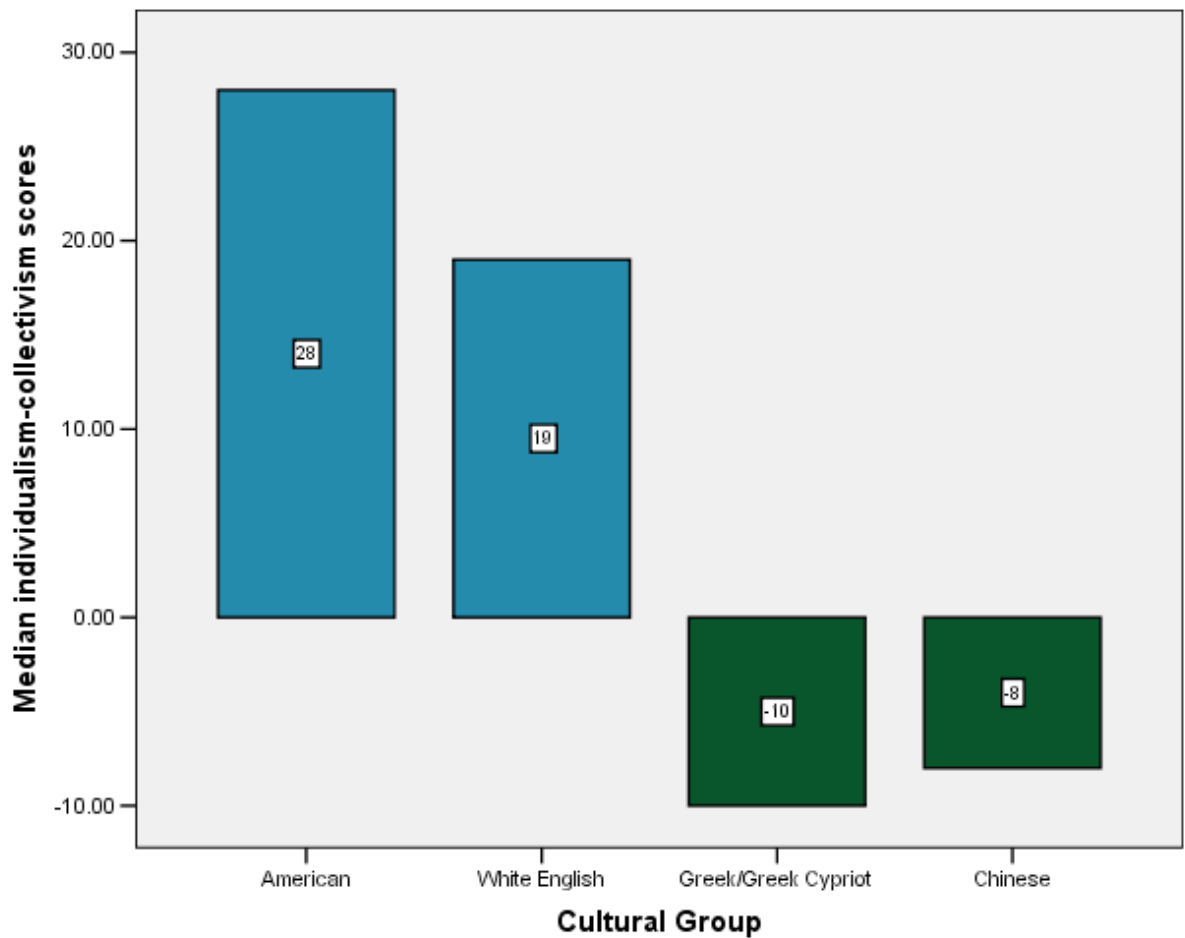
also reveals that individualism scores were generally higher across the whole sample. This suggests that individualistic values were generally more prevalent across the entire sample than collectivistic values.

Horizontal and vertical individualism-collectivism measures were constructed and also scored high on alpha co-efficiency reliability (table 4.19). A horizontal individualism-collectivism HIC measure was then constructed by subtracting each participant's 'horizontal collectivism' score from their 'horizontal individualism' score. A vertical individualism-collectivism (VIC) measure was constructed in the same manner. HIC scores ranged from -40 (highly HC) to 64 (highly HI) across the complete sample, whereas VIC scores ranged from -52 (highly VC) to 58 (highly VI).

Table 4.19: VHIC Cronbach's Alpha-coefficient reliability analysis results

Dimension	Measure	
	Median	Alpha score
Vertical	Individualism	.802
	Collectivism	.845
Horizontal	Individualism	.814
	Collectivism	.890

VHIC scores provided a more detailed picture of the level and type of individualism-collectivism within each group. As can be seen in table 4.20 and figure 4.7, the American group were found to be more vertically-orientated in their individualism, whereas the English group was more horizontally individualistic. The

Table 4.20: Cultural group VHIC scores

	Vertical individualism-collectivism		Horizontal individualism-collectivism	
	Median	**Range**	**Median**	**Range**
American (n=78)	16.5	-18 to 58	9	-12 to 46
White-English (n=75)	6	-31 to 49	13	-27 to 64
Greek/Greek Cypriot (n=77)	-6	-52 to 35	-5	-30 to 32
Chinese (n=75)	-6	-38 to 22	-2	-40 to 20
H	**82.719***		**89.812***	

* P = < 0.01; H = Kruskal-Wallis H Test

Figure 4.7: Cultural group VHIC median scores
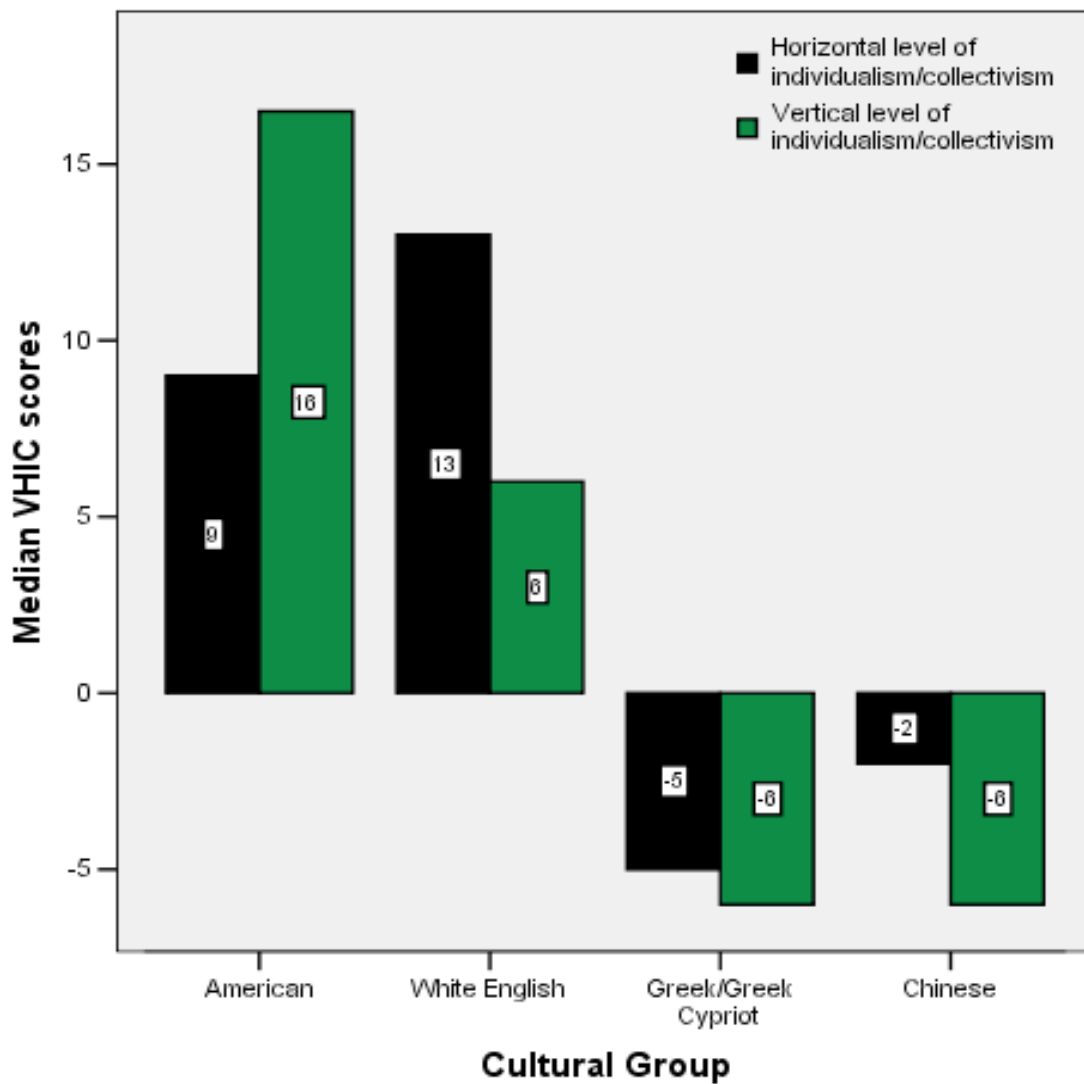
Greek/Greek Cypriot group scored very similarly in both vertical and horizontal measures of collectivism, whereas the Chinese group were more vertically-orientated in their collectivism. The VIC and HIC scores across the cultural group were both significantly different (H = 82.719, p < 0.01; H = 89.812, p < 0.01 respectively).

Spearman's rho bivariate correlations between the CAMI constructs and the individualism-collectivism measure were also calculated within each cultural group to determine whether any associations between these variables exist. The complete set of these test results can be seen in table 4.21. The strongest impact of the individualism-collectivism measure in explaining the CAMI attitudes was found within the American sample, for which three significant correlations were revealed (authoritarianism [rho = -.315, p < 0.01], social restrictiveness [rho = -.349, p < 0.01], and CMHI [rho = .227, p < 0.05]). The only other significant correlation was found within the Chinese group (CMHI; rho = .306, p < 0.01). Far weaker, non-significant correlation scores were found within the English and, particularly, the Greek/Greek Cypriot groups.

Table 4.21: Spearman's rho correlation tests between I/C and the CAMI inventory within cultural groups

Cultural group		CAMI constructs			
		Authoritarianism	Benevolence	Social Restrictiveness	CMHI
American (n=78)	Individualism/ collectivism score	-.315**	.160	-.349**	.227*
White-English (n=75)	Individualism/ collectivism score	-.172	.139	-.143	.042
Greek/Greek Cypriot (n=77)	Individualism/ collectivism score	.131	-.016	-.009	.028
Chinese (n=75)	Individualism/ collectivism score	-.116	.211	-.220	.306**

* P = < 0.05; ** P = < 0.01;

4.1.4 Individualism-collectivism logistic regression test results

Stepwise binary logistic regression tests were re-run for the American and Chinese cultural groups to include the 'individualism-collectivism' measure. Only these groups were re-tested as the individualism-collectivism variable was not found to adequately explain CAMI attitudes in the English and Greek/Greek Cypriot groups. As can be seen in table 4.22, the results revealed that for the American group, adding the individualism-collectivism variable had an impact on all CAMI constructs as it slightly increased overall model strength and decreased unaccounted model variance on each construct.

Table 4.22: Differences in unaccounted-for variance (-2LL) and overall model predictive power (NR²) between regression tests that included and excluded individualism-collectivism (I/C) as an explanatory factor in the American and Chinese cultural groups

Cultural group	CAMI construct	-2LL		N R²	
		Excluding I/C	Including I/C	Excluding I/C	Including I/C
American (n=78)	Authoritarianism	71.446	63.671	.500	.579
	Benevolence	100.638	94.484	.121	.213
	Social restrictiveness	86.440	78.053	.309	.414
	CMHI	85.329	83.291	.337	.363
Chinese (n=75)	Authoritarianism	73.585	73.069	.444	.450
	Benevolence	51.264	51.177	.673	.674
	Social restrictiveness	74.959	73.606	.428	.444
	CMHI	78.444	71.385	.383	.440

It was a particularly influential explanatory variable within the authoritarianism, benevolence, and social restrictiveness constructs as significant independent predictive power for each were revealed (Wald = 6537, p < = 0.05, Wald = 4.200, p < 0.05, and Wald = 7.122, p < 0.01 respectively; see table 4.23). For authoritarianism, its explanatory power was very close to the other previously revealed predictors (educational level, lifetime spent in UK, and mental health knowledge). Overall model power for this CAMI construct was raised from 50% to just under 58% (N R^2 = .579). This was higher than any of the four CAMI constructs. Further, individualism-collectivism was the only significant predictor of benevolence, and the most powerful predictor of social restrictiveness. However, it was not a significant independent predictor of CMHI.

The updated regression tests for the Chinese cultural group (table 4.24) revealed that for three of the CAMI constructs, the individualism-collectivism measure added very little extra to terms of overall explanatory model strength for each construct (table 4.22). The exception was for the CMHI construct, for which it was found to be a significant independent predictor (Wald = 5.958, p < 0.05). Model strength for this construct also considerably increased (from N R^2 = .383 to .469), whereas unaccounted-for model variance considerably decreased (from -2LL = 78.444 to 71.385). The latter two changes were very likely responsible for also pushing 'mental health knowledge' into significant predictive power, although this variable remained less significant than the individualism-collectivism measure (Wald = 4.051, p < 0.05).

Table 4.23: Logistic regression model statistics of significant independent predictors associated with CAMI measures within the American cultural group including total individualism-collectivism statistic

Predictors	CAMI Authoritarianism									
	Variable statistics						Overall model statistics			
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level	-1.431	.545	.239	.082 - .695	6.908	.009				
% life spent in UK	.115	.045	1.121	1.028 – 1.224	6.604	.010				
Marital status										
MH knowledge	-.575	.197	.563	.382 - .829	8.475	.004	63.671	.579	10.659	.222
MH experience										
Individualism/ collectivism	-.040	.016	.961	.931 – .991	6.537	.011				

Predictors	CAMI Benevolence									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
% life spent in UK										
Marital status										
MH knowledge							94.484	.213	9.093	.334
MH experience										
Individualism/ collectivism	.094	.046	1.098	1.004 – 1.201	4.200	.040				

Predictors	CAMI Social Restrictiveness									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
% life spent in UK	.097	.043	1.102	1.013 – 1.200	5.078	.024				
Marital status							78.053	.414	13.675	.095
MH knowledge										
MH experience										
Individualism/ collectivism	-.036	.014	.964	.939 – .990	7.122	.008				

Predictors	CAMI Community Mental Health Ideology									
	B	S.E.	Exp(B)	95% CI (lower - upper)	Wald	Sig	-2LL	N R²	HL X²	HL Sig.
Educational level										
% life spent in UK										
Marital status							83.291	.363	11.457	.177
MH knowledge										
MH experience										
Individualism/ collectivism										

B = Regression coefficient, Exp(B) = Odds change per unit, S.E = Standard error, CI = Confidence intervals for Exp(B), Wald = Wald statistic, -2LL = -2 Log Likelihood, N R² = Nagelkerke R Square statistic, HL X² = Hosmer-Lemshow Goodness of Fit Chi Square statistic, HL Sig. = Hosmer-Lemshow Goodness of Fit significance statistic

Table 4.24: Logistic regression model statistics of significant independent predictors associated with CAMI measures within the Chinese cultural group including total individualism-collectivism statistic

	CAMI Authoritarianism									
Predictors	**Variable statistics**						**Overall model statistics**			
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language										
% life spent in UK							73.069	.450	3.455	.840
Educational level	-.813	.320	.443	.237 - .830	6.464	.011				
MH knowledge										
MH experience										
Individualism/ collectivism										
	CAMI Benevolence									
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language										
% life spent in UK							51.177	.674	4.713	.695
Educational level	1.413	.486	4.108	1.583 – 10.657	8.436	.004				
MH knowledge										
MH experience	.774	.286	2.169	1.240 – 3.796	7.358	.007				
Individualism/ collectivism										
	CAMI Social Restrictiveness									
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language										
% life spent in UK							73.606	.444	6.539	.478
Educational level										
MH knowledge	-.264	.128	.768	.598 - .987	4.257	.039				
MH experience										
Individualism/ collectivism										
	CAMI Community Mental Health Ideology									
	B	**S.E.**	**Exp(B)**	**95% CI (lower - upper)**	**Wald**	**Sig**	**-2LL**	**N R²**	**HL X²**	**HL Sig.**
Age										
Generation										
First language										
% life spent in UK							71.385	.469	6.896	.440
Educational level										
MH knowledge	.263	.131	1.301	1.007 – 1.682	4.051	.044				
MH experience										
Individualism/ collectivism	.045	.018	1.046	1.009 – 1.084	5.958	.015				

B = Regression coefficient, Exp(B) = Odds change per unit, S.E = Standard error, CI = Confidence intervals for Exp(B), Wald = Wald statistic, -2LL = -2 Log Likelihood, N R² = Nagelkerke R Square statistic, HL X² = Hosmer-Lemshow Goodness of Fit Chi Square statistic, HL Sig. = Hosmer-Lemshow Goodness of Fit significance statistic

4.2 Qualitative data results

4.2.1 Interviewees

In order to control for socio-demographic differences between each cultural group, the selection process for the interviewees was conducted in a purposeful manner. Thus basic socio-demographic detail was balanced as closely as possible between each cultural group. In total, 23 interviewees were recruited from the list of individuals who had been previously recruited for the quantitative survey and who had given their consent to be potentially involved for a subsequent in-depth recorded interview. Of these, five were white-English, seven American, five Chinese, and six Greek/Greek Cypriot. All five of the English interviewees and three of the Greek/Greek Cypriot interviewees had been born and raised in England, whereas all of the American and Chinese interviewees had immigrated to the England. Ages ranged from 23 to 61. A socio-demographic breakdown of the interviewees can be seen in table 4.25. The interviews lasted a minimum of 35 minutes and a maximum of one and a half hours. Eighteen of the interviews were conducted in a private area within the interviewee's home, work space or in my own home. The five other interviews were conducted in public settings, including a public park, cafes, and pubs.

4.2.2 Main themes

This section is presented under the headings of the four main themes generated in the data analysis. These were 'individualism', 'collectivism', 'stigma', and 'immigration'.

The interview questions used which in-part subsequently resulted in these themes were as follows:

- **"**tell me about your culture – how would you describe and define it?";
- "how has living away from your native country affected you?" (not applicable for the white-English cultural group interviewees);
- "how is mental illness generally viewed in your culture?" and;
- "why do you think mental illness is viewed in this way in your culture?"

These questions were asked in the above order for every interviewee. They were also presented in a consistent verbal manner. The complete interview schedule that includes the probes chosen for potential use within each interview can be found in appendix 4.

Table 4.25: Socio-demographic breakdown of interviewees

Socio-demographic variable		Cultural Group				
		Total	American	White-English	Greek/Greek Cypriot	Chinese
n		23	7	5	6	5
Gender	Male	12	3	3	3	3
	Female	11	4	2	3	2
Age	Range	22-61	26 - 45	23 - 53	28 - 61	22 - 45
Educational Level	Higher*	13	5	3	2	3
	Lower*	10	2	2	4	2
Social Class	A/B	4	2	1	1	0
	C1/C2	16	4	4	4	4
	D/E	3	1	0	1	1

* = Higher (a grouping of 'university degree' and 'post-graduate degree' responses); Lower (a grouping of 'primary school', 'secondary school', 'A level', and 'college level' responses').

4.2.2.1 Individualism

All interviewees were initially asked to define and describe their culture. This was a direct attempt to explore the interviewees' view of their culture and to understand what they believe are the fundamental values that make up their culture. For the American and English interviewees, the description of these values were found to either directly or indirectly relate to aspects of individualism on numerous occasions and, thus, the theme of 'individualism' for these cultural groups was constructed. The completed analysis yielded an interesting account of what interviewees believed to be the main antecedents, attributes and consequences of individualism. A visual breakdown of these sub-themes can be viewed in table 4.26.

Table 4.26: Antecedents, attributes and consequences of American and English individualism

Causes and/or antecedents	Key attributes	Potential consequences
- Political ideology - Capitalism - Historical factors (US) - Urbanism - Modernity & embracing change - Cultural complexity	- Independence/freedom - Tolerance for uniqueness - Personal goals have primacy over in-group goals - Self-actualisation - Self-achievement 'American dream' (US)	- Lack of community sense (US) - Social isolation and loneliness - Low surveillance - Drug use/misuse (US) - Obesity (Eng) - Self-failure and/or low self esteem (US) - Disadvantaged people suffer (US)

4.2.2.1.1 Key attributes of individualism

The analysis of the American and white-English cultural groups' interviews revealed that two of the most fundamental aspects of individualism are the attainment of personal independence and freedom. An example of this comes from 'CR'; a 28 year old, well-travelled, white American female interviewee, who has been residing and working in England for six months:

In the US, it's quite okay to break away from your family and just do whatever you want, to pursue interests that are important to you, and you're not outcast from society. When I was in China, I found out that they stay with their parents until they get married and even then they pretty much stay with their parents and have their children. So many people live in the same house. Whereas in the US, we leave typically when you go to college, and you don't go back, unless you live in New York and you can't afford rent. The Chinese can't even conceive why you would want to, whereas from our perspective, we would think, 'well, why would you want to stay home?' It's part of the culture - making your own money, supporting yourself, enjoying your freedom, being independent.

This is an interesting quotation as the interviewee has compared a cultural difference (the accepted amount of time that one should remain living with their family) and concluded that level of individualism in either culture accounts for the difference; specifically, the pursuit of personal freedom and independence. These pursuits are also made clear by 'AP', a 33 year old English male, who explains that leaving the

family home for independent living at a university is often both personally desirable and encouraged by English families:

I definitely didn't want to stay at home, not that I didn't like living at home. I mean, I get on well with my folks, but I wanted to get out of there as soon as I had the chance. My folks actually encouraged me to go. They didn't want to hold me back. They probably had enough of me! They went to uni when they were younger. They moved out, and they told me that it was the best time of their life. I think it's like that for lots of English people. It was like that for most of my friends...It's just good fun being on your own in a new place and meeting people, meeting women, spreading your wings, that sort of thing, no one to really stop you doing your own thing. I think it helped me grow as a person.

Another attribute of individualism, connected with the theme of personal freedom, was found to be the comparatively high degree of tolerance and acceptance towards uniqueness, particularly in terms of appearance, values, and behaviour. This is emphasised by 'BD'; a 27 year old, English female, who had two years ago migrated from a rural countryside town to London:

In London, no one would take a second glance at you if you were dressed outrageously, whereas at home you'd get a bit more whispering. For example, there's this one guy I can think of in particular back home. He dresses up in 18th century costume, and he walks around the town, but I don't think anyone really cares too much. Sometimes people do say 'what's that all about', I guess that's human nature, but nothing too sinister. They don't get stigmatised, it's not really anything really.

They just stand out a bit more than they would in London, but that's about it. There's more awareness of things, whereas in London, I'm more in my own tunnel, it's more to do with just me, and less about what's going on around me, even when I'm just walking. I don't take in anything around me.

The above is an interesting piece of narrative as it suggests that uniqueness and individuality are accepted in both rural and urban areas of England, although to a greater extent in the latter (this difference is again highlighted in section 4.2.2.1.3). 'MW', a 45 year old, white American male, who has lived in various American states, also illustrates the tolerance for uniqueness towards individuals in the American culture:

Generally speaking, yes [that the American culture tolerates uniqueness]. *Depending on the sub-culture, it's higher or lower, but, in general, for the average white middle-class American, yes. Individuality is a predominant feature of the American culture so that it in turn expects people to be unique and express themselves differently. That's the reality of individualism. People can really behave or do anything they want because that's their choice, providing they're not committing crime or being dangerous.*

Also found to associate with the goal of attaining independence and personal freedom was the notion of 'self-actualisation', that is, an individual striving to learn about oneself, so to appreciate and utilise their freedom and independence as effectively as possible. One example of self-actualisation as a desirable notion came from the American interviewee 'KE', a 29 year old, white American female states:

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I think that one of the most important things to do in your life is to try to understand who you are, to learn about yourself, to figure out what you want from life. Nobody else is going to tell you those things. And that's good, because even when we make mistakes, it's okay because we can learn about ourselves that way. Knowing who you are, what you want, helps us to live life the way we want. That way we can be happier because we know that whatever we're doing is the right thing for us.

Another example comes from the English interviewee 'AP'. This is a particularly revealing account as the interviewee directly links good mental health with the realisation and actualisation of his self:

I'd say one of them [goals of an individual] *is to grow as a person. I'll give you an example. When I was at uni, I had a relationship with a very controlling woman and most of the time I was depressed about it, but I didn't really know why. It was only until after we broke up that I realised that it was because I'd lost my sense of who I was because I'd became this person who she moulded into what she wanted. So I wasn't me. I'd lost a sense of who I was and I got pretty depressed. So I decided to go travelling, to try to feel alive again, and to see some different countries and different ways of life...In retrospect, it was those experiences that really helped me to realise who I was and what person I actually am, because during that relationship, I'd lost that.*

Another key attribute of individualism was found to be the primacy of personal goals over goals of an in-group for which that individual belongs to, particularly if this does

not result in any obvious harm to others. For example, 'LC', a 41 year old, American female, uses the example of arranged marriages in an Asian culture as a contradictory phenomenon to personal choice having primacy:

I personally wouldn't [allow an in-group to deny you engaging in an activity that you are enjoying]*, unless there was a very, very good reason. If it was just people saying 'don't do it, it's not good for everybody else', I probably wouldn't. I don't think most Americans would...I mean, it certainly wouldn't be a general trend in America, that if your family told you to stop doing it, that you'd stop doing it! I remember when I was in university, I had an Asian friend, it was the first time I'd ever met an Asian, somebody from India or Pakistan, and they were telling me about arranged marriages and they were saying 'our parents arrange our marriages' And I was like, 'what! What are you talking about?!' I mean, I'd heard of it, but I thought it happened somewhere else, out of time, not in 20th century America! This was the University of Michigan, a cosmopolitan place, and people are talking about arranging marriages! Yeah, and certainly, you wouldn't really hear about anything like that amongst Americans, well not in my experience.*

Another example comes from 'BD', a 27 year old, English female who had two years ago migrated from a rural countryside town to London. When asked whether she stop taking part in a desirable activity of her personal choice if her family requested it, she stated:

No, I don't think I would give it up, unless it was my mum and she was desperately upset about it. But if it was something innocuous and harmless, then no...Yeah,

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probably [that this is a common English cultural value]. *It's difficult to say because everyone is an individual but probably. I think people generally would go on with their path.*

A further, American-specific, attribute of individualism was the notion of the 'American Dream'. According to Johnson (2006), despite the definition of this cultural value being under constant discussion and debate, there is a general consensus that it refers to the idea of an individual prospering socially and economically through ability and hard work, regardless of class, caste, race, or ethnicity. This attribute is emphasised by 'CR':

I've lived Italy, here, Australia, and spent some time in China, and one of the distinctive things about being an American is that anything is possible. If you are a garbage collector, you could one day become the CEO [Chief Executive Officer] *of a company, whereas I didn't feel that in many other countries. Anything can be possible. It just doesn't matter what your background is, and I've known people who have had radical life changes like that in the US,* [for example] *the impoverished single mother who's now an executive at a company. There's kind of a sense of, I don't even know what to call it, perhaps 'possibility'. It's the possibility...it's just an attitude difference. That's something I've felt is different in the US compared to all of the other countries.*

The idea of the 'American Dream' was found to connect with a broader attribute of individualism; the act of personal economic and social attainment and/or

accomplishment, or, more succinctly, 'self-achievement'. 'NS', a 33 year old, white American female, states the following in reference to the value of self-achievement:

Independence, achievement, success [are key American cultural values] *I guess to some extent that it depends on where you're from. I'm from the north. Down in the south, the religious values are huge over there...but it's generally an individualistic country, no matter where you are in the country... Everyone is trying to figure out how to be successful because they want to carry on buying things, and feeling good about themselves. The thought that they can be as good as or better than anyone else drives them. I think in general Americans are like that. We have big egos!*

The notion of self-achievement was also stated by white-English interviewees. For example, 'JW', a 53 year old, English male, states the following:

Oh yes, without question [that English people of all backgrounds aim for economic prosperity]. *All English people aim to make money, to prosper in life, to climb the societal ladder...no matter what class you are from, or whatever your personality, if you're of English heritage, you subscribe to capitalism. We live in a capitalist society and that has a profound impact upon all people in England. It makes people want have to make money, to be successful and do well in life. I think people are realistic enough to know they are never going to get rich, so they instead aim to be well-off enough to comfortably live life, at least.*

The idea of capitalism being linked to individualism is raised by other several other interviewees. This is examined in section 4.2.2.1.3.

4.2.2.1.2 Potential consequences of white-English and American individualism

The analysis revealed that one of the most recurring potential consequences of individualism was a 'lack of community sense'. This was a theme that was specifically produced among American interviewees, particularly when compared against other less individualistic cultures and nations. For example, 'NS', and 'LC' state the following:

NS: *Yeah, the sense of community is not as strong. It's very individual based. There's positive and negative things to that. I think that it's great that people are so strong within themselves and so confident, and that is such a good thing, so they can say, 'well, you know what, I'm actually not alright with this'. So that community sense doesn't factor in because you are always thinking of yourself all the time.*

LC: *I think that other cultures have a stronger sense of community than Americans. For example, the Chinese people. They have a much stronger sense community. There's not that communal thing* [in American culture]*, where you all stay together as a group.*

Partially linked with this theme were notions of 'social isolation' and 'loneliness'. Illustrations of this are made by Americans 'MW', 'TN' (a 36 year old, white American male), and English interviewee 'BD':

MW: *I consider myself an American so I'm imbued with many of those values myself. I'm a highly competitive person, I'm highly individualistic myself, but that has also made me self-alienated and very often socially lonely...A lot of Americans cut themselves off from people in pursuit of their own personal desires.*

TN: *There have been times in the past when I've needed some support, someone to talk to, and I found myself not having as many people as I should to do that with. There's a saying in America that you can usually count your only real friends with one hand, and I think that's true...We've become more and more disconnected from our friends, neighbours, and even our families. More and more people use the internet now for staying connected with people but I think in some ways you lose some real human contact if you rely on that. That's a shame, because it means that in the real world we're actually getting more and more disconnected.*

BD: *In a lot of other countries there are a lot more extended families. They are a lot closer I think, whereas here families get stressed out a lot more, so you lose that sort of closeness and it can lead to a lot of isolation I think.*

Associated with the above two sub-themes was the potential consequence of 'low surveillance', that is, the opportunity and/or desire of surveying the affairs of others. As 'KE'explains:

I don't think that people care too much about what their neighbours are doing. It's not that they don't care, it's just that they respect their privacy and get on with their own lives, I think....It's difficult to know what people are up to anyway. I mean,

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there's always the 'stop and chat' in the street, but how much do you really find out

from that. Even in the busier areas it's hard because people are always coming and

going...If someone on in my area had terminal cancer, how would I know?

'SG' agrees that this is also generally the case in English society:

I live on a terraced street so there's lots of families and people on one small road. But

even on my street, I don't know anything about my neighbours. I know a little about

my immediate neighbours, but nothing much, and the other people on my street, I

know next to nothing. That's the way it is in the English culture. People don't get

muddled up in other people's affairs, unless they've been on the news or something!

We say hello to each other, have a little chit chat sometimes, offer to help each other,

that sort of thing, which is nice, but nothing more than that really.

The analysis also highlighted the recurrent claims made by the American

interviewees that the ideas of individualism and/or social isolation were, to a degree,

connected with drug use and/or misuse. For example, 'NS' states:

There are too many drugs – [the philosophy is] *'I'm sad, I'm lonely, I need a*

prescription'. I think everybody and their mother takes medication for something:

depression, anxiety, panic attacks, you name it. I don't agree with that. If people have

problems they should get help from their families and friends but I guess they are

either getting bad advice or haven't got that kind of support available.

A further health concern partially linked to individualism by several English interviewees was that of obesity. Two references of this come from 'SG' and 'GH':

SG: *People are getting fatter and fatter because we are told that it's our life, that we should do whatever we want to do.*

GH: *Look at the children in England today. It's clear that they're not being given rules to abide to. They're just being allowed to do whatever they want because that's the way of life in this country. And now, unfortunately, they are getting fatter and louder and there's also so much anti-social behaviour because they can get away with anything...These are big problems in this country, and they are deep-rooted problems that don't have easy fixes.*

An additional consequence of American individualism was found to be the sense of self-failure and associated low self-esteem that people can potentially experience if they fail at obtaining independence, economic prosperity, personal freedom, and other attributes of individualism. This idea was stated by several interviewees including 'CR', 'JS', and 'MW':

CR: *It's kind of seen as a sense of failure if you're still in the house at age 25, and people are like, 'what's wrong, why are you still at home?' I think people who feel like they are failures get depressed, start drinking and it becomes a downwards spiral.*

JS: *If you can't make it by yourself then there's something wrong with you...If you finish school and you haven't found a job and you need to go home, then that's ok, but you don't want to stay there for too long. Otherwise you're going to feel like a failure.*

MW: *It's a core, self-sustained, Darwinian, culture in the sense that you make it on your own or you fall by the way side. Even though there are some social safety nets in place, in reality, in terms of any kind of real thriving, you are on your own and no one else is going to help you, and that's the philosophy that people understand. It's the way of life and most people regard that as a good thing. But these things have negative fallout, negative consequences, like the feeling of failure, and the problems that come with that.*

'MW' also argues that it is harder for the disadvantaged people to prosper in American society:

We are essentially social beings, and individualism ignores that reality to the detriment of people in all aspects of life, particularly people who can't make it, because of disability, or because they just for one reason or another because of any incapacity or because of race or gender, or whatever, are unable to make it, they are left upon the way side and a huge amount of human capacity is lost as a result.

This notion is echoed by the American interviewee 'TN':

I think if there's something wrong with you, like you've got a mental illness or something, then it's harder to get where you want in America. That's the way it is.

People are competitive with each other, even if they don't show it on the surface, so it's harder for people with problems to make it. That's not to say that these people can't be successful, but I think it's harder for them. Don't forget that there's a lot of people out there who won't hesitate to exploit vulnerable people if it's going further them in some way. It happens all the time.

4.2.2.1.3 Causes and antecedents of American and English individualism

The analysis of the American and white-English cultural groups' interviews also produced several sub-themes concerned with the antecedents and underlying factors behind individualism as a desirable value. Two such interrelated antecedents of American individualism were 'political ideology' and 'historical factors'. For example, American interviewees 'MW' and 'TN' refer to the cultural impact of America's earliest migrants and political principles:

MW: *It goes back to the founding of the country by people who were dissidents in the countries that they left. And so in a sense it attracted a self-selected group of very self-motivated individuals and the culture is one of 'every man for himself'. So the cultural and economic factors that I referred to before, they're self-reproducing.*

TN: *America is a country of individuals. To enjoy that individualism, to search for happiness and to enjoy our freedom, these things are at the root of our founding policies and documents.*

'KE' agrees by asserting that historical political ideology has directly influenced American modern political philosophy:

I think America advertises democracy and freedom today because that is the way it's always been for us since we gained independence from the British after the war, and, generally, I think it's served us pretty well through our history. That's why I think capitalism suits America, because being free to do what you want to do allows people to go to whatever extent and through whatever route they choose to be well-off and happy. It's not like that in communist countries.

However, when the English interviewees were asked about whether their history played a role in forming individualism as a value today, most were uncertain, mainly due to the fact that England's history is both extensive and complex. For example, 'JW', states:

It's hard to say because it is a very long and complicated history with many stages in it. But my guess is that through the ages the English have become more and more individualistic because people have aimed for financial success, especially since the industrial revolution.

The English interviewees were notably more certain with regard to capitalism as a potential antecedent to individualism. Two examples come from 'JW' and 'AP':

JW: *For quite a while now, we have followed the idea of privately owned property, capitalism, and that, for me, means that the individual is put in a position of power and opportunity and freedom.*

AP: *Yeah, I do think they're linked* [capitalism and individualism]. *I think that if individualism means that we can live life as individuals and do what we want, then capitalism suits that, because it's all about the individual competing with other individuals to make more money. I think England is just like that.*

'LC', an American interviewee, states that she believes that America embraces capitalism and individualism more than British countries:

I think [Americans] *do depend more on themselves. I mean I can only contrast it with British culture, that's the only other culture I really know except for Americans, but I think they are more self-reliant than the British. I think it's more socialist over here. If you have a child, you get a benefit. You don't get a benefit in the States! If you are unemployed in the States, my understanding is that there is a certain number of years that you can claim unemployment insurance, and if your unemployed beyond that, well that's tough luck. So, you don't really have a system in the States that's set up for you to say 'well, I can't get a job right now', or 'I'll wait for something'…You literally are really on your own. It's the same with medical insurance. They know that if they don't have money in the bank, they are not going to get medical insurance or even get seen by a doctor, and that's just one of those things that everybody knows and it's accepted. I think it's been like that for a long time, especially with Bush in the presidency, but even before Bush it was like that, definitely.*

There was also considerable agreement found when the notion of urbanism was discussed with the American and English interviewees as another potential antecedent of individualism. Although the consensus was that America and England are generally individualistic countries, several statements by the interviewees suggested that the common belief was that individualism is at a higher level in the bigger, more urbanised cities and regions of their countries. As 'JS' and 'BD', an American and English interviewee respectively, state:

JS: *I've noticed that, in any* [American] *State, you're either a city person or a country person...If you're like me and you're from a big city like New York, and you embrace that way of life, then you have different goals in life. You generally put your career first, ahead of your family, or at least on the same level, and you need to have a strong head to do that, and a lot of thirst for success. But if you're from the country, or even the suburbs of a city, you're probably going to be a little more laid back about life. You'll still want success and happiness but it's less about the money and the success and a little more about your family, your community, being more altruistic. It's a slightly different mentality.*

BD: *I lived in Shropshire, in the main town, not the countryside. It's more a community feel there, where people know each other. Whereas here in London, you don't know your neighbours, or other people living in your streets. Whereas back home you get to know them, and there's more of a community feel. I suppose people go out of their way to help people more as well... I guess it's not a big surprise because in London and other major cities, even though there are more people, they're*

more dispersed in the sense of being in their own worlds. Like now that I live in London, I feel like I am in my own tunnel and I don't notice much around me. I think most people here are like that.

Partly associated with urbanism was the idea of 'cultural complexity' as potential antecedent to individualism, that is, the greater existence of choices and lifestyles available for the people of a particular culture to choose from. Interviewees of the American and English cultural groups both stated that for their cultures, there are many opportunities and pathways available, particularly those who have lived in the more urbanised areas. Examples come from the American and English interviewees 'NS' and 'SG' respectively:

NS: *There's a lot of opportunity here in terms of whatever you want to do with your life. I remember when I was growing up, people would ask me what I'd like to do when I was older, and it would literally change from week to week. One day I wanted to be a doctor, the next a journalist. And that's great, that in America there are so many lifestyles we can choose from. I think that it makes us be who we want to be easier and I think that's great.*

SG: *So many people today are getting divorced or separated, because it's so normal and accepted. Actually, I was reading recently how the single-parents rates in England are one of the highest in Europe...Maybe it's also to do with the fact there is scope for these things to happen. I mean, it's easy to get a divorce, that's the kind of society we live in. You can get anything or do pretty much most things. I guess we're lucky in that sense, especially compared to more strict countries.*

A further sub-theme associated with urbanism (and also cultural complexity) was found to be the notion of modernism and the willingness to accept change. For example, the English interviewee 'AP' states:

I think English people are quite accepting of modern times so we're not bad at coping with things like mental illness, especially people from the big cities like London. I think that in places like that, people do what has to be done, and accept it as a thing of the times without too much hassle, especially compared with more traditional places.

'CR' an American interviewee, agrees, stating:

I think there's a real get up and 'go for it' kind of attitude in the US, especially in the more built up places where there are so many things people can do and achieve for themselves.

4.2.2.2 Collectivism

As previously stated, all interviewees' were initially asked how they would define and describe their culture in order to explore their view of their culture and understand what they regard as their culture's fundamental values. For the Chinese and Greek/Greek Cypriot interviewees, these values were frequently revealed to either directly or indirectly relate to aspects of collectivism. The analysis of this major

theme provided a narrative of antecedents, attributes and consequences of collectivism. A visual breakdown of these sub-themes can be viewed in table 4.27.

Table 4.27: Antecedents, attributes and consequences of Chinese and Greek collectivism

Causes and/or antecedents	Key attributes	Potential consequences

• Communism (Ch)
• Ruralism and traditionalism
• History
	• Group interdependence
	   o Family loyalty and respect
	   o Behaviour regulated by in-group
	   o Prioritised goals match in-group
	• Extended family
	• Group ceremonies and practices
		• High surveillance
		   o Saving face
		   o In-group, out-group social comparisons
		• Strong sense of community
		• Fear when strictly imposed through political regime (Ch)

4.2.2.2.1 Key attributes of collectivism

A key attribute of collectivism in the Chinese and Greek/Greek Cypriot cultural group groups was revealed to be 'in-group interdependence'. This value relates to several sub-themes but in general refers to the interviewee thinking that he/she primarily and firstly belongs to an in-group, such as the family, rather than an independent individual. For example, 'HL', a 45 year old Chinese male who has been living in England for the past year, states of the Chinese culture:

Another shortcoming is the emphasis on solidarity, with the people around us, like our community, our neighbourhood, our family, our company, and not on freedom. In England, in your life, you determine. It is not so much like that in China. We lack personal freedom because the emphasis is usually on the group first.

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Another example comes from 'CT', a Greek 30 year old male, who immigrated to England in the last year. He refers to the family as a particularly important in-group:

To be honest with you, I love my mother, I love my grandmother, and my grandfather when he was alive. While I lived with them, I had the economy and the chance to move out from my house, to live alone, but I know I would like to be in the family. The family is everything. Some people said 'why don't you move?' But when I'm at home, there is my mother, she asks me, 'how was your day?' 'Do you need something?' They give me my food. We chat. We look after each other. I do the same with other people. That is the Greek way. It is different here. Young people, especially, they prefer to be alone, or with maybe one or two friends, but away from their family. It is very different. Here, I sense that if you are an adult and are living with your family, it is embarrassing, shameful. It is very strange to me, to be embarrassed this way.

The above quotation introduces the family as an in-group of paramount importance in the Greek and Chinese culture, particularly in terms of interdependence. The associated sub-themes of 'family loyalty' and 'family respect', notions frequently referred to by the Chinese and Greek/Greek Cypriot interviewees, help to better understand this interdependence. An interesting example of these notions comes from 'HW', a 31 year old Chinese female, who resides in England on a part-time basis:

It's clear that [Westerners] *are more self-indulgent, being happy for who you are, and being what you think is right, and less caring about what other people think. In the Western culture, really, you take care of yourself. In the big world, it's made of little*

individuals, little selves, and those individuals take care of themselves. But for some reason, the Chinese people are not the same. For example, my dad and I have conflict because I always say that 'you need to take care of yourself'…'it shouldn't affect you what other people do'. But my dad can't do it that way. My dad's mother recently passed away, and before she passed away, my dad would be giving her half of his retirement pension, even though he is quite poor. That's the way my dad is, taking care of his elders. I thought it was ok to do that but when my grandmother died, you'd think that would end, but no, my dad pays some of his pension to my aunt now, to take care of her! But that's the way my dad is, it's his Chinese way, his cultural values, and of course my mum has issues with that, that he shouldn't be doing that, but he is a very traditional Chinese man and for him it's his way of showing loyalty and his respect to his elders who helped raise him.

The above demonstrates the Chinese cultural value of family loyalty and respect, particularly to one's elders, even when this may be of personal loss such as financial cost and disapproval from a child, as illustrated in the latter passage. These notions were echoed by each Greek/Greek Cypriot interviewee. Two examples come from 'HS', a 29 year old Greek Cypriot male, and 'HM', a 28 year old Greek Cypriot female:

HS: *I would say that it's very family-orientated, definitely. We look after our elders, and children are very important in our culture. We like to make them happy and look after them, like most cultures, but in our culture it is especially important, and it's a matter of respect that you are a good family member, that you listen to them, and learn from them...For example some cultures say that once an elderly relative needs*

looking after, they should usually go straight into a home, but I think in our

community, they prefer to look after them at home in their house, because we see that

it would be disrespectful to put them in a home. Plus, I think Greeks are better

equipped for something like that, because so often we live in extended families, so

there are people always there to help.

HM: *One of the first things that springs to mind is the fact that culture has always*

taught me a strong family ethos, you know, where family comes first, regardless of

disagreements or disapproval or anything like that. It's very important in our culture

to always strive to be together especially during things like family occasions which

are always very joyous. People get together and do things and we help one another

out. Loyalty is really important too because when I need something I feel like I expect

to get help from a family member or a close friend, because I was brought up always

to be there and help my fellow family members or friends...It's like an unwritten law,

that you have to help out family members and be there for them no matter what.

Otherwise it's really disrespectful. They really do come first. That kind of thing is

important to Greeks, to show generosity, to show that you are there for people,

especially family. You have to put them first.

The above quotations demonstrate how loyalty and respect are expected when one

places the in-group before him/herself, as is the case in such cultures that value in-

group interdependence.

Associated with showing family respect and loyalty, and another aspect of in-group

interdependence, was found to be the concept of placing primacy on the normalised

behaviour and desirable goals of the in-group over that of the individual. According to the interviewees of both cultural groups, this can sometimes cause friction and conflict between members, particularly from younger and less traditional group members, but it is generally a valued and functional feature of group interdependence. Examples of this come from the Chinese interviewees 'HW' and 'TS', a 22 year old Chinese international male student:

HW: *I think in the older generation, definitely, it's like that* [prioritising group behaviours and goals]. *I think people in today's generation, it's not a bad life - they don't have to feel that pressure so much. I know in my past culture, divorce is not something that you do. And for people who might want to but can't* [get divorced], *in their whole lifetime, like my dad, it would be just terrible. I don't know what I would do if I was in my dad's position. I don't think I could cope as well as my dad has. But for him, it's important to put aside what he might want, because he thinks so much about what other people think about him, and because of that he makes sacrifices in his life.*

TS: *To be a good person in my culture, you need to be progressing to a good university, a respected university. You must get a degree, and then a good job. But I think a good job is different for different people. For my parents, they think a good job is always something steady, with no adventure, a stable job, a good career. But for me, I didn't want a stable job. I wanted something more challenging. My view conflicts with them. I had to face that, because in the Chinese culture you are supposed to follow your family's wishes but I try to do my best.*

This notion was found to also be very important and prevalent within the Greek/Greek Cypriot culture. The following example comes from 'PC', 31 year old Greek Cypriot male who has been residing in this country for 20 years. He both describes the cultural value of prescribing to established norms, and documents the potential stigma that rejecting such norms for personal preference can create:

PC: *There are many rules that you have to follow. For example, it's seen as a sign of respect to go to the local church during Easter. If a Greek chooses to be an atheist or an agnostic, you're risking yourself getting criticised and looking badly and you're bound to negative attention about it. I'm actually an atheist and when I decided to be one I did very consciously thought through the consequences of that choice. I knew that a lot of other Greeks who I know are fairly religious might be fairly critical of me, and might judge me as being disrespectful...They think that I should be religious no matter what I believe. My family is religious, my community is religious, so I should be prescribing to that religion, and my own personal beliefs about the meaning of life and whether god exists is not as important as the community's opinion, so really I should be thinking and doing what the community and your family expects. I think a lot of the times, Greek people expect you to do what is right for them first.*

Another main key attribute of collectivism revealed in the analysis was that of belonging to an extended family. 'LZ', a 38 year old Chinese male, supports this facet of the Chinese culture, despite the introduction of a limited birth policy in 1979 to control the country's population:

LZ: *In Chinese culture, the relations with family members is very strong because the families, they are not nuclear families, they are much more often extended families than compared to Western countries like England. We live with our parents, our brothers, our sisters, our cousins, our grandparents - don't forget Chinese people live for a long time so there are many of us! Chinese families have become smaller because of the one-child law, but still there are still so many extended families, even in the small houses. It says something about our culture.*

Greek/Greek Cypriot families also consist of an extended network of members. As 'AN', a 61 year old Greek Cypriot female describes, this is a valued and traditional cultural phenomenon:

AN: *I was back in Cyprus recently and joining my cousin for a family meal and there were so many people. It was crazy! There was his wife, her sister, his mums, their three children and his seven grandchildren. And it's great because they all live so close to each other and are in each other's company all of the time. That's how it is in the Greek culture, there are so many people under one roof a lot of the time...We respect our elders. That's the way it has been in our culture for a long time, and I think that it works.*

Engaging in group ceremonies and practices was revealed to be another important collectivist cultural phenomenon. For the Chinese culture, the interviewees cited numerous examples that centred on traditional community activities:

LZ: *Doing things together is very important in the Chinese culture. It is about harmony and being part of the community. For example, if you go to city park in the morning, you will see* [people] *doing things together, like tai chi, running, exercising, playing table tennis, even dancing. I have never seen this kind of interaction in the West. So many activities are done in groups....These are our ways because we are very traditional people...We learn from a young age that we must honour society by being trustworthy, hardworking and a good member of the community. These are Confucius' teachings.*

The Greek/Greek Cypriot interviewees also frequently referred to this cultural feature, with specific frequent references to large family practices and wedding celebrations. As interviewees 'AN' and 'PC' state:

AN: *We love a good party! Celebrating is a very big part of our culture. It's like all of the Greeks are one big family and if someone is getting married then loads of people go to the ceremony or celebrate with the family. When I was growing up I remember being a little child and I'd see newlyweds walking through the streets of our village with people playing violins and the particular wedding melodies, so that everybody would hear that these two people were getting married and to let people know that they can walk with them, through the streets together. It was to announce their matrimony. They still do that today, you know, because tradition is really important to the Greek people.*

PC: *Greeks like their big barbeques, big family dinners. A lot of it revolves around food, having big, big celebrations with lots of people. Christenings, engagements,*

weddings, you name it. If there's a reason to celebrate, the Greeks will celebrate. I think it's in their nature that they are very friendly, it's in their culture to be friendly with lots of people. Things like privacy and being alone and doing your own thing isn't really a Greek thing. It's more about being together as one big family, so they can feel Greek and show their 'Greekness'.

4.2.2.2.2 Potential consequences of collectivism

Several sub-themes relating to the potential consequences of collectivism as a cultural value were also produced, includingthe existence of high levels of cultural surveillance, both in terms of opportunity and desire. One example is described by 'AN' who argues that Greeks, from rural areas in particular, enjoying surveying the affairs of others around them:

Greeks love to talk, and to spy, and to know what's going on. In a place like Cyprus, and especially in the less developed places, like the old villages, places like that, there's not much going on, you know, and knowing about the news of other people is kind of exciting to them. But even other Greeks, I feel like they want to know what their neighbours are about and what they do. At big family meals a lot of the conversation centres around not only your family has been doing and what accomplishments they've recently done, but also about the news that they've heard about other people, good and bad, the gossip.

A very similar belief was held by the interviewees in regard to the Chinese culture, as illustrated by 'AH', a 48 year old female Chinese migrant:

People in China judge other people and it always feels like people are watching others. Everyone knows their neighbours very well, at least where I come from [a suburban region of the Henan province], it is that way...When I came to live in England one of the things that I noticed was most different was how people here say hello to their neighbours but they really know nothing about them. People keep to themselves and privacy is very important. Privacy in China is important too, but your neighbours know what you are doing. They know your family and they know about you. It is very different. Here I know nothing about my neighbour.

Associated with high surveillance and collectivism was found to be the notion of 'saving face', that is, the attempt to maintain good self-image and avoid the shame of embarrassment and dishonour. The undertaking of face saving was also revealed to potentially add pressure and stress. These ideas are discussed by the Chinese interviewee 'HW':

When I was growing up in China, if something happened at home you wouldn't go around telling your neighbours or any other people, and you try and keep face like that. It's all about saving face. It's a shame when people lose face, right? I would say that losing face would be bad but saving face would be good in the Chinese culture. People care what other people think about them. They don't want other people to think bad of them. If somebody dies, I don't remember telling my friends about it, you're not supposed to, even that is kept within the family. You don't go and tell the world. It's not a good thing to do that, to advertise sad affairs, let's put it that way. Mind you if something good happened, like I got good grades, something good,

that's different. But we don't want to talk about the bad things...We're very proud

people and we can't admit mistakes or talk about the bad things that have happened.

The aim of avoiding losing face from the community and other in-groups was
reiterated within the Greek/Greek Cypriot interviewees. One example comes from
'HS':

I think in the Greek culture you've got more of 'you know, come on, no that's not very

good, what are people going to think, what are people going to say?' Keeping your

dignity, and your family's dignity, those are important things. You don't want people

talking about you behind your back because that would be embarrassing and would

probably come back up to your family. The whole thing can come with a lot of

headache, especially if bad things about you and your family do come out.

The high level of surveillance in the Chinese and Greek cultures was also found to
associate with providing a platform for social comparison, that is, a drive for
individuals and/or groups to examine outside realities in order to evaluate their own
opinions and abilities (Festinger, 1954). Interviewees from both of these cultural
groups described occurrences of upward social comparison, that is, the tendency to
compare themselves to others who are deemed socially better in some way, and also
downward social comparison, that is, the defensive tendency to compare oneself with
someone whose troubles are more serious than one's own (Suls et al, 2002). As 'HW'
and 'HL' state with regard to the Chinese culture:

HW: *If something is happening with the neighbours, they think 'hey, at least I'm not that bad! They have someone with a bad temper, or they have someone who is mentally ill…we don't have that, we're good'. That makes them feel better.*

HL: *I remember many times when I was young my parents talking about telling me that how they wish that I had become a doctor like the person across the road from us, and how proud their family is, and that we should try to live like they have. I came from a poor family in China. But the pressure they put on me made me work harder to be a success. I wanted my family to be proud of me, and now I think they are.*

Greek interviewee 'PC' describes how during family meals in Cyprus, the news from other families are discussed and serves as a comparison to his own family:

PC: *In the Greek culture, things are talked about, often when we're all having dinner together at home. Like I said before, there's a lot of networking, and people talk with each other about each other, that's the way it is, and because there are so many rules about what is appropriate behaviour, if someone from another family gets caught stealing or taking drugs, it's going to be talked about and criticised and that family will be looked down upon, not just that person. I suppose they need other families to compare themselves against, whether that's looking down upon inappropriate behaviour or something else that's bad, or whether it's applauding something good that has happened.*

Another important recurring consequence of collectivism was found to be the existence of a strong community sense. The Chinese interviewees partly associated this phenomenon with the distrust of other communities and cultures. However, the Greek/Greek Cypriot interviewees stated that this, to a degree, related to the fact that Greek people are generally warm and friendly people. 'TS' and 'CT' make reference to these notions:

TS: *People in this country, compared to China, are less community orientated, I think. Everyone is in hurry to push everyone else away to do what they want to do. In China, I don't think we are like that so much. We think about our community more – it is very important. We have more respect for our neighbour. If you go to* [London's] *China-town, you can see this. We like to be together, even in a foreign city...I think it is maybe because we don't like to be with other people from other cultures, we are more comfortable with our own. Sometimes my Chinese friends say that you can't trust other people, but you can trust our own people. Maybe that's why we have a strong feeling of community, because we trust each other.*

CT: *My Greek friend called me, he said 'I have a friend, he's Greek, and he wants to meet you!' We met in a pub or something, and for the 2 weeks he was here, this guy, all the time, all day he has something to do because always someone is calling him to arrange to go out to see the city…everything. They are Greek friends in the community. We help each other. When I arrived here, to this country, I thought maybe the English people I knew can do something similar. But nothing. London, English people are more cold. Greek people are in general more friendly, more warm in*

everything. I think in this way, it helps the Greek community to be strong, to work each other.

Another example of the strong sense of community and networks in the Greek/Greek Cypriot culture came from 'PC', who referred to an incident that he experienced in Cyprus:

When I was on holiday a couple of years ago in Cyprus, I was with a Greek friend of mine. We were driving on the high-way a bit too fast. The police pulled us over. The policeman was saying that he was going to give him a speeding ticket, but then my friend told him that he knew a police officer in the local town and that he was a close family relative. I could see from the policeman's face that he was torn, torn between doing his duty by the letter, and with being loyal to his community. After thinking about it a bit more, he said 'well, ok, I'll let you go, just slow down so you don't get pulled over again'. I found this amazing because in England, if the same thing happened to me, I'm sure that it wouldn't make a difference because I'd be treated in the same way as everyone else....Maybe in Cyprus it's more about who you know and if you do know people it means that they 'have your back' so to speak, they know you are a trustworthy person.

The above quotation interestingly illustrates that in collectivist cultures, where a strong sense of community exists, people may place loyalty and favour to those from their perceived in-group.

4.2.2.2.3 Causes and antecedents of Chinese and Greek/Greek Cypriot collectivism

The current political system of communism in China was provided by all of the Chinese interviewees as a possible explanatory factor for collectivism as a key cultural component. For example, 'HL' states that this is the most important determining reason for the lack of individuality amongst the Chinese people:

I think the lack of Chinese individuality is not determined by their traditions and their historical culture. The citizens lack of individuality is linked to the political regime, I think. Since 1949, the communist party has ruled the country and it is a totalitarianism regime. This regime is different to the Confucian way. It resembles the old Soviet regime, the Soviet communist party. But I think the communist party isn't, like many people think, evil. But the citizens have no rights to defy them in the country. I think the Confucian theory, it is not contrary to Western theory because it emphasises the human value, to respect the individual. But in China, it is not this way, the system we use today, they regard the citizens as just instruments and now we lack individuality. Even the internet is controlled in China because the regime does not want the people to have such freedom.

'AH' agrees, stating that the effects of communist rule, including the fear of free speech, can mostly been in the current first generation of Chinese people:

It is not as open as Western countries. If you look at my parents and that generation you will see that they are closed to their own life because they live under the

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Communist party and they have to control what they are doing. When they are

working in a company you can see it especially, they have to be careful with what they

say to people as they be politicians or powerful people. Yes, they were scared. They

couldn't talk. Because in their time Chairman Mao was in charge and had a very

hard hand on everything. He made people act and think in specific ways and at the

same time I think this scared people. Now I don't think it is as bad... People are still

fearful but it is more open than before.

What is clear from the above quote is the potential consequence for individual and

societal fear of strictly imposed collectivism, seen especially during Chairman Mao's

political regime. As this was emphasised by a number of Chinese interviewees, 'fear'

was also constructed as a potential consequence of collectivism, although specifically

in regard to when it is strictly imposed by political forces.

The analysis revealed two other explanatory factors of collectivism: 'ruralism' and

'traditionalism'. These themes were viewed by interviewees as interlinked as people

from more rural areas were believed to hold more traditional values. 'LZ' states that

even after the effects of globalisation are taken into consideration, in the more rural

regions of China, life is very different:

In southern China, not in the bigger city, the living way is the same. In the

countryside, it's more traditional Chinese, and I think the living way is the same, it's

not changed very much. So before globalisation, and what people do after

globalisation, it's not too different. It's still a more simple life and the communities

are stronger. But in the big city, the capital, they have been influenced by

globalisation. People are more westernised. They are still Chinese people but they are not so traditional. They have some different priorities.

'TS' concurs, asserting that although personality and age are also important factors, in the more suburban and rural areas of China, people are more traditional, and therefore also hold more collectivistic values:

Maybe it's a bit more [individualistic] *in the big cities. But from where I am, in the middle-smaller towns, it's not. I think the younger children, the next generation, have become more similar to the Western culture, and older than me they are more traditional. Also it depends on the person, on their personality. And the parents, it depends on them a lot. I think if they are from the more smaller towns, like where I am from* [a suburban region] *or from the countryside then you become a more traditional person.*

Interviewee 'AN' was one of several Greek/Greek Cypriot interviewees who also referred to ruralism and traditionalism as a potential explanatory factor for collectivism:

I would say that it's a generally collectivist country [Cyprus] *but even more so in the less developed places, the old villages, the more rural areas, the poorer areas. Those people are more traditional. People know each other in those places, in the traditional villages, and like I said before, they usually don't have much more to do than find out what other people are doing and talking with their neighbours. That's the way it is there.*

The impact of a long, rich and proud history was also stated by the Chinese and Greek/Greek Cypriot interviewees in reference to potential causal factors in collectivism as a cultural component. Examples come from the Chinese and Greek interviewees, 'HW' and 'PC' respectively, who illustrate their history's influence:

HW: *The Chinese history goes back thousands of years, about 4000, I think, and we are proud of this, because not many countries and cultures in the world can say this...If you look at our history, you will see that things like respect for elders, respect for your fellow citizens, harmony. These are still very strong values today, because this is what our history has taught us. We know how to be Chinese through learning about our history, and learning from our ancient philosophers. These were great people and we are very proud of them.*

PC: *They're very proud people, mainly because of the history, and they don't want to lose their Greekness. They want to hold on to it and show it to each other. If they meet a Greek person who doesn't speak Greek or doesn't know much about the culture, they'll look down upon them, because they think it's very important to embrace it, because there's so much to it, and so much history.*

4.2.2.3 Mental health attitudes and stigma

All interviewees' were asked describe their views on how people with mental illness are regarded in their culture. This was a direct attempt to better understand the degree and type of mental health attitudes and stigma existent in each culture.

4.2.2.3.1 Mental health attitudes and stigma in the American culture

The completed analysis of the American cultural group interviews yielded an interesting account of how and why people with mental health problems are regarded. One of the most frequent statements made by interviewees concerned how commonplace and culturally accepted disorders such as anxiety and depression are in American society, particularly in the northern-American states, and areas which are wealthier and more urbanised. For example, 'CR', stated:

I went to a dinner party in America recently with five people and we were just chatting, and everybody on the table was on something except me, and I was like, 'shit'. I just was liked shocked at it. They were all on Prozac, although maybe other types of anti-depressants because Prozac is less trendy now, or on anti-anxiety drugs. They were split between being on anti-depressants or anti-anxiety medication.... There's no shame in it. It's bizarre. I think that's an American thing too. 'Oh, I'm on…whatever'. I have no problem about people talking about it, but they are so a matter of fact about it: 'I went to the grocery store and bought cereal, I'm on…whatever'. That's a very American thing, especially in the north. I think in the South, and in poorer places it's a little different, but I think even there it's getting more accepted.

Many of the interviewees held the belief that such public openness of their condition(s) was to some extent the result the large-scale media advertising

campaigns of 'normalisation' carried out by the pharmaceutical industries in America as a means to increasing drug sales. As 'CR' and 'JS' explain:

CR: *There's so much stuff out there, so many drugs. And now I see this stuff on television and advertisements and magazines and things like that, so they're really marketing it pretty big. They're making things like anxiety and depression as easily treated as a headache, that they're comparable, the same thing. It's crazy because they're not the same thing at all!*

JS: *It's getting more and more common actually. Pharmaceutical companies are massive in the States because the drug industry is so vast and profitable. So many people have some sort of depression or anxiety nowadays, you know. It's quite common, and when people get something, they usually get treated with some sort of drug and that makes money for those companies. I think those companies have done a lot of marketing and advertising over the years to make it feel that it's normal to take their drugs if you have depression or whatever, just so that their sales keep going through the roof.*

'NS' agrees that it is relatively easy to acquire medication for a mood disorder. She also states that high medication use and ease of obtaining a prescription could be due to the fact that medical insurance, received through many employment packages, pays for these medications that otherwise may not be affordable:

There are too many drugs. All you need to do is say to your doctor, 'I'm sad, I need a prescription'. I don't agree with that. It's down to money. Everybody has their

insurance that they get through work and that it's paid for, so I don't think they can afford those kind drugs without their insurance policy. But, on the positive side, they have money to do all of these tests and research that can possibly find drugs for all sorts of problems.

Seeing a psychiatrist was also stated by interviewees as a generally accepted act:

LC: *Over here* [in England]*, nobody wants to say, 'oh I'm seeing a psychiatrist'. You don't tell people, because they will think that you are mentally ill, that you're going to go mad in a minute. Whereas in the States, it's very accepted and nobody would think much about saying 'oh yeah, I'm seeing a psychiatrist because I have an issue that I want to talk out with them'. I think they are a lot more willing to talk about those sorts of things...It's just more out in the open and everybody sees that that's a normal person who just has an issue. Maybe it's the availability as well. It seems like there's a lot more psychiatrists in the States.*

'MW' agrees that counselling and seeing a psychiatrist for less severe psychological disorders in the United States is generally culturally accepted. However, he elaborates that for psychotic conditions, such as schizophrenia, cultural stigma is present:

Mental issues are everywhere - the use of psychotropic drugs is massive…huge, across the pond. And so virtually anybody you meet there is a very good chance that they are on psychotropic medication for problems like depression, anxiety, stress, and if they are middle class, that they have had or are in counselling of one kind of another...Those types of problems are accepted in the States, but there's still a large

amount of stigma when it comes to problems like schizophrenia. That's rarely talked

about, I mean, in relation to its actual presence in its culture.

The attitudinal separation of mood and psychotic disorders was reiterated by each of the other American interviewees. Conditions such as schizophrenia were described by interviewees as being seen as dangerous, and a significant obstacle towards societal prosperity, with marriage-ability and employment prospects likely to be effected. However, despite this, interviewees also agreed that the cultural view of such conditions is cautiously becoming more positive, especially in terms of seeking professional treatment, and when their attitudes are compared to other countries:

NS: *I think that people with clinical, psychotic, diagnoses, there are always going to people who are judgemental, a bit wary. I think people are afraid of how dangerous they could be. But overall, in the States I think it's great, and much better than most other countries, especially from the East and less developed countries. I'm trying to think of everybody I know in Maine, and in New England, and I know a few people who have had a serious mental health problem, and their families, they've been really good about it. As far as talking about it openly, maybe within the family, I'm not sure, it depends on the type of family, but most people would definitely be open to treatment. That is absolutely fine.*

When asked about whether 'serious' mental health problems are regarded by the typical American family as a shameful thing, 'NS' responded:

No, they wouldn't be victimised. It's not like it is in other countries. I'll give you an

example. I have a Chinese friend who was new in the States, and her brother, I don't

know exactly what his psychiatric problem was, he didn't tell his wife about it. Only

after 10 years she found out about it, because he preferred not to talk about it.

Americans tolerate mental illness much better and there is generally a lot less stigma

than say the Chinese. I don't know if it's because of money, where you can get it

covered on your insurance, whereas here if you want, if you want to see someone, that

would have to be private, you'd have to pay for that. Whereas in States, it's something

you're paying for every month in your pay cheque anyway, so you feel like you ought

to use it. That can motivate them to be ok with getting treatments. I guess it may also

be something to do if you haven't yet accomplished all the things you want to, if its

career, money, relationships, if you have been feeling down about it and you want to

see a therapist, and you don't do anything about it, then obviously it comes down to

you...Maybe motivating yourself to see a therapist and get help, helps us to stay on

top of things and that sort of helps us to achieve all the things we want to achieve.

The above quotation indirectly refers to the idea of individualism potentially causing
mental health problems, both in terms of the stress caused by relentlessly pursuing
one's goals, and the consequences to the self for failing to meet selected goals. 'MW'
and 'CR' also refers to the possibility of individualism indirectly impairing mental
health:

MW: *My sense is that there's more there really that's connected with this idea of 'you*

are on your own buddy - if you can't make it, that's too bad' [in American culture].

There are social safety nets in place – there are programmes, and there are legal

accommodations for persons with mental illness, and people are going to use them if they need to, but they haven't got a lot of personal support and usually no community support.

CR: *I think in the U.S., people feel more alone and a little more isolated than other cultures where there are bigger families and stronger communities. So there's less support for people, and people feel on their own. That's probably the culture's fault though, because we are generally people who value being alone and having small, nuclear families. Most of the people we know are through on-line communities like Facebook! But on the upside, I think that feeling like you're on your own can sometimes make people feel more confident to get professional help, because you know that there aren't many people with their finger in your business judging you.*

'CR''s quotation is interesting because she is referring to three previously cited potential consequences of American individualism, 'a lack of community sense', 'social isolation', and 'low surveillance' (section 4.2.2.1.2), and her belief that these cultural components may allow the individual and/or family suffering from a mental health problem to feel unrestricted from any possible community stigma when seeking appropriate professional services. The idea that low levels of surveillance could be associated with people feeling free of stigma when seeking professional treatment is echoed by 'JS':

I just think that if you're the type of person who's got their head in their own book all of the time, then, firstly, how are you going to notice other people's problems and, secondly, are you really going to care all that much? I think that's going to allow

people who do have a problem to feel more comfortable about being open about mental illnesses and doing what they have to do to get better, because you're not going to be worrying so much about what other people think, because you know they don't really care anyway.

Social class and the quality of education were two other factors mentioned by several American interviewees in relation to what they believe links with mental health attitude formation. 'MW' illustrates their importance:

I think that it corresponds to increases in education levels and welfare levels that in general as you go up the scale in terms of education and wealth, there's a more enlightened attitude about it. So as more people have risen from the working class to the middle class and so forth, as that process occurs, there's a greater accommodation for it because of the better standards of education. But again because of the self-advocacy aspect of the culture, you have to take care of yourself and that includes your family. Your family, yourself, I mean the nuclear family and the individual are virtually the same thing. So a middle class parent, in particular, is going to be used to doing what they need to do for their child, in terms of getting them extra tuition, or getting them special schooling, or getting them whatever help or medical assistance that they need. So, again, depending where they are on the social structure and the quality of education they're receiving, will result in different levels of stigma, and different levels of access to services.

4.2.2.3.2 Mental health attitudes and stigma in the English culture

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The completed analysis of the white-English cultural group interviews also produced an intriguing account of how and why people with mental health problems are regarded. These interviewees also agreed that disorders such as anxiety and depression are viewed with more tolerance, acceptance and sympathy than psychotic disorders. Schizophrenia was commonly cited by interviewees as a particularly stigmatised mental health problem. Interviewees agreed that people in the English culture still maintain high social distance levels, due to the unpredictability and fear of danger that those perceived to be afflicted with this condition represent. These views are illustrated by 'SG' and 'BD':

SG: *Depression is quite common I think, across the country, probably a bit more than what people think. A lot of people get it, they go to their GP, they get some sort of anti-depression drug, and they get on with their lives. That sort of problem is generally accepted in our culture, I don't think it's seen too negatively. I think people view it with sympathy because they know that it can happen to anyone. But I think it's different with something like schizophrenia though. People are scared when they come across someone with schizophrenia...I think if someone saw you as a schizophrenic or a bit loopy, they'd stay away from you, and would try to ignore you.*

BD: *There's a lot of sympathy for people suffering. I think with depression, people can be sympathetic but also lose patience with depressed people. There isn't a lot of blame on specifically on the person because it depends on the cause and often it can't be their fault, but there is sometimes a lack of patience with depression. But if they are displaying behaviours which are very negative or harmful to other people then I think that would be viewed very critically. I think people would stay away from that.*

They'd probably not want to be seen as being negative about it, but very privately they would be scared of it...Having said that, I think English people's view of it is getting better. It's probably better than it's ever been, but it's still stigmatised.

The belief that there is at present less stigma attached to mental health problems in the English culture than ever before was supported by all of the English interviewees. The reasons provided for this attitudinal improvement were better education, particularly via the media, and more societal awareness, due to the increased presence of community psychiatric services:

GH: *I think it's changed a lot over the past couple of decades from what I gather. I think through the media it's come clear that there are loads and loads of people that are suffering with mental illness, that we perhaps didn't know before. So I think people are more in touch with it, more accepting of it. But at the same time, I think the general public don't know much about it unless they have suffered from it. They probably don't understand it fully, really, so I think there's a long way to go. But the media has helped to educate us, especially in areas like depression. By media I'm talking about the papers and the TV, although tabloids sometimes do distort things. I think depression is the most common and therefore it's more acceptable and people are more open about it. I think we read more newspapers than any other country, so most people are fairly well educated about it, compared to many other countries. I think it's down to education.*

BD: *People don't understand mental illness, like schizophrenia, so there more scared of it. I think that's the root of the negativity. I think if people were educated to*

understand it then that would help. If you say someone is schizophrenic, and you

don't understand it, you are going be wary and scared of that person. I personally

don't know a lot about schizophrenia but I know that most of the time the people who

do suffer from it aren't going to harm anyone else but because there are some cases

where people do, then that's the view they take, that it's dangerous, because they

don't understand it.

Interviewees were also in agreement that people in the English culture would

generally seek the appropriate professional treatment and care required despite the

possible presence of stigma. For example, 'AP' states:

I think the average English family would probably send their child immediately to get

some professional help, and probably learn as much as possible about it themselves.

But they would trust the experts and go with what they say. If they say, 'your child

needs to be kept in a psychiatric hospital' they would go along with that, I think...I

think it would be more important to get the proper help than to spend time worrying

about what other people think. I don't think they would care what other people

thought about it so much. They generally wouldn't be too ashamed about it... If people

are scared about what they're thinking about their child, it might prevent them from

doing the right thing.

The above statement is interesting because the interviewee is referring to the notion

that the welfare of the individual is of greatest importance. This, 'AP' states, allows

the person afflicted with the mental health problem, and his/her family, to feel

unrestricted in both being open about their situation to others, and accessing the appropriate professional care if necessary.

4.2.2.3.3 Mental health attitudes and stigma in the Chinese culture

The Chinese interviewees' account of mental health attitudes and stigma revealed that a great deal of stigma towards mental health problems exist in the Chinese culture. This stigma, as 'HL' and 'AH' illustrate, includes the notions of shame, loss of face, and failure for the Chinese individual and their family:

HL: *I think it is viewed as a very shameful thing. If someone has a mental illness, then it must mean that his family has problems, their morals must be wrong. The family would look bad, and they would be very embarrassed, especially if other people in the community found out. They would be discriminated against. It will affect their life, their chances to marry, their chances of getting a job. These are very important things for a family.*

AH: *Oh no, it's not seen well. I think that it would make the family seem less normal to others. People would talk, and say things like 'there's problems in that family' and things like that...It has to do with family honour. It's not an honourable thing to have such a problem in your family. It's like if you are suffering from a financial crisis, you wouldn't want people to know it, because people would judge you and maybe take pity on you. Honour is very important.*

When asked if Chinese families would generally try to conceal the existence of a mental health problem to others, interviewees agreed, stating that this would be an attempt avoid the stigma, with the particular aim of preserving face:

HW: *When I was growing up it was never mentioned, then of course when you are hit with it, you think 'boy, that must be bad', because nobody talks about it. Nobody talks about it. My mum's condition is not severe, it's not something that people can look at her and say* [whispering] *'oh yeah, she's mentally ill'. But I know people do ridicule it and treat you differently. That's why people don't talk about it, because they know people will stigmatise you. So it was kept totally private. I think people who were involved in my life, they didn't know about it, in China. I wouldn't say that my mum is ill, no. At some point my mum actually went to the hospital, I told my girl friend, 'oh yeah, my mum's in hospital.' I didn't tell my friend that she was mentally ill though because I was afraid that they wouldn't come to my house anymore, and they won't be friends with me anymore.*

Another sub-theme of mental health stigma in the Chinese culture was that of 'strong family support and loyalty'. This was revealed when the interviewees were asked what would happen if a family member is being treated for a mental health problem by psychiatric services. As 'HW' and 'LZ' explain:

HW*: With my parents, they're still together. My dad has suffered a lot because of it, because my dad's torn between his own happiness and his duties. It doesn't matter as long as you are happy but he just struggles with it a lot. And now he's missed his whole adult life, so I really do feel very bad for my dad. But he feels he has an*

obligation as a husband and a man to do what's morally right, so he stands by my mum's schizophrenia, even though she has not been a real wife to him for many years.

LZ: *I think the Chinese family would be supportive. They would try to understand and help the person, and would go with them to the hospital to decide together with the doctors what is best. Yes, there is a bad view of mental illness in China, but they would not abandon him.*

A number of potential causes of such stigmatising attitudes were also provided by the interviewees. The most cited reasons for this were a lack of mental health education, a lack of cultural awareness, high surveillance, traditionalism, ruralism, and the lack of promotion and availability of quality mental health services in China, the blame for which was directed towards their governmental policies. For example, 'HL' refers to the latter:

If a Chinese family wants to get cure for a mental illness, it is very expensive, not like here [in England]. *So the mental illness people are wondering the streets, they can't wear clothes, they are treated as rubbish. So when the normal people watch them, they feel very uncomfortable. They don't understand it. I think the problem stems with the government. Our government does nothing to deal or address with mental illness because we must be seen as living in a perfect world with no problems. They don't want to acknowledge these problems. They tell us that the problems are in the other countries! But it is our culture which has many serious shortcomings. It is too judgemental, it is too practical, I think. We have developed the technology but we have not developed the science. When I was an undergraduate, we had a course about*

the mind, the mental state, but it was the only course. Most people in China don't go to university, so the common Chinese people have no scientific view. They just have bad feelings and thoughts about it without any reasoning. They see it as a problem with the character, and the person's morals. This is not scientific. They don't think about it very carefully. Their reaction is natural, not scientific. But I think if the government did more than they are doing now, the attitudes might change more.

The view that Chinese people lack the mental health education necessary for a scientific appraisal of mental health problems is echoed by 'LZ':

Actually, many Chinese people probably have mental illness in their life. But the mental science is not developed – it is not a popular science. Mental science is seen as a Western thing. It comes from the west, so it is not accepted by normal Chinese people. So many of them have questions about mental illness, but they don't know anything about it. They don't know if they have it. They don't know what it might mean or what to do with it. They might not know they have a mental problem. They don't know that it is a disease. They think it is very abnormal to have mental problems. But it is normal, a general status of life.

The notion that people from more rural areas, who lead more traditional Chinese lives, are particularly stigmatising towards mental health, was stated by the majority of the Chinese interviewees. 'HL' illustrates this:

The Chinese people in the big cities, they don't care so much if you have [a mental health problem]. *Everyone is busy! When I came to London, I found London is also*

busy. It is as crowded and as busy as Beijing. But the people here aren't nervous. The Chinese people are very nervous, about their future, about their living, about their house, about their job, about their child. They worry about themselves too much. This is the modern way. But it's different in the quieter areas, the smaller areas. It is more traditional, a more simple way of life. If you have a mental crisis, people will know about it. They are more conscious of what is happening on around them. They do not have so many distractions like in the big cities.

The above refers to the concept that stronger stigmatising attitudes exist where there are higher levels of surveillance, which can be found in the more collectivist areas where less cultural complexity exists. When this theory was queried with other interviewees, many supporting statements were provided. One such statement derived from 'TS':

I don't know much about mental illness, like many other people. It is normal not to know much especially where I come from [traditional suburban area]. *It's difficult to see it my communities in China, maybe because I don't know much about it. But I do think that families would be ashamed if their child was mentally unhealthy...News travels fast where I'm from so I think families would be scared to admit they have a problem. They don't want people in the town to know...It's not this way so much in the cities. People don't care about other people so much, and I think there are probably more ways to get help. I think people would be less frightened to get help, and they would also have more money to pay for the expenses.*

4.2.2.3.4 Mental health attitudes and stigma in the Greek/Greek Cypriot culture

The Greek/Greek Cypriot interviewees were also asked to describe their beliefs as to how and why people with mental health problems are considered in their culture. Every interviewee believed that, in general, mental health problems are regarded with a high degree of stigma, although the type of stigma was found to substantially vary between mood and psychotic disorders. For the latter, the stigma revealed was that of social restriction, discrimination, distance, but also sympathy. For example, 'PC' states:

If someone had schizophrenia in a family, it would be viewed sympathetically. People would feel sorry for them, sad for them, and that is embarrassing in a way, for the family, because people will be treating them differently...I think the circles of people around them, the community, they would probably distance themselves because they would see that there is something wrong with that person. They would think that that person is unstable and maybe could be dangerous. And for Greeks, protecting their children, protecting their family, these things are very important, so I think that if someone has schizophrenia and they found out, then they'd want their children and their family to stay away. They wouldn't want to risk it...Yes, definitely, I think so [that their chances of marriage-ability and employment would be minimised] *because they wouldn't want any problems like that closer to them.*

With regard to non-psychotic disorders, it was the existence of authoritarian attitudes that was emphasized by the interviewees. This attitude was prominent because it was found to be rooted with the incorrect assumption that conditions such as anxiety and

depression can be quickly resolved through will-power and mental strength, and that those afflicted have themselves and/or their family to blame if they are not resolved:

PC: *I think Greeks would be more critical to the person suffering with their depression. They would say that it was their fault, and that they have the responsibility of personal control and that they have made the wrong choices in their lives, that they have no one to blame but themselves and that they should work hard to get themselves out of it. They think that they should just get out of it, snap out of it, with just determination and working hard.*

The notion of concealment was another prominent sub-theme of mental health stigma in the Greek/Greek Cypriot culture. One example comes from 'HM' who describes two past personal incidents of hiding mental health problems:

When I was 14 years old, I was in my aunt's house in Cyprus and I was wondering around and stumbled on a girl a few years older than me in a large cot in a dark room rocking forward and back. I was so scared that I ran out to where my family was and didn't tell anyone what I saw. Then, years later, my dad was talking in hush tones to my mum about my aunt. Apparently her daughter – my cousin in the cot – died from her mental illness. Imagine that, at 14, I didn't know that I had another cousin, especially when you bear in mind the fact that I'd been going to Cyprus every year and I'd never met her, and even today, 13 years after, no one has spoken to me about her. That's made me really sad. Personally, other than that incident, I've never been surrounded by any other severe mental illnesses, other than depression, loneliness and isolation, which I guess is also a very bad illness. I should know,

because a few years ago I went through a really bad time and I had to see someone, but, you know what, not once did my parents, brothers or sisters talk to me about it. My mum has very definite traits of a depressive person, she cries a lot when things go wrong or she feels under a lot of pressure, but because she was never taught to talk about these things or to find ways to cope, she can't recognise her condition as being depression, so she can't get the right help for it. My parents have often been very reluctant to let us know if they are feeling isolated or depressed, because it's a sign of weakness and they bottle it all up, for pride's sake. It can lead to a very hostile environment, which doesn't help. If I tell my mum that in my opinion she has depression, she will absolutely deny it, half because she doesn't understand what depression really means, and half because it's quite shameful to herself to admit to having a mental illness, especially for someone of her generation. But I must say that despite everything, my family have never said a derogatory comment about anyone with any kind of mental illness, and they are very sympathetic, especially people with who have no control over their illness, like schizophrenia.

The above is a very insightful extract as it documents two acts of concealment; both of which aimed at avoiding the feeling of self-shame and loss of pride. It also highlights a lack of awareness and understanding of mental health problems in the traditional, first generation Greek/Greek Cypriot culture. If a mental health problem is suspected, the result could be self-denial and/or self-stigma. It also reiterates the sympathetic attitude towards disorders such as depression.

The analysis also produced themes which related to the causes and factors of Greek/Greek Cypriot mental health attitude formation. These included, as stated

above, a lack of understanding and education, viewing mental illness as a threat to cultural and personal pride, and the presence of high community surveillance. 'AN' and 'HS' depict these sub-themes:

AN: *Greeks talk a lot. So if people heard about it, they'd talk. They would be scared of what people might say, like 'that family hasn't taken proper care of their child', which is of course probably a load of rubbish. I think it would be hard for a family to know that people are talking about them and their child. Greeks are very proud people. They are proud of the culture and the history, they're proud that their Greeks. So if you have a mental illness in the family then that pride is threatened, especially if people start talking, even if it is only sympathetic talk. They don't want people to feel sorry for them.*

HS: *They'd definitely try to hide it. People would try to be supportive though, but they would keep it from most family and friends, and sweep it under the carpet. I think they'd see it as embarrassing, and shameful, so that's why they'd hide it. I think because people are always looking over everyone's shoulder, it makes it even more important to try to hide it because they know people want to know what's going on. The English call it 'keeping up with the Jones''. The Greeks love to know what's going on; 'oh yeah, how are you? What are your kids doing? Are they in school or are they married?' So if you have a son or daughter who's mentally ill then that's going to be shameful and they'll avoid telling others. I think there would be a lot of anxiety over it, a lot of gossiping and questioning, again because they wouldn't understand what it entails, especially if in the traditional communities. Those people don't have a good education because they come from poor families and working-class*

families. They only know what they see on TV and hear from other people, which are usually stereotypes...Stupidly, Greek families think that because they have a mentally ill son or some kind of mental health issue, they think that they'd lose respect or stature in the community.

4.2.2.4 Immigration

Interviewees in the American, Chinese and Greek/Greek Cypriot cultural groups were also asked about their immigration experiences. Probes were used to direct the interview towards understanding how living away from their native country has affected their cultural identity. Specific interest during this enquiry was on whether immigration has any prospective affect on levels of cultural identity affect, specifically in relation to individualism and collectivism values. A visual illustration of themes interaction, derived from the analysis of this subject matter, can be viewed in figure 4.8.

Figure 4.8: Immigration and cultural identity affect in the American, Chinese, and Greek/Greek Cypriot cultural groups
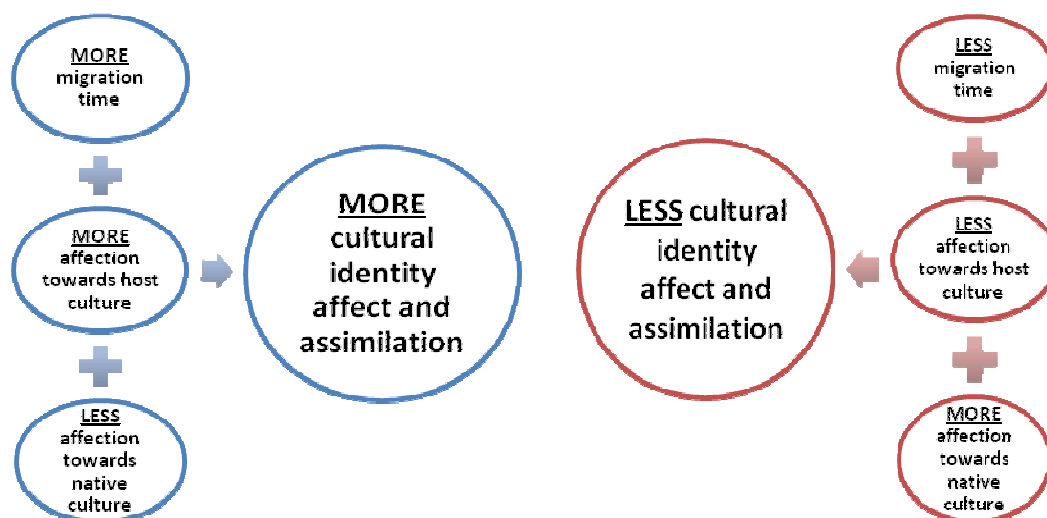
4.2.2.4.1 American immigration and cultural identity affect

American interviewees provided an interesting account on whether their cultural identity, and, in particular, their level of individualism, had altered since migrating to the United Kingdom. 'CR', a 28 year old white female interviewee from Florida, who has been living in England for six months, described that she does feel that her cultural identity has begun to change. She states that this change is fuelled from her desire to avoid fulfilling the negative stereotypes that she feels English people hold towards Americans, as she is not a patriotic American, and to smoothly assimilate into the English culture, which feels is less individual and more community orientated and thus holds in positive regard:

I think I've been very conscious in trying to drop a lot of the arrogance that's stereotypical of Americans... Americans in general are very patriotic. I'm not so patriotic. So I've been conscious of that arrogance and have been trying to drop that, because I think that style can alienate a lot of other people. I am from the US and that's where I'm from and I'm cool with that. I don't feel the need to put it in somebody's face. I can't disguise my accent, but all in all I'm pretty chilled about it. And there's some nice things about living in Europe, living here, it's been nice getting to see those things and integrating them into my personality, like I'm ok with paying more taxes so it gives back to medical programs and services back to the community. Whereas if you'd say to someone in America that I pay 17.5% sales tax, they'd be like 'wow'. They'd find that pretty intimidating. America is very self-centred, whereas in Britain it's more about giving to the community. I kind of felt like that before I went

left which was why I was quite attracted to coming over to a country like this. I like

that philosophy. So I'm happy to give back in order to contribute, which I think from

an American perspective is not very individual-orientated. I've developed that living

here.

'LC', a 41 year old white female who has been living in England for 15 years, also
argues that her cultural identity, over the years, has become much more in line with
the English culture, which she views as less individualistic, less ethnocentric and also
holds in high regard. However, despite increasingly identifying herself with the
English culture, she describes her belief that she will always be looked upon by others
as 'the American', due to her American background and accent:

Americans in general are very insular. They are very, very friendly but they can't see

out of their own little world. They see America as very big, and it is, but they think it

is the whole world and that's really irritating. Like my relatives back in the States,

they aren't interested in my life. They never ask me questions. They don't, in 15 years,

I've had only a handful, come over and see me here. And even when I see them, if it

goes beyond America, you have fallen off the face of the Earth and they can't relate to

that, and they don't even try. I'm aware of that now. I got the perspective living here,

I think. It's made me to not want to be seen with Americans...When I first came here, I

went to school in Oxford Polytechnic. Then I felt totally American, and that lasted a

couple of weeks. And then, I sorted of started enjoying the fact that I was here, the

differences, and doing different things, not sort of staying with the Americans. I was

only here for about four months. Then I came back the next year, and I hardly ever

met with an American, and I didn't want to. I kind of rejected the American culture. It

was always like that afterwards, I never sought out Americans. I never thought 'oh, I miss the American culture'. And by staying here longer and longer and longer, Americans and America became sort of more foreign to me than where I was living. It was about seven years after I went back to the States on holiday. I actually looked around, and that felt like the foreign country, not this one. So it's kind of a strange thing, because over here, I'll never really be accepted because of the accent, and people always look at me as 'the American', which always kind of offends me, because I think I'm actually not very American now.

A similar story of cultural identity affect was provided by the other American interviewees, including 'MW', a 45 year white American male who has lived in the United Kingdom for eight years. He too states that he has over time assimilated into the English culture, but also acknowledges that he will never be able to fully disassociate himself from being American:

I guess I would put it that I'm highly critical of the typical American culture but I'm imbued with many of those values myself. I'm a highly competitive person, I'm highly individualistic myself, so in a sense, I'm self-alienated, because some of the things I'm criticising, I could say the same about myself. I guess I would say that I'm not as much in that way now and that's partly because I'm not in that context that you can change, and because I'm in the new context, I'm effected by this new context, which is much more socially friendly, more conducive to being sensitive to your social surroundings. But as much as I integrate into this culture, I guess I will always still feel American, and others will see me that way as well.

In conclusion, the American interviewees in this study are those who lack a high degree of patriotism that might otherwise have prevented them from taking the chance of migrating to a new culture. They are fuelled with the desire to avoid the negative perceptions of Americans held by other people, many of which perceptions they generally agree with. They are additionally aware of the fact that they will always be associated with the American culture to some degree, both by themselves and others, due to their background and accent. They also value the English culture, and, as more time passes with them residing in England, increasingly assimilate within this host culture.

4.2.2.4.2 Chinese immigration and cultural identity affect

The interviewees from the Chinese cultural group also provided an interesting account on whether their cultural identity, and, in particular, their level of collectivism, had altered since migrating to the United Kingdom. 'AH', a 48 year old Chinese female who has been living in England for the last ten years, states that she has to some extent assimilated into the English culture, which she values and appreciates. However, she still predominantly feels culturally Chinese, for which she is happy about and consciously strives toward:

I have been living here for quite a few years now so I think I'm influenced by the English culture. Things are different here, like the pace of London is faster than my home in China, and people are quiet but also liberal minded. I think I have become more liberal over the years here, and I feel like I live a better quality of life than I could at home. So to answer your question, maybe I am 80% Chinese and 20%

English, if you mean, by culture. So yes, I still feel very Chinese. I think I am proud of my culture. I try to hold on to it. China has an ancient history. That's something to be proud of. Maybe living here makes me need to hold to my culture even more. Maybe I'm afraid I'll lose it if I don't.

The analysis of 'HL''s interview, a 45 year old Chinese male, demonstrates how migration length impacts of cultural assimilation. He also holds the view that the Chinese people need to learn embrace other cultures, despite their cultural pride and distrust of other cultures:

I have only been living here for 8 months so it's difficult to have been affected. It's been too short of a time for me not to feel 100% Chinese. But I like the English culture, from what I have seen already. Before I left China, my universe was China, and we learn to not emphasise other countries, but now I think western countries are better than China. They still have many, many problems so I think the Chinese people shouldn't be pessimistic, but we should embrace other cultures, like I have been trying to do. I think the Chinese people need to do this because they only stick with each other. They are proud people but also they do not trust others.

'LZ', a 38 year old Chinese male who has also been living in England for the past two years, agrees that Chinese people in general find it hard to assimilate into other cultures. His reasons for this are the Chinese collectivistic nature that hampers them from embracing out-groups, and the lack of China's multiculturalism, particularly from western nations. However, he feels that he has lived long enough in England to

begin to notice a change in his own cultural identity, in the sense that he is a more 'open' and less conservative individual:

The Chinese, even when they go abroad, there is still Chinese food, Chinese community, China town. I can find the Chinese newspaper. They can stick to being with their culture. That is the traditional Chinese way...Personally, I am not so traditional. I can say that I am slightly influenced by the western culture already. I'm influenced in the thinking way. I'm changed. I'm improved. I will not be such a conservative person. I try to make myself understand that I should be open. I should be open. I should talk to other people from other cultures, background of people, for example, Italian. In China, they don't have many other cultures, especially from the big powers, such as America and other western countries. But I will not think like that. I will open my mind and my heart to absorb the western political system, social system, and culture, to compare, at least, to learn more about my own culture. To learn.

The above extracts illustrate that the Chinese may, to some extent, hold back from assimilating the values of a host culture that they have migrated to, due to their collectivistic nature that comprises degrees of ethnocentrism, pride and out-group distrust. This is fuelled by the availability of large Chinese enclaves in London. However, the interviewees who have resided in England for a longer time have demonstrated that the assimilation of an out-group culture, which they value, is possible.

4.2.2.4.3 Greek/Greek Cypriot immigration and cultural identity affect

The cultural identity affect of Greek/Greek Cypriot immigration to England was also explored, with specific emphasis on the impact of living in a more individualistic host culture. The analysis revealed a similar story to the Chinese cultural group, with notions of cultural pride and collectivism providing a platform for the interviewees to remain culturally identifying themselves as mostly Greek. An example of this comes from 'CT', a 30 year old Greek male who immigrated to England in the last year. He describes the pride he feels towards his native culture; a key motivating factor in retain his Greek cultural identity. He also describes his dislike for the urban English culture for which he will consciously avoid incorporating into his identity:

I still feel Greek. I have only been here for six months. My English is also not so good, so people will know I am not English. With more time, yes, I can say that I will become more English, but not now. Now, I spend time with my Greek friends, these are the people I know. We stick together, we help each other which is a good thing. I don't know many English people yet, only some colleagues and my housemates...I like being Greek. We have a beautiful history, something to be proud of... I want to stay feeling Greek. It's important, maybe even more important now I am living away from my country. But I think if I live here for a year, I will adapt to this culture and it will incorporate into me. But, I try to not incorporate in some things because some things in the English culture is not good. It's not the same to be a little bit cold, that's not such a big problem, but they are 'losing their minds'. You know, you go in the underground and everybody is thinking something different. They don't have any presence in the moment. Everybody is going, everybody is running, and they don't enjoy the present moment. They are rushing. They work too much. They are a work

culture. All work. They are like machines...And when they are not doing that, they just go to a pub and get drunk. And that's, that's awful. It's a totally different culture to Greeks, even the Greeks in the big cities like Athens. I'm sure about that.

Another illustration of these notions comes from 'HS', a 29 year old Greek Cypriot male who has lived in England most of his life. He agrees to feeling pride towards the Greek culture, but equally also values and appreciates his English cultural identity, due to the fact that he has spent most of his life in England:

I think compared to most Greeks, I'm very English, I think, because I've embraced the English culture. Like my dad has always said to me, you've got to take the good from the Greek culture and the good from the English culture and mix them, because the English have some very good things in their culture as well. The way that I speak is obviously very English, some people say I have a cockney accent. So I would say that I'm a cocktail, a mixture of culture. Being a police officer, I would work in a very English or British circle where most people I work with are English, so you do tend to find yourself adopting their culture a little bit more. But when I come home I find myself slipping straight back into the Greek way of life. And it's the same when I go to Cyprus. When I go there, I slip back into the Greek way. I speak Greek more, I adopt more of the mentality because I've got so much more contact with them. So I would say that I've become Anglicized. By that I mean that I've adopted the British or English ways such as the way they speak, the mannerisms, doing things that English people do like going to the pub, going for a country walk in the park, a Sunday roast. But like I said it often depends on what context I'm in.

The notion of cultural identity being affected by context is also referred to by 'AN', a 61 year old Greek Cypriot female, who has lived half of her life in England:

Oh yes, definitely. I was raised in Cyprus for nearly thirty years so I couldn't ever lose my Greek values or identity now. I suppose one way of describing it, if you wanted me to use percentages, would be that I'm 100% Greek and 10%, maybe 15% British now. And I can't escape the fact that I live in England now. That's got had some influence on me, for sure, but I haven't lost any of my Greekness, no way. I love our culture. I sent my kids to Greek school. I read the Greek paper, I listen to the Greek radio. I've made a lot of effort not to lose touch with my culture, because that's who I am. I think. When I'm in Cyprus now, I don't feel English at all – I'm 0% over there, but I'm sure that the people around me in Cyprus think of me as a bit English. But whatever, that doesn't bother me.

In summary, the analysis of how migration has impacted on this group's cultural identity reveals a similar story to that of the Chinese cultural group. This group's interviewees also depicted a strong level of pride towards their native culture, one which they are eager to retain. When the English culture is valued and appreciated, the likelihood of their native cultural identity amalgamating with the new host culture increases. This is consolidated further if a significant amount of time is spent residing in the host culture. One dissimilarity with the Chinese group, however, may be an apparent extra willingness to embrace an out-group's culture, perhaps because the theme of out-group distrust was not raised, despite the availability of large Greek communities stemming from their collectivistic nature.

Chapter 5: Discussion

5.1 Introduction

The main purpose of this study was to develop our comprehension of the way culture influences mental illness stigmatisation. This objective was approached from an original perspective; that of exploring the potential relationship(s) between the 'individualism-collectivism' cultural paradigm and mental illness stigma, which, despite numerous intimations within existing research literature, had never previously been investigated. Further, the investigation sought to identify other underlying factors which helped to explain the mental health attitudes existent in the sampled cultures. Additional aims included measuring each culture's levels of mental illness stigmatisation in terms of their individualistic and/or collectivistic value orientations and how these may have been affected by the acculturation forces.

The following sections present this author's interpretation and discussion of the data collected, and how the above aims have been addressed. The mental health stigmatisation levels of the Chinese and Greek/Greek Cypriot cultures and a discussion of what factors (excluding individualism-collectivism) explain these attitudes are firstly presented. This structure is then replicated for the American and English cultures. A specific, in-depth, view of how the individualism-collectivism paradigm explains mental health attitudes in these cultures follows. An examination of how these cultures fit within the individualism-collectivism paradigm is then presented, followed finally by a consideration of whether the non-English sampled cultures' individualism-collectivism values have been affected by UK-acculturation.

5.2.1 Greek/Greek Cypriot and Chinese mental health attitudes level and type

Since previous research has revealed mental health stigma to be a highly prevalent phenomenon in the native Greek/Greek Cypriot (Madianos et al, 1999; Economou et al, 2005) and Chinese (Kwok, 2000, 2004; Song et al, 2005) cultures, one may view this study's results as indicative of a positive shift towards more tolerant attitudes having taken place within these cultures in recent times. Increasing globalisation, modernisation, societal wealth, and anti-stigma campaigns have likely all had an impact on attitudinal shift, particularly in urban areas where such factors have their biggest impact. A positive shift was first suggested by Madianos et al's (1999) work on mental illness attitudes in the Greek culture. Their comparison of community attitudes between 1979/1980 and 1994 revealed that, although stigmatising attitudes were still prevalent, a significant shift towards more positive mental health attitudes had already began. Specifically, they found that the 1994 participants living in the capital city Athens (a highly urban area) were more liberal-minded about mental illness, as well as generally more tolerant and less authoritarian compared to the 1979/1980 group. They also found that the most positive attitudes were in general held by Greek females, who were particularly more liberal and benevolent-minded, as well as younger Greeks who were significantly less socially restricting than the older participants. These were findings that were mirrored by this study's results, in which females were found to be significantly more benevolent, and younger people less socially restricting and authoritarian (section 4.1.2.3).

Ford's (2007) research on mental health in modern China also suggests a changing attitude towards mental illness, albeit one which is still stigmatising. He found that the stigma attached to mental illness and psychological problems in China remains ubiquitous, but that it is slowly fading, particularly for women, who are engaging more regularly than ever before in obtaining counselling for their mental health problems. Men, however, are still suppressing their emotions in order to save face. Indeed, this study's qualitative findings strongly support the phenomena of face-saving and maintaining dignity as important themes in mental health stigma for both the Greek/Greek Cypriot and Chinese cultures, particularly in people from rural regions, where less cultural complexity exists (and, accordingly, less tolerance for social deviation), and where the impact of a growing Westernised market economy is less profound. Partial support for this comes from Wu (2005) who examined Phillips et al's (2004) findings that rural Chinese residents are significantly more likely to commit suicide than their urban counterparts, commonly as a result of mental health problems. Upon qualitatively investigating Philips et al's results, Wu discovered that in rural communities, the collective does not view people with serious mental health problems as fully competent and morally-worthy individuals, since such people so clearly deviate from the established norms of the collective group (which are both fewer and more rigorously enforced than in urban settings). Therefore, Wu argues that many of the attempted suicides in rural areas stem from such stigmas and the subsequent experience of loss of face. Phillips et al also adds that these problems are exacerbated by the fact that in such areas there is a lack of nearby mental health services as well as a particularly low level of public knowledge about mental illness.

Thus, the positive CAMI attitudes in the Chinese and Greek/Greek Cypriot groups in this study could reflect a changing time in these cultures. However, these findings need to be taken into context as the majority of this survey's Chinese and Greek/Greek Cypriot participants were immigrants from urban Chinese and Greek/Greek Cypriot regions whose cultural values are more likely to be affected by globalisation and Westernisation than their rural, more traditional counterparts. The remaining participants in this survey were UK-born, and therefore acculturated to the English host culture (whose attitude to mental health problems is more favourable). This impact on stigma level can be seen in table 4.6, where UK-born Chinese and Greek/Greek Cypriot participants can be seen to have significantly less stigmatising CAMI scores than their lesser acculturated migrant counterparts.

The finding of more positive than expected attitudes in the Chinese and Greek/Greek Cypriot cultural group does not mean that stigmatising attitudes in these cultures are not currently present. On the contrary, when the interviewees in the qualitative survey were queried about level and type of mental health stigma that exists among others in their native countries, notions of shame, loss of face, rejection, concealment, self-stigma and public stigma were described. Both groups also expressed the cultural reluctance of accessing professional mental health services due to the desire of concealment and fear of stigma. These findings describe a picture of mental health stigmatisation which parallels previous literature. As Kwok (2000; 2004) states of the Chinese culture, and which this study's findings also revealed, academic and occupational achievements can elevate an individual and their family's status, whereas the existence of a mental health problem can bring shame and reduce status.

The qualitative finding that psychotic mental health disorders are associated with a particularly high degree of social distance and fear within the Greek/Greek Cypriot group is also supported by previous research. As Economou et al (2005) also found, descriptions of social distance and restriction were particularly common in this group due to the fear of criminality and danger they pose to their families and community. Moreover, Leff and Warner (2006) document that compared to many other countries of the world, Greece is one of the most negative in viewing people with mental health problems as dangerous. This is again reiterated in my previous study (Papadopoulos et al, 2002), where it was revealed that, compared to white-English people, Greek/Greek Cypriots were significantly more likely to view those afflicted with mental illness as dangerous and less intelligent. The current study's qualitative analysis also ascertained that authoritarian attitudes are more strongly connected with 'less severe' psychological disorders such as depression and anxiety. This is because – according to the interviewees – Greek/Greek Cypriots view syndromes such as depression and anxiety as controllable through will-power and hard work, and thus may view those with such mental health problems in a less lenient and sympathetic manner. Greater sympathy was instead found to be reserved for conditions perceived as mentally uncontrollable, such as schizophrenia and dementia, despite potentially high social distance and restriction levels that are applied to people with such problems. In cases where perceived uncontrollable mental health problems occur within a family, there was agreement, particularly within the Chinese interviewees, that the family remains loyal and caring towards those suffering. Such loyalty appeared to be due to an unconditional cultural and moral obligation that family members have towards each other. Such notions are supported by previous research where ties between family members in these cultures have been found to be strong

and where the welfare of the family member is placed first, despite the likely existence of community stigma (Pearson, 1993; Papadopoulos, 1999; Kung, 2001; 2003).

5.2.2 What factors (excluding individualism-collectivism) explain mental health attitudes? An examination of Greek/Greek Cypriot cultural group

The results from this group's quantitative analyses revealed that there are a number of social factors that correspond with higher or lower stigmatising mental health attitudes. Specifically, the older, first generation Greek/Greek Cypriots were significantly more likely to view mental illness in an authoritarian and socially restrictive manner. This finding is not surprising as it has been well established that younger people are more likely to hold more positive mental health attitudes, both in research studies specific to Greek/Greek Cypriots (Madianos et al, 1999; Papadopoulos et al, 2002) and to other general population studies (Wolff et al, 1996; Pescosolido et al, 2008). This could, at least partially, be interpreted as being a result of UK-acculturation, since younger Greek/Greek Cypriots were predominantly of second or third generation; having been born and grown up in this country they had inevitably been influenced by the UK's prevailing cultural norms during their 'forming' early years. The potential attitudinal effect of UK-acculturation is substantiated by the fact that those Greek/Greek Cypriots whose first language is English scored significantly lower in measures of authoritarianism and social restrictiveness. These are participants who are also more likely to have acculturated to the UK-host culture than their older, first generation, 'Greek as first language', counterparts. Being single also correlated with more positive attitudes, particularly

within the social restrictiveness construct. This finding, however, is likely a consequence of the 'age' factor, since younger participants were more likely to be single in this sample, as opposed to being married/cohabiting or divorced/separated/widowed. Also less authoritarian and socially restrictive were Greek/Greek Cypriots who knew more about mental illness, and whose educational levels were higher. The most powerful explanatory factor of authoritarianism, however, was that of previous experience of mental health problems, as this was the only independent predictor of this attitudinal construct. Thus, Greek/Greek Cypriots with previous experience of mental illness were less likely to be authoritarian. This factor also significantly correlated with levels of benevolence, as did the 'gender' variable, in which females were found to be significantly more benevolent towards mental illness than males. The gender variable was also revealed as an independent predictor of this construct, although its reliability as a predictor was also found to be contentious as it possessed low confidence intervals, a modest regression coefficient, and that its predictive power only just entered into significance.

As stated earlier, according to previous research and the findings from the qualitative analysis, authoritarian attitudes in this group are generally reserved for non-psychotic conditions such as depression and anxiety. This is because these conditions are misunderstood as a failure of character strength due to the belief that these are more controllable disorders. Thus, as the results advocate, more knowledge about and, especially, more experience of people with such conditions should help to protect against such inaccurate and authoritarian appraisals of non-psychotic conditions, as well as mental illness in general. These factors may also aid in promoting benevolence (an area that needs more addressing for men than women) and in

reducing social restrictiveness, particularly within the older, less educated, first generation community.

The fact that Greek/Greek Cypriots scored comparatively low in terms of mental health knowledge and previous experience (tables 4.15 and 4.16), further advocates the need to improve knowledge and understanding about mental health in this culture. Such low knowledge and experience levels can be interpreted as a possible cause and consequence of the concealment of a mental health problem, due to the likelihood of it being stigmatised - a frequent cultural endeavour already revealed by previous research (Dunk, 1989; Papadopoulos, 1999; Madianos et al, 1987) and by this study's qualitative interviewees. One particularly striking qualitative account that reflects such themes was provided by the Greek interviewee 'HM' (see 4.2.2.3.4) who had recently learned that her family, due to stigma and shame, concealed the existence her cousin who had died years earlier from a mental illness, while her first-generation mother who suffers from depression does not fully understand or accept this affliction. This is not the first time that relatively low levels of knowledge in this culture have been revealed. Psarra et al (2008) found a lack of information and education about mental health issues in a sample of 156 Greek policemen, concluding that there is a clear need for more and better educational programs in the mental health field for police officers, which can be seen in England and the USA (Pinfold et al, 2003; Daniel, 2004). Furthermore, Papadopoulos et al (2002) found that compared to white-English participants, UK-based Greek/Greek Cypriots held significantly lower levels of mental health knowledge and previous experience.

However, despite these problematic areas, there is also reason for optimism. As already stated, the CAMI scores for this group were surprisingly positive. Improving attitudes have also been reported in a longitudinal cohort study by Madianos et al (1999). They placed partial explanation for this on the systematic implementation of various mental health anti-stigma initiatives and governmental reforms. This is supported by Bellali and Kalafi (2006) who examined Greece's psychiatric care reforms and stated that "significant progress has been made in the provision of mental health services" (p34). Psara et al (2008) stated that one of most effective initiatives has been the deinstitutionalisation of the mental health system, highlighting significant decreases in psychiatric hospital beds over the last ten years as a consequence of a more community-centred care philosophy currently existing. Their inquiry also revealed that there has been more government funding towards establishing autonomous ways of living for the mentally ill, such as sheltered apartments and boarding houses. Such processes are likely to increase the community's contact with people with mental health problems, despite the high levels of social distance that the general Greek public appear to desire for (which, according to the qualitative interviewees, is particularly true for those with psychotic disorders as these are perceived as particularly threatening to safety). Indeed, unlike the 2002 study, there are now no numerical or significant differences in mental illness contact between this group and the white-English group (see table 4.15). Specifically, 66% of the Greek/Greek Cypriots in the quantitative survey reported a prior experience with mental illness, which is only slightly lower than the white-English group (72%). Thus growing contact levels, positive mental health care reforms, anti-stigmatising mental health campaigns and increasingly optimistic public attitudes are providing hope that the lingering presence of mental illness stigma, particularly in terms of

authoritarianism, social restriction and distance, are slowly being reduced in this culture.

5.2.3 What factors (excluding individualism-collectivism) explain mental health attitudes? An examination of the Chinese cultural group

The analyses of explanatory factors within this group revealed in many respects a similar story of mental health stigma determinants seen in the Greek/Greek Cypriot group. For example, the quantitative analysis revealed that the younger, second/third generation, more UK-acculturated Chinese participants (whose first language is also more likely to be English) are more likely to hold more positive attitudes towards mental health problems. This generational divide is demonstrated further by the finding that Chinese participants who have lived most of their lives in the UK are considerably less likely to be stigmatising, especially in measures of authoritarianism and benevolence. This disparateness in attitudes is likely due to the fact that lower mental health knowledge and educational levels exist within the more traditional, first generation Chinese, probably because many of these immigrants have not been afforded the same level of education that members of the next generation have in this country. This is not because of any difference in education quality between the two countries, but rather a consequence of the type of older Chinese immigrants who live in the UK. According to Baker (1994) and Jones (1985), these immigrants predominantly consist of those from low income, rural, agricultural backgrounds, and unskilled, male, post-war labourers, many of whom were recruited into the UK's catering business finding work through collective kinship networks. A further potential explanation for such difference could lie in the fact that the younger,

second/third generation Chinese are known to be excelling in British schools (Office for National Statistics, 2005) which appears to be helping in producing more enlightened attitudes towards mental illness. One should also not overlook the potential impact of poorer written and verbal English skills that often exists amongst many older, first generation Chinese migrants. This is a notion known to impact the sphere of mental health in a number of ways, including the impact it has on mental health service utilisation. As Blignault et al (2008) explain, Chinese immigrants who have difficulties grasping the English language are much more likely to find it difficult to understand the healthcare system of an English-speaking country, consequently not accessing services when and as often as they should. Pirkis et al (2001) argue that this can produce a multitude of potential negative outcomes including the exacerbation of a condition gone untreated and the missing of an opportunity to improve one's knowledge about mental health knowledge on a scientific and evidence-based level. Blignault et al go further to show that even when services are accessed, immigrants and the service providers face another set of difficulties ranging from the communication with clients to a lack of cultural competence in staff.

Associated with the above were the findings that this cultural group generally held low levels of mental health knowledge and previous experience. These two measures are strongly associated with each other (table 4.16), since if one lacks knowledge about mental illness, he/she is less likely to have encountered it, and is less able to correctly recognise it. Indeed, this group scored the lowest mean and median knowledge and experience scores across the four cultural groups (tables 4.14 and 4.15). The notion that the Chinese are relatively lacking in mental health knowledge

was substantiated by the data from the qualitative in-depth interviews. The consensus among interviewees was that there is a lack of 'scientific' and 'practical' knowledge with regard to mental illness, particularly in rural, less affluent areas, where it is instead viewed as a moral problem and character flaw. These findings are supported by previous research literature. For example, Song et al (2005) found that the Chinese commonly view mental illness as directly related to moral judgment as well as supernatural factors, rather than in a scientific, evidence-based manner. Both Li et al (1999) and Kwok (2004) also found that the Chinese are provided little education about this area and thus possess little knowledge about the various degrees and types of mental health problems, consequently intensifying mental health stigma. Hsiao et al (2006) explain that a key problem is the false traditional Chinese assertion that psychotic illnesses are the only types of mental illness, and that non-psychotic illnesses, such as depression, are physical illnesses. They argue that such a poor level of understanding may result in delaying the use of mental health services, which undoubtedly compounds the problem. In terms of the low experience levels of this group, as previously stated, this may reflect a relatively poor ability to successfully label a condition as a mental health problem. Indeed Klimidis et al (2007) reflect just this, when they found that in a large-scale Australian-Chinese sample, the Chinese do not accurately label mental disorders such as depression and schizophrenia, particularly when compared to their Australian cultural sample, mainly due to their poor mental health knowledge. The existence of such a low experience score may also reflect successes in concealing recognised mental health problems in the Chinese culture. It may also signify a psychological reluctance to admit to the awareness of mental illness, both towards themselves and other in-groups, due to the potential

stigma, shame, and loss of face; processes supported by the qualitative interviewees and previously established in mental health research in this culture.

In summary, there appears to be a need for this cultural group to continue replacing the traditional, stereotyped, character-appraising view of people with mental health problems with a more scientific, knowledgeable, and objective understanding of these issues. This has arguably been started with the younger second/third generation Chinese, who are less stigmatising, more knowledgeable, and generally better educated about mental illness than their first generation, Chinese elders. Face-saving, shame, and fear of stigma from other Chinese remain salient that, in conjunction with their poor understanding of mental illness, are likely instigating concealment which perpetuates stigma and potentially inhibits beneficial service utilisation.

5.2.4 American and white-English mental health attitudes level and type

According to the quantitative survey results, these groups' mental health attitudes were significantly more positive and less stigmatising than the Chinese and Greek/Greek Cypriot cultural groups. Moreover, their CAMI scores were generally very positive, particularly within the American survey group. Although these results may provide an initial cultural representation of positivity and enlightenment, such generalised assumptions must be tempered by keeping in mind the nature of the American and English samples in this study which is neither accurately representative nor generalisable. What they instead may be considered to represent are people who are white, and from wealthier, suburban and/or urban regions. They also represent Americans from northern States. These are people known to hold less stigmatised

attitudes, and access professional mental health services more regularly than their poorer, southern and central-American, non-white counterparts (Schnittker et al, 2000). Nadeem et al (2007) corroborated this when they examined the extent to which mental health stigma accounts for the underuse of mental health services among low-income, American ethnic minority groups including black and Latina women. They found that compared to higher income white American women, black Afro-Caribbean American women were more likely to highlight stigma concerns, and that these and Latina women were less likely to want treatment for their mental health problems. Schnittker et al (2000) have also documented the divisions in mental health attitudes across the United States when they too substantiated that northern-Americans are more knowledgeable about, and significantly less stigmatising towards, mental illness. Ayalon and Arean (2004) have revealed that Caucasian Americans are more knowledgeable and less stigmatising, while Buys et al (2008) have shown that Americans from rural regions are culturally accepting of depressive symptoms. Such disparity in attitudes can also be found within the United Kingdom. For example, Wolff et al (1996) revealed that ethnic minority British people are more likely than indigenous white-British people to hold much more stigmatising attitudes, and to be generally less knowledgeable on this matter, while also more likely to object to stigma-reducing intervention campaigns. Marwaha and Livingstone (2002)'s study on the stigma experienced by depressed elders also revealed that white-British people are less stigmatising than their British ethnic minority counterparts.

Therefore, given the nature of the English and American participants in this study's quantitative survey, it is not surprising that the results are indicative of generally very positive mental health attitudes. Undoubtedly, a larger, randomised, general-

population survey may have produced less positive attitudinal scores. In spite of such a methodological shortcoming, this survey's results still provide a valuable story of modern-day mental health attitudes in Americans and white-English people from wealthier and more suburban/urban backgrounds; factors which are known to represent more progressive and tolerant views of mental illness. Indeed, this was also the account depicted by the American and English interviewees within the qualitative component of the study. They too described a generally positive and liberal portrayal of mental health attitudes, particularly towards 'less severe', non-psychotic disorders. Interviewees from both groups concurred that attitudes for conditions such depression and anxiety are generally more positive than ever before. The American interviewees went further to state that these conditions are relatively commonplace in today's American society, and as such have become normalised and less stigmatised. They also concurred that while there has been attitudinal progress on a general level, people living within more urbanised, affluent, northern American regions have progressed the most and hold much more accepting and tolerant views of mental illness than those from the poorer, lower class, Southern regions. The English interviewees, however, were less divisional in terms of geography and more general about their optimistic appraisals of increasingly tolerant attitudes towards mental illness in the United Kingdom. Interviewees from both groups also emphasised that their countries are in general less stigmatising compared to many other nations. These themes therefore support the optimistically positive appraisals of mental illness found within the quantitative survey.

There are also several research studies which corroborate these optimistic notions. For example, Dinos et al (2004) qualitatively examined the stigmatisation level and type

within 46 British people afflicted with some sort of mental illness (36 of whom were Caucasian). They found that although stigma was a concerning phenomenon for nearly every interviewee, particularly those with psychosis or drug dependence, their analysis revealed that most interviewees did not experience a great deal of stigma within the British culture. They stated : "Very often participants' discourses were not negative and were not related to stigma...people with depression, anxiety and personality disorders did not express very strong views about the general public and did not appear to have undergone the same degree of discrimination [compared to those diagnosed with psychotic or drug dependence disorders]...Some had even received positive reactions from others...and expressed the opinion that the general public was positive towards people with mental illness" (p179-180). The authors also found that a significant number of their interviewees (including those with psychosis) had little difficulty in disclosing information about their mental illness and did not feel any shame or anticipate negative reactions from the British public. Many also stated that their illness did not prevent them from achieving things at a social or a personal level. Further evidence of an increasingly non-stigmatising British culture comes from the UK's Department of Health (2007). Their large-scale, generalisable, quantitative survey of public attitudes towards mental illness in 1,700 UK-based participants also revealed relatively tolerant and positive attitudes. For example, they found that the large majority of their participants disagree with both the view that people with mental illness are a burden to society (78%), and the view that such people do not deserve our sympathy (87%). Kessler et al (2008) examined and compared the dynamics of mental and physical illnesses/disabilities in low, middle, and high-income countries. They found that in the latter, such as the UK and the USA,

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treatment-rates for such disorders, although far from ideal, are considerably higher than compared to low and middle-income countries, such as China.

The assertion of a relatively healthy level of service utilisation in the American and English cultures was supported by interviewees from both of these groups in this study. They argued that if a mental health problem developed in a family member, they would ideally seek professional psychiatric services. American interviewees went further to state that the act of voluntarily seeking a psychiatrist or psychologist for one's depression, anxiety, eating and/or sleep disorder is becoming increasingly more normal and commonplace in the American culture. This is because the welfare of the individual is considered first, despite the presence of any potential stigmatisation from people in their extended family, network of friends, work colleagues, or community. This attitude was also revealed to be prevalent within a study conducted by American Psychological Association (2004) when they found that mental health stigma is now less of a hindrance than ever before in terms of people seeking and obtaining mental health treatment in the United States. Their findings revealed that nearly 500 out of 1000 randomly sampled adult Americans reported a visit to a mental health professional by someone in their household this year. In addition, over 900 of those sampled stated that they would personally consult mental health services, or recommend them to a family member, if a mental health problem was experienced. Nearly half of their participants also agreed that mental health stigma towards accessing services has decreased in recent years in the United States, while two thirds of these participants agreed that they would not be concerned if other people found out about them accessing mental health services. More telling evidence comes from a recently published study by Golberstein et al (2008) who investigated

the associations between perceived public stigma and mental health care seeking in a large sample of American undergraduate and post-graduate students (n=2,782). They found that perceiving stigma as an obstacle in seeking treatment was mostly a belief only held by older, male, non-white students, as well as international students, those from lower socioeconomic backgrounds, and students with less experience about such services. The authors conclude that while stigma is still an important phenomenon within the American culture, its power as a barrier to mental health care may not be as a strong and pervasive as currently assumed.

While this study and recent research studies examining mental health attitudes in the American and British cultures bestow a degree of optimism, mental health stigma remains present and harmful in these two cultures, especially with regard to psychotic disorders. For example, the qualitative interviewees argued that the presence of stigma is still generally prevalent across both these cultures, albeit less so than in the Greek/Greek Cypriot and Chinese cultures. Moreover, interviewees argued that psychotic disorders such as schizophrenia are publically seen in a more negative manner, particularly when hospitalisation is required. Consistent descriptions of fear, danger, and the need for social distance, across the socio-economic spectrum, towards those with such disorders were provided. They also argued that those currently or previously afflicted with a psychotic disorder are less likely to marry, find employment, and generally prosper in society. These suggestions support a large collection of previous research findings that underline how psychotic disorders such as schizophrenia is generally associated with the most negative evaluation of competence and dangerousness (Pescosolido et al, 1999; Link et al, 1999; Wang et al, 2007). Certain sub-groups within these cultures are also likely to suffer from the fear

of stigma, such as military personnel who have been afflicted a mental health conditions. A report by Tanielian and Jaycox (2008) highlighted the 'invisible wounds' that are occurring in at least one in five military personnel; specifically those of post-traumatic stress disorder and major depression. They found that that the fear of being stigmatised played a significant role in preventing nearly half (47%) of personnel in accessing professional services.

The qualitative analysis also suggested that being publicly open about receiving psychotherapy was generally much more of a difficulty within the English culture than the American culture as they felt that personal privacy matters more, and that stronger negative stereotypes of psychiatrists exist within the English culture. Such views are supported by Morgan (2006) who argues that such practitioners in the UK are still being viewed with a large degree of public stigma. He too suggests that this problem partially lies within the lack of openness that British people suffer from, since seeing such therapists is an extremely intimate process that requires delving into one's innermost thoughts. A recently published study by Vogel et al (2008) found that the view of psychotherapists in American culture is also not entirely positive, and that it may have become more negative in recent times partly through popular television American sitcom programmes. They found that the portrayals of psychologists in such programmes may contribute to an unfavourable perception of mental health services, since therapists are generally portrayed unethically (sleeping with clients, implanting false memories, talking about clients outside the session).

Overall, it appears that the findings of this and other relevant, recent research studies, portray an optimistic view of mental health attitudes in the American and English

cultures; one which is progressive and increasingly tolerant towards mental illnesses, in particular non-psychotic disorders. However, evidence also indicates that stigma is generally still existent and in many respects damaging, especially within non-Caucasians and ethnic minority enclaves, and other specialised groups such as military personnel and those from more rural and poorer socioeconomic backgrounds. These and other explanatory factors are examined in greater detail below.

5.2.5 What factors (excluding individualism-collectivism) explain mental health attitudes? An examination of the American cultural group

A number of quantitative and qualitative explanatory factors were found to be associated with the mental health attitudes found within the American sample. One such quantitative factor was the acculturation indicator: 'percentage of lifetime spent living in the UK'. Conversely to the Greek and Chinese cultural groups, it was revealed that the more time this group had spent living in the UK, the more negative their measures of authoritarianism, social restrictiveness, and community mental health ideology were. Indeed, this was the only factor found to independently predict levels of social restrictiveness. This suggests that the longer an American spends in the UK, the more closely their mental health attitudes align to white-English attitude levels. Although this suggests that UK-acculturation has a negative attitudinal impact on this group, this relationship should be treated tentatively since this is the only quantitative factor which is indicative of acculturation level. A supporting indicator of acculturation affect would have been if any differences were found between generations. However, since these participants were all first generation Americans, all of whom born in the United States, such analyses were not possible. Furthermore, the

composition of this group was notably younger than the other cultural groups. These are two factors that reflect a relatively young and new UK-living American population, particularly those migrants who are younger adults working in the City of London (Smith, 2008). Furthermore, despite the negative relationship between lifetime spent in the UK and stigma attitudes, it should be highlighted that those Americans who have lived in the UK longest still held much more positive mental health attitudes than participants from any of the other cultural groups (table 4.10).

The other quantitative factors revealed as important in this group included highest educational level, previous mental health experience of, and current knowledge about mental health problems. These are certainly not surprising explanatory factors as they have been found to be important in a plethora of previous research studies (Wolff et al, 1996a, 1996b; Griffiths et al, 2008). They are factors that are likely to be important across most cultures and other sub-groups in terms of calculating mental health stigma levels, since it is logical that when people are more versed and knowledgeable about mental illness, they are less likely to fear and stigmatise it, since it is less of an unknown. Further corroboration of this association is the fact that the American group were the most generally educated, most knowledgeable and most experienced about mental illness compared to the other cultural groups; accordingly, they held the most positive and non-stigmatising attitudes. Knowledge and educational level were factors particularly strongly associated with the authoritarianism construct, since these two factors independently predicted authoritarian attitudes from all other factors collected in this quantitative survey. What these results do not indicate or conclude, however, is a complete causal relationship between these factors and authoritarianism (or any of the other CAMI constructs). The regression model statistics show that while these

factors are significant predictors of authoritarianism, the overall regression model power is only 50% (N R² = .500). Therefore, in terms of understanding what predicts authoritarianism (and the other CAMI constructs), there is considerable unaccounted-for predictive power. The finding of considerable unexplained variance (2LL = 71.446) substantiates this, as does the fact that the confidence levels of these explanatory factors are not particularly tight. Thus, although factors such as educational level, knowledge, and experience must be considered critical to our understanding of stigmatising attitudes in this cultural group (and others), they are unquestionably not perfect or sole predictors of mental health attitudes. It is for these reasons that a qualitative examination of cultural stigmatisation can be useful, since the unaccounted-for variance in understanding authoritarianism (and other attitudinal constructs) can be explored.

Another potential explanation for such positive CAMI survey attitudes in this group was identified in the qualitative analysis: the existence of frequent pharmaceutical television and newspaper advertisements which has led to a growing 'normalisation' of disorders such as anxiety, depression, and hyper-active attention-deficit syndrome. Interviewees also argued that it was these kinds of non-psychotic, 'less severe' conditions for which most cultural acceptance is reserved for, as these are increasingly being viewed as commonplace, manageable, and 'normal'. They explained that this is because drug marketing campaigns are reaching out to the general public and reducing societal stigma through educating them about the existence and nature of such disorders. The potential stigma-reducing effect of the media advertisements has been previously credited by the APA (2004). However, researchers such as Mintzes (2002) and Boddenheimer (2003) warn about the

consequences of such advertisement campaigns, arguing that while such advertisements have significantly increased consumer demand for psychiatric prescription drugs, they have done so by misleading consumers to make requests for products that are in fact often unnecessary and/or less effective than non-pharmacologic treatment options. Frosch et al (2007), who highlight that the United States and New Zealand are the only two developed countries in the world that permit 'direct-to-consumer drug advertising', also question the positive value of such campaigns, arguing that while they do educate the public, this is only to a limited degree as the information about the actual causes of a particular disorder are not provided. They also argue that characters are commonly portrayed as having lost control over their social, emotional, and physical lives without medication, and as such minimise the value of health promotion through alternative lifestyle changes. Strange (2007) goes further to call for a ban on direct-to-consumer drug advertising, stating that "overt and covert appeals to seek drugs should not be confused with legitimate desires to improve knowledge of health and illness, reduce symptoms, improve health, empower communication with health care professionals, and gain social approval or a sense of control of life. Ads designed to sell drugs are not our unbiased allies in improving health care or health" (p102-103). The existence of a pro-drug American society was further supported by the interviewees' assertions of medication for a mood or anxiety disorder being relatively easily acquired, due to the fact that medical insurance policies, often provided by employers, pay for prescription drugs that otherwise may be unaffordable. The prominence of such a pro-drug culture therefore could be argued to be providing positive benefits in terms of increasing public awareness on a multitude of mental health problems. As awareness and knowledge are two key factors known to reduce stigma, there is a case to be made

that, while there are some important detrimental consequences, such a large pro-drug culture plays some part in reducing some of the stigma attached mental health problems.

5.2.6 What factors (excluding individualism-collectivism) explain mental health attitudes? An examination of the white-English culture

The general stance of these interviewees was that the public's view of mental health problems, although still regularly stigmatised, is at a level of tolerance and positivity that has never previously existed in the English culture. A lot of emphasis for why such progression has occurred was placed on the informative articles about mental illness found in England's popular broadsheet newspapers, the internet, and television documentaries. The 'National Institute of Mental Health in England' have also recognised the importance of the media in this area and in 2004 launched the anti-stigma campaign 'SHIFT' which includes a specific target of encouraging and promoting better and fairer media coverage of people affected by mental health problems. Meek (2006a; 2006b) examined such UK anti-stigma initiatives and concluded that campaigns such as 'SHIFT' and other media enterprises are being effective in reducing mental health stigma as they are successfully increasing public knowledge, awareness, and bringing mental illness to the forefront of a public issue. He argues that the mediums of television and film are two of most important channels for outreach and stigma reduction, since they are able to raise awareness and influence public perception of how mental illness manifests and how they are treated. A recent report by the UK's Office for National Statistics (2007) provides further support for media being effective in increasing positive attitudes among the English population.

Their large-scale quantitative survey of the English public's attitudes towards mental illness revealed that over half (56%) of their sample had perceived some sort of media publicity in the last few years on mental illness (most credit went to the television news and national newspapers), and that nearly half of these people believed that the media impacted upon their attitudes in a positive manner. A slightly larger proportion cited that this publicity had no effect on their attitudes, and only a very small proportion stated that this publicity increased their negative attitudes.

Therefore, it is possible that this study's survey results, which disclose a moderate level of tolerance and benevolence for this group, and the optimistic comments made by the English interviewees, are at least partially the result of the media increasing public knowledge by generating awareness and critical discourse on this issue. Further, if the media is generally producing a positive effect, with knowledge and understanding increasing as a result, then it is also logical to assume that any negative public depiction of mental illness (which is also commonplace within the media) may be being more critically challenged than ever before. Indeed, Thornicroft (2006), a leading British researcher in mental health attitudes, argues that how people interpret information received from the media, whether positive or negative, is usually dependent on three factors: our pre-existing background knowledge of what these diagnoses mean, our attitudes on what emotional reactions toward mentally ill people are socially acceptable, and our understanding of what types of behaviour towards people with mental illness are socially allowed. Thus, if the English public is presently more knowledgeable, empathic, and tolerant towards mental illness, any negative, stereotypical, media depictions that are presented are less likely to be accepted and more likely to be critically considered.

The notions discussed above suggest that the value of mental health knowledge in affecting attitudes cannot be understated. Its importance as an explanatory factor for this culture is also demonstrated within the quantitative analysis, as the 'mental health knowledge' variable was found to significantly positively correlate with lower authoritarianism and social restrictiveness, and higher benevolence and community mental health ideology (table 4.7). This variable was also revealed to predict each of these attitudes (except CMHI) independently of all other potential explanatory factors examined in this study. However, and unsurprisingly, it did not demonstrate a direct causal relationship with attitudes, and thus other explanatory factors must also be considered useful in predicting mental health attitudes for this group. Indeed, participants' educational level was revealed to be important as those with a higher educational level were significantly more positive in their attitudes towards mental illness in each of the CAMI constructs. This was also the case for those who scored higher on previous experience levels. These are not surprising findings as education and previous experience level has been found to hold significant importance in each of the cultural groups' analyses. They are also factors whose importance and power are well documented by many previous research studies both within this cultural group (Wolff et al, 1996; Papadopoulos et al, 2002; Dinos et al, 2004) and in general (Holmes et al, 1999; Corrigan et al, 2001). What was slightly surprising, however, was the finding that higher religiousness levels within the English sample significantly correlated to higher levels of social restrictiveness and less regard for community mental health ideology. These correlations were weaker in significance than mental health knowledge, experience and general education, and thus could be argued to be a weaker explanatory factor, yet it is still an interesting factor to

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consider. Leavey (2008)has linked the increasing use of religious and faith-based organisations to the transfer of Britain's psychiatric care from the institution to the community. Together with colleagues (2007), Leavey examined 32 various London-based male clergy (including Christian ministers, rabbis, and imams) and found that such clergy often play a prominent role in providing mental health care since many community members, particularly those from Jewish and Muslim backgrounds, prefer to primarily or only seek religious care as opposed to professional psychiatric services. For such people, the clergy are seen as a better alternative than the psychiatric professionals who are evaluated as cold, mechanical, uninvolved and short-term. However, they found that clergy are generally not confident about managing psychiatric problems, since they are underscored by anxiety, fear and hold stereotyped attitudes towards mental illness. In addition, Leavey et al state "Generally, the participants had received little or no training in mental health as part of their ministry development. Possibly in consequence, evidence of psychological literacy was variable...The informants seldom differentiated between psychotic illness and the more common mental disorders such as depression and anxiety. Moreover, in describing those mental phenomena generally associated with psychosis, auditory or visual hallucinations, the boundary between neurosis and psychosis was often presented as blurred, if not inseparable." (p552). Leavey et al add that although clergy were naturally sympathetic towards those suffering from mental illness, they also held a fear of such individuals, and described views similar to the stigmatising stereotypes and fears that are common among the general population. Therefore, it is feasible that people who are choosing to access religious care over psychiatric care, or who choose to learn about mental illness primarily through religious channels, may be receiving information and care that is based less on accurate scientific evidence, and less likely

to reduce the stigma attached to mental illness. This is supported by Leavey et al who state that stigmatising attitudes about mental illness tend to initially determine religious, rather than a psychiatric help-seeking, and as such the process could be viewed as a 'vicious cycle'.

5.3 Individualism-collectivism as an explanatory factor of mental health stigma

In keeping with this study's original aims, the role of the individualism-collectivism paradigm and its potential associations with mental health stigma was also investigated. This was carried out using both quantitative and qualitative methods. For the former, tests of correlations between this measure and the four CAMI constructs were conducted for each cultural group. Where appropriate, logistic regressions for each CAMI construct were re-run in order to establish whether individualism-collectivism was explanatorily powerful enough to be an independent predictor of any or all of the CAMI constructs. Model strength was also re-examined to view whether adding this variable had increased overall model predictive power, and decreased unexplained variance. The qualitative examination involved analysing discourse themes that directly or indirectly referred to the impact that this paradigm has on attitude and/or stigma formation within each culture.

The results of these analyses partially supported the hypothesis that the individualism-collectivism paradigm can be applied to explain mental health stigma level and type. Statistically, the paradigm had a stronger impact within the Chinese and, particularly, the American sample groups, with both unaccounted-for variance in CAMI scores decreasing, and model predictive power increasing. For the American sample, the

paradigm was found to be effective in explaining authoritarianism, benevolence, and social restrictiveness. Conversely, the only CAMI construct which the paradigm significantly influenced within the Chinese group was CMHI. Its impact on this construct reduced unaccounted-for model variance and sharpened model power to the extent where the 'mental health knowledge' variable was pushed into significance as an independent predictor of CMHI attitudes. This again reaffirms the importance of knowledge as an explanatory factor in this cultural group.

More specifically, higher scores of individualism in these groups correlated with more positive mental health attitudes, whereas higher scores of collectivism correlated with more negative mental health attitudes. Since individualist values were also found to be prominent within the American group, this branch of the paradigm was considered more important in explaining mental health attitudes than collectivism. The opposite was true of the Chinese group, since collectivist values were found to be more encompassing of this group.

In contrast, the paradigm had little or no statistical effectiveness in explaining how Greek/Greek Cypriots and English groups stigmatise mental illness. One potential rationalisation for these differences could be that the American and Chinese groups scored the lowest and highest CAMI stigma scores respectively. This suggests that the paradigm's explanatory power corresponds to the level of stigmatisation within a particular culture. Indeed, the paradigm was found to independently predict three of the four CAMI attitudes within the Americans group, which was also found to be the least stigmatising group. While the Chinese group were the most stigmatising group, their scores cannot be considered to be extremely stigmatising. This fact may explain

why the paradigm could only independently predict one of the four CAMI measures in this group. These results also suggest that collectivism plays a more explanative role for groups that are strongly stigmatising, whereas individualism plays a more explanative role for those who are more positive in their attitudes towards mental illness. Indeed, where stronger attitudes about something exist, as does the extra scope for explaining it. If this theory is to be assumed, then it would also be expected the paradigm would be explanatorily effective for groups who are more stigmatising than the Chinese in this survey, and that their negative stigma scores would more likely correlate to levels of collectivism than individualism.

It is also likely that how individualistic or collectivistic a particular group is will associate with how explanatorily effective the individualism-collectivism paradigm is in explaining mental health attitudes. The fact that the paradigm was most effective in explaining attitudes within the American sample, and that this group's individualism score was considerably higher than any of the other groups' individualism-collectivism scores, supports this theory. Indeed, the notion that the more strongly individualist or collectivist a culture is, the more it is influenced by the paradigm's mechanics, is one which is also supported by many researchers of the individualism-collectivism sphere, including both Triandis (1995; 2001) and Hofstede (1997). However, the finding that the English group does not benefit from the individualism-collectivism paradigm as an effective explanatory factor is inconsistent with this idea since its individualism score was higher than the Chinese group's collectivism score. It is likely that this incongruity is the result of the English group scores reflecting horizontal individualism more than vertical individualism (these notions and findings are discussed further in section 5.4.1). According to Triandis (2001) and the findings

of Triandis and Suh (2002) and Yang et al (2007), in horizontal individualist cultures, people pursue their independence and uniqueness but emphasise a stronger preference for societal equality and community than those from vertical cultures in which hierarchy and class inequality is more readily accepted. Therefore, the hypothesis that people from individualist cultures are more likely to tolerate diversity and deviation from the norm because such cultures are more fragmented, due to the desirability of personal goals, holds more weight for vertical individualist cultures than horizontal-individualist cultures. This offers a reasonable explanation for why the individualism-collectivism paradigm was less effective for the English group compared to the Chinese group.

This study's hypothesis extends to the idea that collectivist cultures will be more stigmatising due to the lower levels of diversity and fragmentation usually found in such cultures, and the associative fact that people who deviate from the norm are more visible to the community due to higher surveillance levels. Thus, it might also be expected that the individualism-collectivism paradigm is more effective in explaining mental health attitudes within horizontal-collectivist cultures compared to vertical-collectivist cultures, since community strength is higher and cultural complexity is lower in horizontal-collectivist cultures. However, this study cannot directly evaluate whether such a difference exists, since both the Chinese and Greek/Greek Cypriot cultures sampled in this study are both generally more vertical than horizontal-collectivist cultures (see section 5.4.2). One may argue that this hypothesis lacks some credence when considering that the Greek/Greek Cypriot sample scored slightly higher than the Chinese group in horizontal collectivism, yet the Chinese group were found to be more stigmatising. However, it is possible that the

negative impact of poorer knowledge, education and personal experience levels about mental health problems in the Chinese sample overrides the explanatory power of the individualism-collectivism paradigm in this culture. Indeed, these factors have been shown to be more consistent statistical predictors of CAMI attitudes in this group than the individualism-collectivism paradigm. Furthermore, although the Greek/Greek Cypriot sample did score higher than the Chinese in the horizontal measure, this was a small difference, and cannot be used to dispute its vertical collectivist nature. Indeed, as this survey incorporated non-randomised, non-representative methods, none of the statistical results can be accurately generalised to the wider population. Additionally, the findings of all previous research literature point to the Greek/Greek Cypriot culture being one which is more vertically than horizontally orientated (Triandis and Vassiliou 1972b; Triandis, 1995; Broome 1996; Koutsantoni, 2005).

However, the quantitative survey finding that individualism-collectivism does not play a role in mental health attitude formation within the English and Greek/Greek Cypriot culture should not be unconditionally accepted. On the contrary, according to the qualitative interviewees from all four cultural groups, individualism-collectivism was argued to play an important and multifaceted role in their cultures. Specifically, the qualitative analysis revealed the following themes that associate with individualism-collectivism and how these impact on mental health stigma: cultural complexity, traditionalism, community surveillance level, and geography (rural versus urban differences). These themes are discussed below.

5.3.1 The interrelated roles of community surveillance, ruralism/urbanism, conservatism/liberalism, and traditionalism/modernism in understanding mental health stigma

The majority of qualitative interviewees from each group argued that this paradigm does impact on the level and type of mental health stigma in their cultures. This included interviewees from the English and Greek/Greek Cypriot cultures whose survey attitudes were not statistically associated with individualism-collectivism. Some of the interviewees were aware of the individualism-collectivism paradigm and thus referred to it in a direct manner when they were asked about their opinions on what causes the attitudes towards mental health problems in their culture. However, most interviewees, particularly from the Chinese and Greek/Greek Cypriot groups, referred to the paradigm in an indirect manner, proposing ideas and stating opinions that corresponded to several established and previously identified important concepts that associate with the individualism-collectivism paradigm. One of these was 'community surveillance' – the idea that there exists differing levels of surveillance between members of the public in cultures and communities. This study's original hypothesis was that collectivist cultures would be more stigmatising partially because of the likely existence of higher levels of surveillance in such cultures. With higher level and quality of surveillance comes extra visibility and therefore people's business and problems are more exposed and potentially known to their fellow community members. Consequently, the need and motivation to conceal a mental health problem is more likely, which of course causes many of its own problems, including the fear of accessing services, and denial of a problem due to shame. This was a process that was generally agreed to by the Chinese and Greek/Greek Cypriots interviewees since they

are themselves originally from collectivist cultures and thus more personally aware that such a process can and does occur. Indeed, several interviewees from both of these groups provided detailed descriptive accounts of personal experiences of the attempted concealment of mental health problems by their families, an act mainly motivated from their acute awareness of how their community and other important collectives would judge them (for example, family members, friends, colleagues, neighbours). Concealment was most likely to occur if the disorder was one regarded as 'more severe', and the negative consequences that could ensue, including damage on their family's respect, dignity, and face. American interviewees also agreed with such notions and processes and, frequently, without prompting, cited the Chinese and other collectivist cultures as examples of where community surveillance is high and where such after-effects can occur. Both English and American interviewees consistently agreed that surveillance is in comparison is generally both lower and damaging in their cultures. The consensus among American interviewees was that if a mental health problem occurred in their family, concealment would not be a priority act. Rather, accessing services and receiving as much help as possible was their main and primary motivation. The underlying reasons for this were clearly connected to the individualistic value of the welfare of the 'individual coming first'. Such notions were also found within the English interviewees although to a lesser extent. Instead, these interviewees, more frequently than Americans, indicated their unease about other people learning of their or their family member's mental health problem. However, since they also felt that their fellow community members are generally not extremely stigmatising of mental illness, their unease was more rooted within the idea of others invading their privacy. Indeed, the motivation for privacy in this culture was more apparent than within the American culture. This is a cultural value that has been

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documented before as important in the English culture. For example, Paxman (1999) argued that privacy is a defining characteristic of the English culture, adding that "the importance of privacy informs the entire organisation of the country, from the assumptions on which laws are based, to the buildings in which the English live" (p117-118). It is possible that these value differences reflect the vertical nature the American culture compared to the horizontal nature of the English culture. As Triandis (2003) states, horizontal individualists, while being self-reliant and unique, do not generally like the idea of 'sticking out'. Thus, the concepts of privacy and keeping affairs personal are more valued principles than in vertical individualist cultures. Indeed, the statement 'I like my privacy' is a measurement item found for horizontal individualism within Triandis' VHIC measurement tool used in this study. Hence, Americans, in comparison, care less about others knowing about their business including, from examining this study's discourse analysis, their mental health problems.

Therefore, the findings of the qualitative analysis supported the idea that community surveillance levels differ according to the general individualistic or collectivistic orientation of the culture, and that it is an important phenomenon when considering mental health stigma. The analysis also supported the idea that American and English cultures are generally individualistic, whereas Chinese and Greek/Greek Cypriot cultures are generally collectivistic (see section 5.4). However, the analysis also served to underline that, while examining differences on the general-cultural level can be useful , categorising in this manner is a broad and simplified process. Thus, while cultures such as China that are categorised as generally collectivist are indeed more likely to hold higher community surveillance levels than individualistic cultures, this

is not necessarily always the case. As Triandis (2006) outlined, different geographical areas within a country can significantly impact on whether processes such as community surveillance are likely to be low or high, since each area can vary in affluence, class, age, and a number of other social and demographic factors. One such factor revealed in the qualitative analysis that was particularly important when considering individualism-collectivism were the differences between rural and urban areas. Interviewees from all four groups agreed that mental health stigma is more likely to occur in more rural areas, where less awareness, knowledge and professional services for mental health problems are existent, and where surveillance of other peoples' affairs is more recurrent. Surveillance in rural areas is high because, according to previous literature (Chick, 1997; Triandis, 2001), and the views of this study's interviewees, people know each other and deal with the same small group of people all of the time, and thus there is less privacy and anonymity about one's affairs. This is intensified by the fact that in rural regions population density is generally much lower than in urban areas. Further, there are fewer lifestyles available since cultural complexity in rural regions is usually lower (Triandis, 2006), meaning that deviation from the norm is more visible. In contrast, urban people, while indeed having contact with many people on a daily basis (more than rural people), instead experience interactions that are substantially less profound and occur mostly between anonymous individuals. Certainly, the qualitative interviewees also indirectly argued that urbanism and cultural complexity were associated and that both of these factors are causes/antecedents to individualism. Further, the partially associated notions of low surveillance, found in urban areas, and 'social isolation' were stated as potential consequences of individualism. Therefore, the qualitative analysis revealed support for the above described processes.

The idea of geography playing a role in understanding stigma has been cited by previous research. For example, in an action-plan put forward to combat the stigma and discrimination held towards people suffering from HIV, Flowers (2006) described the importance of rural versus urban stigma differences, and revealed many of the same stigmatising processes as described above. For example, he argued that in rural areas, to be HIV positive is fundamentally different from living in cities such as London or Brighton. In these large cities with higher prevalence, there is increased access to HIV related social support, peer support and a sense of an accessible HIV positive subculture. Service providers are also more likely to be familiar with working with a range of HIV positive people. In areas of lower prevalence, individuals are more easily identified through social dynamics such as community surveillance. Furthermore, Flowers argued that for people who live in more urbanised areas of higher prevalence, the costs of disclosing their condition is less than those in low prevalence areas. This is because in rural communities, individuals are much more likely to suffer from HIV-related gossip, as they are relatively easy to identify due to higher levels of community surveillance and the lower prevalence of this condition amongst other people. The idea of a higher prevalence of health disorders in urban regions includes mental health problems, according to several previous large-scale research studies (Meltzer et al, 1995; Paykel et al, 2000; Lehtinen et al, 2003). Sundquist et al (2004) has gone further to reveal a linear association between increasing population density and first-admission rate for depression. In fact, according to Weich et al (2006), the evidence from the data collected from 7,659 adults in England is that living in the countryside may actually boost one's mental health, mainly due to the existence of more meaningful interpersonal relationships and

higher perceptions of safety. However, Brook (2006) argues that despite the potential

for better mental health, rural areas are problematic in terms of having less access to

appropriate services and significantly higher levels of mental health stigma and

discrimination, for the same reasons outlined by both Flowers' (2006), and this

study's findings. This within-cultural difference was cited by many interviewees,

particularly from interviewees who had migrated from rural areas to urban-London

and thus had strong personal insight on this matter. It is a finding that highlights that

collectivist groups can be found within cultures that are generally regarded as

individualist and reminds us that within-cultural differences can be equally as useful

as between-cultural differences in understanding mental health stigma level, type and

formation.

The qualitative analysis also revealed interviewees' beliefs that people from rural

areas are not only more likely to hold collectivist values, but also values that are more

traditional and conservative. These three notions have been previously argued to

correspond with each other (Triandis, 2006; Bush et al, 2008), since traditionalism is

usually more easily found within cultures that have a long and rich history which is

usually the case of collectivist cultures (see section 5.4.2). The analysis also suggests

that the likelihood of traditionalism and conservatism is amplified when considering

rural people who live in generally labelled collectivist cultures. Interviewees argued

that such people are more likely to view mental health problems in a less enlightened,

more stigmatised manner, compared to their more individualistic, liberal, urban

counterparts who embrace change and deviation from the norm quicker and with less

anxiety. The suggestion was that conservative, traditional people are more wary of

any modern-day threat to their established mode of life, including that made by

mental illness. In contrast, interviewees associated people from urban and/or individualistic cultures as being more likely to value modernism and embrace change. This is highlighted by the English interviewee 'AP' who states that English people are in general relatively accepting of modernity, "especially people from the big cities like London". The interviewees also argued that such people are more likely to be open-minded about mental health problems and as such less likely to fear and stigmatise such conditions. Research by Jost et al (2003) partially supports such assertions. Their systematic review found that intolerance of ambiguity, lack of openness to experience, uncertainty avoidance, need for personal structure, and the threat of loss of position or self-esteem all contribute to the degree of one's overall conservative values. They concluded that conservative values are aimed at reducing threat and uncertainty, which, according to this study's analysis, also likely extends to mental illness. An older research study by Altemeyer (1981) found that politically conservative individuals rank higher on right-wing authoritarianism, and are correspondingly likely to be more restrictive of personal freedoms and more ethnocentric. Cunningham et al (2004) substantiates this when they found that prejudice values toward many disadvantaged groups are more likely to be found within people who hold rigid and traditional ideologies. These studies together substantiate the possible association between traditionalism, conservatism and mental health stigma found within the qualitative analysis. However, these are findings that could be considered by some as highly contentious, especially since these studies have a political focus and thus the possibility of researcher bias. Therefore, it is important that, as in all research, to consider the objectiveness of the authors and question the neutrality of their positions.

Despite the possible associations between conservatism, traditionalism, ruralism, collectivism, and more prejudiced mental health attitudes, it is important to make the following reminders. Firstly, to this author's knowledge, there are no other research studies that have investigated the link between mental health stigma, conservatism, and traditionalism. Further, these associations are not quantitatively substantiated in this study, and the conclusions drawn from the qualitative analysis cannot be externally generalised with confidence. This is because only a relatively small proportion of discourse within each interview centred on these themes, and thus the depth of analysis associated with strong rigour is arguably lacking with regard to these specific themes, even though they were consistent and frequent enough to be considered as important sub-themes by this author.

In summary, the quantitative results indicate that the less stigmatising a culture/group is, the more likely individualism will positively correlate with attitudes, such as in the case of this survey's American group. Conversely, the more stigmatising a culture/group is, the more likely collectivist scores will positively correlate. This was partially reflected by the Chinese group but would likely be evidenced further by groups that are more stigmatising towards mental illness. The analysis also intimates that these correlations are more likely to exist if the culture is vertically individualistic or horizontally collectivistic. Where these correlations grow stronger, it is also likely that the paradigm's explanatory power will increase. The qualitative analysis revealed a number of themes that associate with the individualism-collectivism paradigm which important in our understanding of mental illness stigma on a between-cultural and, importantly, within-cultural level. Specifically, it illuminated the importance of the inter-related roles of surveillance, concealment, ruralism/urbanism,

conservatism/liberalism and traditionalism/modernism. Thus, it is clear that there is a reasonable level of evidence which supports the hypothesis that the individualism-collectivism paradigm at least partially associates with mental health stigma, and is a useful ingredient in furthering our understanding of the level, type, and formation of mental health stigma.

5.4 An examination of the American, English, Greek/Greek Cypriot, and Chinese sampled cultures

One of the original aims of this study was to identify where each of the four sampled cultures fit within the individualism-collectivism paradigm and to compare the findings with those from previous research. This was conducted for two main reasons: firstly, to provide a measurement scale to test mental health stigma against. Secondly, to provide a contemporary assessment of traditional labels, that is, that the English and, particularly, American, cultures are individualistic, and that the Greek/Greek Cypriots and Chinese are generally collectivist cultures. This is important because, as Triandis (2006) argues, a global culture has now emerged, with different cultures interacting with each other in more ways than ever before. Thus, it is likely that cultures are changing and as such it is important to provide up to date cultural data that is contemporary and reflects some of these potential changes. Associated with this was the goal of specifically examining whether and how acculturation affects the individualism-collectivism paradigm. This examination was conducted as it is an area that Triandis has previously stated needs further researching, and, since three of the four sampled cultures in this study are UK-migrants, the opportunity to assess the impact of acculturation existed.

Overall, the results of the quantitative analysis revealed support for the traditional labels of American and English cultures as individualistic and the Chinese and Greek/Greek Cypriot cultures as collectivist cultures. The contrasts in these groups' median individualism-collectivism scores were also found to be significantly different. The qualitative analysis revealed a more detailed picture the causes/antecedents, attributes, and consequences of the American and English cultures' individualism, and the Greek/Greek Cypriot and Chinese cultures' collectivism.

5.4.1 The American and English cultures and their vertical-horizontal individualism-collectivism (VHIC) value orientations

The quantitative survey found that, compared to the other sampled cultures, the American sample held the most individualistic and vertical value orientations. As stated in section 2.9.3, a plethora of previous research supports the notion that the American culture is generally a highly individualistic one (Markus and Kitayama, 1991b; Holt, 1997, Harewood et al, 1999; Triandis, 1995; 2006, Kitayama and Uchida, 2003; McCrae et al, 2004; Hoftede, 2008). A considerable amount of studies also document this culture's general vertical nature. Triandis (1995) was one of the first researchers to conceptualise the American culture as generally vertical, especially within the middle and upper classes. He based this assumption on Weldon (1984)'s and Markus and Kitayama (1991)'s findings that such Americans are offended when they are labelled as 'average', and would rather be cited as distinct, distinguished and 'sticking out'. Triandis argues that this is typical of vertical-individualistic cultures, as

such people want to do 'their own thing' but also be 'the best', while those from horizontal-individualistic cultures also want to do their own thing but at the same time emphasise the need for equality among others in their in-groups. Kemmelmeier et al (2003), who measured the VHIC nature of seven cultures at the individual and societal level, stated that "in brief, the psychological concept of vertical individualism values competition and outperforming others; horizontal individualism characterizes the desire to be unique and different from equal others; vertical collectivism includes valuing tradition and respect for the family; last, horizontal collectivism entails a sense of interdependence and connection with in-group members" (p312). They found that their American group (n=382) was individualistic and more vertical than horizontal, thus supporting this study's results and Triandis' previous assertions. However, like many studies that sample American populations, their participants were mainly of European/Caucasian American background and are therefore not representative of the widespread multiculturalism that presently exists in many parts of the United States.. For example, Hofstede (1997) has shown that Hispanic-American countries are substantially less individualistic than an American national sample. Vandello and Cohen (1999) also highlighted this when they found considerable individualism-collectivism variation between the northeast and southern American states (the former being much more individualistic). They argued that the 'Deep South' region is more collectivist because of their defeat in America's civil war, the institution of slavery, relative poverty, and the prominence of religion. They also identified higher levels of collectivism in California and Hawaii where there are many collectivist migrant populations. On the other hand, they argued that the 'Mountain West' and 'Great Plains' are the most individualistic regions in the United States. Triandis (2006) echoes such variances, stating that "it is important to

remember that there is much variability within any country. Thus, the United States, while generally high in individualism, is not uniformly individualist" (p213). This is an important point, particularly for this study as the sampled Americans were nearly all Caucasians with European ancestry and predominantly from the north-eastern American States which research has revealed to be particularly individualistic. Thus, the support offered in this study for the American culture being vertical-individualist can at best only be attributed to Americans with similar descent and background.

The quantitative analysis also found support for previous research that has labelled the English culture as individualistic (Gilani, 1999; Lewis et al, 2000; Orford et al, 2001; Ryckman and Houston, 2003; Hofstede, 2008) and more horizontal than vertical (Singelis et al, 1995; Kabanoff, 1997). The American qualitative interviewees, who were in an good position to compare and contrast the English and American cultures, consistently (although indirectly) agreed that the English culture is more horizontal than the American culture. It was also evident in the analysis that there more references by the American interviewees to terms such as 'self-reliance', 'competition', and 'on your own' when the American culture was described, whereas themes relating to socialism, community, and egalitarianism, were comparatively higher in when the English culture was evaluated.

As stated in section 2.9.4, Hofstede's (2008) scores of cultural dimensions for the United Kingdom were found to be similar to the scores of the United States, particularly with regard to individualism (UK: 89, US: 91). Triandis (2003) agrees that these two cultures are generally similar in this respect, stating that Americans should therefore find it relatively easy to work and adjust to life in the United

Kingdom, especially since both countries speak the same language. Indeed, when the American interviewees in this study were asked about their experiences of migration to the UK, they generally agreed that their transition to life in the UK had progressed relatively smoothly, attributing the similarities of the two cultures as a reason for this. These interviewees also valued the English way of life, learning to appreciate and, with enough time, assimilating the horizontal, more egalitarian, nature of the English culture into their personal value system. For example, 'CR' an American interviewee, expressed how happy she had become at "giving back" to the English society that she had felt had provided her with more social support than what she would have received in America. Indeed, the affection one holds towards a new host culture was identified within the qualitative analysis as a key factor in how likely cultural identity will be influenced by immigration to a new culture. These American interviewees who enjoyed the English culture also made clear that they had never been very patriotic even before immigrating to the UK. Indeed, this suggested that a low level of affection towards one's native culture may hasten the assimilation process of the host cultural values into their personal value system. The amount of time spent acculturating to a new host culture was also identified as an important factor. Its importance is reflected by the fact that the American survey group, who have generally not resided in the UK for much time (median = 4 years), remained much more vertical than horizontal. This group's general level of individualism is, however, unlikely to significantly change even when taking into account the effect of migration time and affection towards a native and host culture, since individualism is highly prevalent in the English culture. Significant change will instead be more likely to occur on the vertical-horizontal level, since these cultures differ in this respect, but enough time needs to have passed, as well as a positive affection held towards English

life. Berry (2001) also examined how migrants acculturate into a new, dominant, host-culture. He argued that when this happens, four processes can occur: they adopt the new culture (assimilation), reject the new culture (segregation), choose elements of both cultures (integration), or reject both cultures (marginalisation). Using Berry's framework, it would appear from the qualitative analysis that Americans tend to firstly integrate the two cultures, and, over time, potentially assimilate into the English culture.

Hofstede has linked the UK's high level of individualism with the high level of Christianity found in the UK. Indeed, nearly all of the English participants surveyed in this study were raised as a Christian, two thirds of who also stated that this was still a religious affiliation that they follow. However, this was not an antecedent of individualism stated by English interviewees in the qualitative component. Instead, interviewees cited capitalism as a main reason for the present individualist nature of the English culture. For example, the English interviewee 'AP' stated that if individualism relates to personal freedom, "then capitalism suits that, because it's all about the individual competing with other individuals to make more money". This highlights how it is logical that the English culture values individualism, since capitalism is, at least partially, a complimentary notion, and is an ideology that has largely been supported and embraced in England's present and past. Indeed, some of England's most noted philosophers in recent history have also described the presence and approval for capitalism and, indirectly, individualistic notions, including Thomas Hobbes, Jeremy Bentham and Adam Smith. The latter, for example, pertinently stated in his classic text 'An Inquiry into the Nature and Causes of the Wealth of Nations' (1776; chapter 2, paragraph 2): "It is not from the benevolence of the butcher, the

brewer, or the baker, that we can expect our dinner, but from their regard to their own interest." Macfarlane (1978) linked the notions of historical capitalism and present day English individualism when he provided evidence of individualism in Britain as early as A.D 1200. Macfarlane's findings indicated that only a family's oldest son inherited family land so that it would not be lost into several divisions. The other sons, who had through their family learned about having a good life, would have to work hard and pursue various entrepreneurial activities to become affluent; a factor known to directly associate with individualism. Thus, there are examples to support the notion of historical capitalism as an antecedent to present day English individualism.

The analysis of the qualitative accounts provided by the English interviewees also illuminated several components of individualism. One of the broadest and most important traits of individualism was found to be the goal of attaining independence and personal freedom. This proved to be a fundamental aspect of individualism as interviewees consistently connected the idea of being individualistic to the idea of leading a life free of collective influences and attachments. Several sub-themes of independence and personal freedom also emerged during the analysis, including placing primacy on personal goals over in-group goals (so long as no in/out-group obvious harm ensues), tolerating (and often valuing) uniqueness, and self-actualisation (learning about self-identity). These are themes that largely correspond to aspects of individualism, and support various pieces of previous research (Triandis et al, 1990; 2003; Singelis et al, 1995; Hofstede, 1997). Another important attribute of individualism was found to be the value of 'self-achievement' (prospering with no or minimal support from others), which linked to the American-specific individualism

attribute of the 'American Dream' – the highly valued principle of attaining social and economic success whatever the negative and hindering personal circumstances an individual may be in. This attribute reflects the vertical-aspect of the American culture since valuing competition, beating others, and viewing oneself as the best have been established as vertical characteristics, while they can also be argued to be underlying assumptions of the 'American dream'.

A number of potential consequences of individualism were also indirectly described by both the English and American interviewees. One of the most important consequences, especially in terms of how individualism explains mental health stigma, were statements that referred to relatively low levels of cultural surveillance (see section 5.3.1). The interpretation of the interviewees' discourse was that individualistic people do not strongly desire or need to closely monitor the affairs of other people in their in-groups. This is because such people are more self-orientated and thus reserve priority on monitoring their own goals and actions so to attain independence, self-achievement and self-actualisation. Thus, there is no real need to survey the affairs of others other than out of personal interest, and to evaluate whether others are doing better or worse in terms of social and economical attainment. Partially associated with low cultural surveillance was the idea that individualistic cultures are also more likely to suffer from social "disconnection" and stronger levels of loneliness than those from collectivist cultures. Specifically, the American and English interviewees described having only a few meaningful relationships with others. Explanations for this were centred on the existence of small families and having few real friends, the latter for which they indirectly blamed on their lives being too fast-paced due to their pursuit of self-achievement and other personal goals. They

explained that people are increasingly more likely to contact others through social networking websites such as 'Facebook' at the expense of real-life social contact as the pace of their lives make it difficult to do otherwise. Both Moody et al (2001) and, more recently, Sum et al (2008) supported that heavily relying on the internet for social networking increases emotional loneliness, despite the fact that these sites are essentially communication tools, since it reduces regular face-to-face contact which is necessary in decreasing emotional loneliness. A recent report by the UK's Office of National Statistics (2008) revealed that loneliness may be an increasing social trend in the UK as more people than ever before are living alone than ever before and that the average occupancy of households has fallen from 2.9 in 1971 to 2.4 in 2007. This is a problem that has been more strongly documented in the American culture. For example, McPherson et al (2006) compared national statistical data taken in 1984 and 2004 on friendships and social relationships and found that, on average, each American in 2004 reported 2.08 close friends that they felt they could discuss important matters with, whereas this number was 2.94 in 1985. This finding relates with some of the American interviewees asserting that people can "usually count their real friends on one hand". They also revealed that the number of people who said they had no one to discuss personal matters with more than doubled, to nearly 25%, and that family confidants also dropped. They concluded that a weakening of community connections is in part responsible for increasing social isolation. Indeed, a 'lack of community sense' was another socio-cultural phenomenon stated by American interviewees, particularly when compared against other less individualistic cultures and nations, including the United Kingdom which they viewed as more egalitarian and community orientated than the United States.

Other potential consequences of high levels of individualism were identified as various kinds of addiction and substance misuses. Interviewees partially linked these problems with adults who are socially isolated and lonely, an idea that has some credence in research literature, as loneliness and low levels of social support have been extensively shown to be detrimental for both mental and physical health for all types of people and in a number of areas. For example, Burgess et al (2008) conducted a large-scale survey on the mental health profile of callers to a telephone counselling service in Australia (also a highly individualistic country). They found that the most frequent callers were people who reported concerns with loneliness, physical illness and anxiety, concluding that decreasing emotional loneliness and increasing social support can have significant positive health outcomes. Cole et al (2007) have provided further evidence that loneliness damages health when they revealed a biological explanation for this association. Specifically, their study found that certain genes were more active in people who reported feelings of social isolation and that many of these identified genes have links to the immune system and tissue inflammation. Similarly to Burgess et al, they concluded that increasing the quality of friendships one has can be a crucial remedial process for improving one's health. Loneliness has also been shown to partially account for drug and alcohol misuse. For example, both McDade et al (2006) and Seitz and Stickel (2007) have argued that loneliness is an important (although partial) explanation for why older adults increase their alcohol consumption to unhealthy levels. Storch et al (2004) showed how loneliness partially predicted alcohol and drug use in a sample of 287 American undergraduate students, although only within female participants. In a culture where such substances are increasingly easy to obtain, it is perhaps not surprising that some Americans could turn to alcohol and/or other substances in the face of fervent

emotional loneliness and social isolation. This is a point that was also put forward by some of the American interviewees. For example, as 'NS' states, the philosophy in the American culture is often "I'm sad, I'm lonely, I need a prescription." The English interviewees, however, cited the problem of obesity in England's children and adolescents, placing indirect blame on the individualistic values that they are instilled during their socialisation. Indeed, Erez and Earley (1993), Triandis (2001), and Rudy and Grusec (2006) have all shown that child-rearing practices significantly differ between individualistic and collectivistic cultures; specifically, that in individualistic cultures, child-rearing is less authoritarian in style, and that less emphasis is placed on family conformity, obedience and dependability, while more is placed on self-reliability, exploration, and independence. Thus, at least in principle, such research and the findings of the qualitative analysis suggest that in individualistic cultures, as a young person slowly gains more independence and personal freedom, they might feel less careful about acting healthily, as well as less fearful of parental ramifications. As Zucker et al (2008) stated in regard to alcohol misuse: "it is a behavioural act and is more likely to take place among young people who act impulsively and who are interested in new sensations and new experiences" (p254). The links between harmful and/or unhealthy behaviour in young people and their levels of individualism-collectivism is an area that would benefit from future research exploration.

Two other potential consequences of individualism were identified during the qualitative analysis of the American discourse on culture and values. One of these referred to the idea of individualistic Americans experiencing harmful feelings of self-failure and lowered-esteem when they are unable to successfully realise their

independence, personal freedom, economic prosperity, and other attributes of individualism. This is also an area worth examining in future research as it poses a question not previously put forward: what are the potential negative consequences of an individualistic person failing to fulfil the values of an individualistic culture? The other potential consequence referred to the idea that disadvantaged people find it harder to prosper in such cultures. However, this appears to be specific to vertical-individualist cultures, since there are likely to be more supportive factors for the disadvantaged in horizontal-individualistic cultures where, in theory, they offer extra community support and service for those who are disadvantaged (Chen et al, 1997; Olsen, 2006; Triandis, 2006).

In summary, an interesting account of American and English cultural value orientations is provided by the interviewees of these groups and the existent supplementary research evidence. The quantitative analysis revealed that both of these cultures are generally individualistic, particularly the American culture. However, this assertion can only more confidently be made in reference to middle-class, urbanised, Caucasians with European descent. This and other cultural similarities partially explain why Americans will acculturate relatively easily to the English culture, although time and personal affection to their native and English-host culture may also influence this. As expected, many of the cultural antecedents, attributes, and consequences put forward by the qualitative interviewees that relate to individualism overlapped between these two groups. However, several differences were also identified which most likely associate with the fact that the American culture is vertical in structure whereas the English culture is more horizontal. Some of these differences pose questions that would benefit from future research.

5.4.2 The Chinese and Greek/Greek Cypriot cultures and their VHIC value orientations

The Chinese and Greek/Greek Cypriot cultural groups sampled in this study's quantitative survey revealed value orientations that were overall slightly more collectivist than individualist. Their differences in individualism and collectivism scores were less pronounced than those found in the English and, in particular, American groups for whom were far more individualist than collectivist. Most previous research suggests that these two cultures maintain a stronger level of collectivism than what is reported in this study. There are four potential reasons for this, all of which indicate that acculturation and/or globalisation has impacted on their levels of individualism and collectivism. Firstly, it is possible that, despite methodological limitations, this study's survey scores are accurately representative of these cultures' current individualistic scores. As previously discussed, globalisation is now a very real phenomenon which has impacted on cultural values in ways that have most likely eroded many traditional cultural values. This is particularly the case for cultures which have become more Westernised due partly to increased American mass media access which propagates American individualistic values (Triandis and Trafimow, 2001; Triandis, 2003; 2006). Indeed, according to Yang and Kleinman (2008), the impact of globalisation on China has greatly reshaped traditional Chinese society. This can be seen with their transition to a market economy, including an emergent private sector, new foreign investment, and imported Western cultural media. Zhou (2002), who extensively examined China and its level of collectivism, also argues that individualism is becoming increasingly popular in China, if far from

being prominent, especially with the younger generation. He too argues that this is potentially because of the recent transition to a market economy, culture exchange with the West, mass media, and the one-child policy. Further, those who live in urban areas within traditionally-labelled collectivist countries are especially likely to be influenced by Westernisation and globalisation. This is a notion that several Chinese and Greek/Greek Cypriots interviewees directly made. Secondly, these scores may be indicative of migrants who have successfully acculturated to the English-host culture. Indeed, compared the American migrants, the Chinese and, especially, Greek/Greek Cypriots in this study have resided in England for much longer, therefore providing the extra time necessary to integrate and/or assimilate into a new host culture. As previously stated, the qualitative analysis of the discourse centred on migrants' acculturation identified the amount of time one spends in a new culture as crucial to their level of acculturation, a factor that the Greek/Greek Cypriot and Chinese interviewees also repeatedly referred to. Thus, one could speculate that the groups' lower than expected collectivist survey scores are, at least partially, due to their successful acculturation into a more individualistic English host culture. Thirdly, acculturating to the English culture is likely to have a greater impact on values for people from the Greek/Greek Cypriot and Chinese cultures as the differences in cultures between these and the English culture, compared to the American and English cultures, are more pronounced. Finally, the type of Greek/Greek Cypriots and Chinese people that voluntarily migrate into an individualistic culture are less likely to be those bound by a strong level of cultural interdependence since they have chosen to leave many of their in-groups in search of a new life. Further, those who voluntarily migrate to a new culture are likely to be liberal-minded, risk-taking, and less conservative people, especially when the new culture is very different. These are

notions which are potentially associated with individualism (see section 5.3.1). This would imply that immigrants, especially those from a collectivist native culture entering an individualist host culture, may be more individualistically-orientated than their native counterparts to begin with. Triandis (1995) stated this when he considered the early American and British immigrants, who he concluded must be individualistically-orientated since they chose to leave their in-group(s) behind, breaking traditional behaviours, in hope for a more affluent, opportunistic life. Gerganov et al (1996) examined Bulgarian individualism-collectivism and found that collectivists were less liberal both politically and economically whereas those who showed a willingness to leave their country were significantly more likely to be more individualistic, since these people had intentions to initiate private economic activities in other countries with more opportunity.

However, even when taking into account the influences of globalisation and acculturation, this study's Chinese and Greek/Greek Cypriot survey samples remained more collectivist than individualist. There is an array of research evidence that supports this assertion (e.g., Triandis, 1995; 2003; Leung et al, 2001; Hofstede, 2001; 2008; Rose et al, 2003) (see sections 2.9.1 and 2.9.2). For example, Rose et al (2003) argue that although Greece is undergoing changes in its social values as a result growing urbanisation, it remains a traditional, collectivist culture with an emphasis on interdependence, concern for the in-group, duty, family, and respect; notions which this study's interviewees also cited. Bakopanos and Gifford (2001) revealed that parents frequently measure their personal success in terms of the successes and failures of their children and that a great part of the family's "activity and planning aims to secure the means for the child's advancement on which the family's

advancement is based" (p359). Consequently, high levels of parental involvement in child rearing and parent-dependence follow, placing the children in situation where they are expected to bring honour and respect to the family. These are clearly very collectivist cultural attributes which this study's qualitative Greek/Greek Cypriot and Chinese interviewees also emphasised. A more recent study by Wu and Keysar (2007) revealed contemporary and unique evidence of Chinese collectivism (and American individualism). They showed this by examining the ability of Chinese and Americans in taking other people's perspectives into account. Their results showed that the Americans, due to their individualistic cultural nature, are much more challenged in understanding someone else's point of view compared to the Chinese, are more used to doing this, due to their collectivist cultural nature. They stated that "the interdependence that pervades Chinese culture has its effect on members of the culture over time, taking advantage of the human ability to distinguish between the mind of the self and that of the other, and developing this ability to allow Chinese to unreflectively interpret the actions of another person from his or her perspective." (p605). The assertion that the Chinese culture remains collectivist in spite of the influences of globalisation is partially supported by Yang and Kleinman (2008) who found that 'moral' status and upholding face remain salient in modern-day Chinese culture. Thus is because many important psychological, social, and cultural structures are retained even in the face of rapid technological and economic advancement. Attributes of collectivism were also frequently stated by this study's Chinese interviewees, especially with regard to their native country. Most frequently stated were the notions of prioritising in-group goals and group interdependence, which included family loyalty and respect, regulated and controlled behaviour.

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The Greek/Greek Cypriot and Chinese interviewees were also asked about what has led to their current collectivistic attributes and orientations. Their explanations either directly or indirectly centred on (a) the effect that a long and culturally rich history has had on the perpetuating collectivistic values, (b) the increased likelihood of collectivist values in rural areas viewed as more   traditional, and (c) for the Chinese, the value impact that   their country's communist political system has had, particularly on the first generation Chinese. The latter antecedent was rooted in their beliefs that communism removes the emphasis away from expressing and pursuing individuality, instead placing primacy on the needs of country's collective will, both on an individual and societal level. These interviewees also commonly cited the potential consequence of individual and societal fear of breaking away from a collectivist ideology, particularly during Chairman Mao's regime which was perceived as a particularly strict regime focused on ensuring high levels of societal collectivism. A number of authors also assert that communism can create and perpetuate collectivist ideology. For example, Singelis et al (1995) included communism as an antecedent to vertical collectivism in their detailed examination of individualism and collectivism. Further, when Umpleby (1990) carried out opinion surveys in the old USSR, he found a high level of vertical collectivism which directly linked with its then communist political ideologies. Triandis (1995, p143) has argued that "democracy requires individualism. In those areas where collectivism is most strongly present, there are few examples of democratic regimes". Zhou (2002) agrees, arguing that since communist rule in China began in 1949, a series of collectivistic cultural attributes have ensued, which continue today in spite of the more recent socialist-economic reforms.

As stated, having a long and rich history was also found to be an antecedent to collectivism, with interviewees making clear this was a proud part of their heritage and that they therefore felt obliged to perpetuate cultural traditions. Indeed, cultures that have a long history are usually also those that are also currently traditional (Triandis, 1995; Hofstede, 1997; Fernando, 2003). Type of history is also likely to be an important antecedent to current individualism-collectivism levels. For example, in both Greek and, especially, Chinese cultures, many historical philosophers have emphasised collectivist notions as paramount to society and culture, such as Plato and Confucius (see section 2.5). These assumptions are strengthened when the English, and especially, American, cultures are considered as their history is shorter, and imbued with philosophies that emphasise the importance of individualistic notions (seen in works by Hobbes and Tocqueville, for example). Interviewees from both groups also asserted that in rural regions less affected by globalisation and urbanisation, levels of traditionalism are likely to be particularly high, and as such so will collectivism. These are associations that have been previously discussed in section 5.3.1 and show substantial credence to ruralism and traditionalism being interlinked and associated with collectivism.

The vertical and horizontal orientation of the Greek/Greek Cypriot and Chinese collectivism was also statistically assessed. With regard to the former, to this author's knowledge, this was the first attempted direct assessment of such orientations. Previous research studies have indicated through particular clues in research literature that the Greek/Greek Cypriot culture is more vertical than horizontal. For example, Triandis and Vasillou (1972b) showed that traditional Greeks submit to in-group authorities in power relatively happily. Broome (1996) similarly argued that Greeks

are not intimidated by status or hierarchy, and in fact readily comply with it. Hofstede (2008) reported that Greeks score highly on the 'power distance' cultural measure, meaning that they are likely to allow inequalities of power and wealth to grow within the society. Koutsantoni (2005), who qualitatively examined the academic writing style various Greeks in search of clues to Greece's cultural characteristics, revealed several themes that point to a vertical orientation, including the obligatory cultural act of acknowledging an individual's higher status, and that one lower in status may still have close ties with that person. These findings all suggest that the traditional Greek culture may be vertical since accepting inequality and socio-cultural hierarchy is a key facet of vertical cultures, an assertion that Neuliep (2005) also made in his useful review of intercultural communication. However, this assertion was not fully supported by this study's findings as the Greek/Greek Cypriot sample scored similarly in vertical and horizontal measures with the former very slightly more prominent. The less than expected vertical nature of this sample could reflect that this sample is not accurately representative of traditional Greek/Greek Cypriots. This is because (a) nearly 43% of the sample were born and raised in England, (b) as previously discussed, voluntary migrants from traditionally-labelled collectivist cultures may not be as traditional as their native counterparts since they have chosen to break away from their in-groups, (c) similarly to the American group, this sample may have at least partly assimilated the horizontal values that are present in English-host culture, and (d) the sampling methodology was not randomised.

The Chinese culture has instead benefitted from a more detailed examination of this area with the consensus being that this is generally a vertical-collectivist culture. For example, Triandis (1995), Chen et al, 1997), Pye and Lew (1998), and Matsumoto

(2001) have all stated that the Chinese culture is slightly more vertically-orientated even though authorities advocate horizontal themes (such as communism). The results of the Chinese Culture Connection (1987) study indirectly support this as it revealed that people from the Taiwan and Hong Kong are not tolerant of out-groups, are distrustful of others, and highly competitive. These were themes also stated by the Chinese interviewees in this study. Hofstede's (2008) cultural dimension scores revealed that the Chinese, similarly to the Greeks, are high on 'power distance', thus accepting and embracing power differences and socio-cultural hierarchy. These are values that are indicative (although not conclusive) of vertical cultures. Chen et al (2002b) agreed the Chinese only lean towards vertical-collectivism. Specifically, they found that most of their sample comprised vertically-orientated Chinese who supported their government's 'socialist' and 'liberal' economic reforms. In contrast, the horizontal collectivists were opposed to these reforms as they viewed these reforms as weakening solidarity and country cohesion. These were people famously seen protesting during the 1989 Tiananmen Square incident. This study's survey results showed that the difference between vertical and horizontal value orientations is not strong, although it does lean towards vertical collectivism, thus supporting previous research. Had the sample been randomised and taken place in China, it is likely that the results would have revealed a stronger vertical orientation, since this would have more accurately reflected an aspect of traditional values not potentially influenced by a horizontal, individualistic English culture.

In summary, the existing research consensus points to the Greek and Chinese cultures being vertical-collectivist in their value orientations. This study's findings concur that both the traditional and migrant Chinese culture leans towards such categories,

although probably slightly more so for the former since acculturation to the English-culture is likely to have had some impact on this sample, particularly those who have resided in England for longer and who hold affection towards the English host-culture. The Greek/Greek Cypriot interviewees make a good case for the Greek culture also being collectivist, which is substantiated by the quantitative survey findings. However, question marks remain over the vertical-horizontal orientations of the culture, since there are no research studies that directly measure this aspect of Greek culture, while this study does not show any discernable difference in such orientations. Globalisation has also likely impacted these groups' values, particularly those who reside in urban settings, consequently decreasing levels of collectivism. However, many attributes of collectivism remain salient in this group, possibly due to people from these cultures feeling obliged to perpetuate cultural traditions that are both rooted in history and felt with pride. Thus, a strong sense of community, group interdependence, and family loyalty and respect remain important cultural facets both within migrant and, especially, indigenous Chinese and Greek/Greek Cypriots.

Chapter 6: Conclusion

6.1 Introduction

As stated in the opening chapter of this thesis, the main objective of this study was to further our understanding of how complex cultural processes influence the stigmatisation of people with mental health problems, thus enabling to health-care professionals to be more culturally sensitive and competent when working with both patients and their families. To establish whether this objective has been met, this chapter will begin by discussing the contributions of this study with reference to the main findings. It will also discuss the limitations and will conclude by offering some recommendations for policy and practice as well as suggestions for further research.

6.2 The main findings: Their contributions and implications

The first aim of this study was to explore the levels and types of stigmatising attitudes present in four UK-based cultures: white-English, Americans, Greek/Greek Cypriots, and Chinese. This endeavour was undertaken in order to help inform mental health clinicians, and guide policy makers at a national and local level in making informed, practical decisions towards implementing more effective anti-stigma strategies (see section 6.3). The results are pertinent in relation to the white-English culture since to date there has been a limited direct examination of stigma level and type in this culture. Furthermore, the survey represented to my knowledge the first time that UK-based American migrants have been examined about such themes. Specifically, the results showed that the American cultural group held the most positive attitudes

towards people with mental illness, followed by those who identified themselves with the white-English cultural group, followed by the Greek/Greek Cypriot group, and, lastly, the Chinese group. While this ordering was not surprising, what were slightly unexpected were the latter two groups' attitude questionnaire scores, which suggested neutral to mildly positive evaluations of people with mental health problems. This may be indicative of a positive shift towards more tolerant attitudes having taken place within these cultures in recent times, possibly due to increased education (particularly when comparing the UK-born, second generation Chinese and Greeks to their older, first generation counterparts), knowledge and contact level, which have stemmed from globalisation, social capital increases, and anti-stigma campaigns. Nevertheless, the results from the qualitative analysis still indicated that people from their countries of origin continue to hold stigmatising attitudes, particularly in rural and more traditional areas, and that concealment, shame, fear, and loss of face, remain salient. Another implication of this aim's findings was that attitudes held within the white-English and American cultures are in general currently particularly promising. These groups' results also imply that attitudes have continued to move forward in a positive, tolerant direction, and should be viewed as evidence that stigma can be combated. Although there is still room for attitudinal improvement, particularly within certain sub-groups (such as rural, conservative, and those living in poorer regions) these participants' general regard and response to mental illness could be used as a positive template for others.

The second aim of this study was to explore the underlying cultural reasons for stigmatisation in the four sample cultures. Most of the socio-demographic and other tested explanatory factors integrated within the quantitative survey were revealed to

be at least significantly associated or correlated with one of the four CAMI stigma constructs (authoritarianism, social restrictiveness, benevolence, and community mental health ideology [CMHI]) across the four cultural groups. For the white-English group, not holding extreme religious values, possessing a good level of general education, and having higher and more meaningful levels contact with mental illness helped explain why this group's attitudes were generally positive. However, mental health knowledge was revealed to be the best overall explanatory factor, which the qualitative interviewees credited the broadcasting and newspaper media as the vehicles for helping them to develop it. This finding supports the recent Department of Health's (2007) English attitude survey finding which also found that the television and newspaper media have an important positive effect upon this group. This indicates that anti-stigma campaigns which have included initiatives on promoting fairer and more educated television and newspaper coverage of mental illness are having a positive and significant effect, and should be used more frequently.

Knowledge about mental illness was also revealed to be a strong explanatory factor within the American group although UK living-time and educational level were also meaningful factors. American interviewees also credited the media for their current level of tolerance for mental illness, although specific credit was directed at the extensive pharmaceutical advertisement campaigns which market treatments for various mental health problems, as well as the role of insurance policies in paying for many forms of treatment. The American interviewees explained that the latter factors have led to a current climate of 'normalisation' among many mental illnesses which, in turn, has increased openness and helped decreased public stigma. This may partially explain why UK-living time was significant, since the aforementioned

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factors are removed while living in the UK. Further, Americans acculturating to the English culture may become more private about their mental health problems, since this is a prevalent value in the English culture. There are several implications of these findings. Firstly, if mental health problems are normalised, public openness is likely to increase which should decrease stigma. Secondly, if the public are aware that treatments for mental health problems are free, they may utilise services more often which could accelerate the treatment process, returning the patient to acceptable levels of mental health thus decreasing societal stigma on the individual. The final implication is that these findings show evidence that successful acculturation may alter and align one's mental health attitudes to be more similar to those prevailing in the host culture.

In terms of Chinese attitudes, the level of education one holds was the most useful explanatorily factor. This reflects the generational divide between first generation migrants and the UK-born Chinese, since the latter are benefitting from an education that many of their first generation elders have not been fortunate enough to receive, and consequently developing less stigmatised and more liberal and accepting attitudes. The problem of stigma remains more strongly within the first generation Chinese whose general education and accurate mental health knowledge is comparatively poorer. Their poorer written and verbal English skills may also hamper service uptake and, when services are accessed, mental health professionals may struggle to effectively communicate with this group as well as appreciate their traditional cultural needs and values. Thus, anti-stigma campaigns need to be focussed on educating this sub-group about the meaning of mental illness and the ways to effectively view and manage it. Such campaigns should ideally be delivered in their

native language and by people they trust, such as their second generation Chinese, UK-born Chinese counterparts.

The generation divide described above was also found within the Greek/Greek Cypriot group, as being younger, second or third generation, being better educated, and having English as one's first language were all significantly associated with holding less stigmatising attitudes. The younger generation were also found to have better knowledge and experience levels than their first generation counterparts, while females in general were also significantly more benevolent. Another finding was the stronger prevalence of authoritarianism and malevolence attached to mental health problems that are perceived to be 'less severe' and controllable, yet also impairing of social functioning, while attitudes of social restrictiveness and community fear are more readily reserved for 'severe', psychotic, uncontrollable disorders. This implies that, as with the Chinese, the stigma problem is more strongly rooted within the traditional, first generation Greek/Greek Cypriots, particularly among the males. Thus, anti-stigma campaigns should target these sub-groups, with a focus on reducing fear of psychotic disorders and reducing authoritarianism towards mood, anxiety, and personality disorders. This should be performed through providing evidence-based knowledge and extra contact with various forms of mental illness, so that familiarity and knowledge can be increased Indeed, anti-stigma initiatives and positive governmental reforms in Greece are currently underway which aim to increase awareness, contact, and knowledge about mental illness in a hope to cultivate more enlightened attitudes. Based on this survey's results and recent research (Madianos, 1999; Bellali and Kalafi, 2006; Psara, 2008), there are encouraging signs that such initiatives may already be having a positive impact, however these need to continue.

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The third aim was to explore whether and how the individualism-collectivism paradigm can help to explain mental health stigma. To this author's knowledge, this research question has not previously been explored. The results revealed partial support for the hypothesis that this paradigm can explain mental health attitudes. The paradigm was statistically robust in the Chinese sample and, and, particularly, American sample, although not the white-English and Greek/Greek Cypriot samples. Higher levels of individualism correlated with more positive attitudes, whereas higher collectivism positively correlated with more negative attitudes. It was accordingly concluded that the lower a particular culture's stigma level is, the more likely individualism will be explanatorily significant. Conversely, the higher the stigma level, the more likely collectivism will be explanatorily significant. Similarly, the more individualistic or collectivist a particular culture is, the more likely it will be effective in explaining positive or negative mental health attitudes respectively. It was mainly for these reasons that the paradigm was more explanatorily effective within the American and Chinese groups, since these groups scored highest in individualism/positive attitudes and collectivism/negative attitudes respectively. The qualitative analysis revealed that the themes of community surveillance, concealment, ruralism/urbanism, conservatism/liberalism, and traditionalism/modernism are inter-related and either directly or indirectly associated with how individualism-collectivism paradigm explains mental illness stigma on a between-cultural and within-cultural level.

The implication of these findings is the contribution they make to our existing understanding of mental health attitudes. Further, any future research aiming to

provide a holistic understanding of the causes of mental illness stigma on an individual and/or, especially, a socio-cultural level, should include a consideration of the paradigm's role. The latter is of importance when research samples consist of participants who hold highly collectivistic and/or individualistic values. There are also implications for anti-stigma initiatives which should take into consideration the role that the paradigm and its associated qualitative themes play on mental health attitude formations, particularly in collectivist cultures where stigma may be more prevalent. Mental health professionals should integrate the paradigm into their understanding of culture, so that they aim to be sensitive, knowledgeable, and competent when dealing with people whose behaviour, values, and attitudes are being sampled from collectivist or individualist notions.

Another contribution that this study makes are the findings associated with how individualistic, collectivistic, vertical, and horizontal the UK-based white-English, American, Greek/Greek Cypriot, and Chinese cultures currently are. As previously stated in section 2.4.3, according to Triandis (2001, 2006), people in 'vertical' cultures more readily accept that societal hierarchy is a natural state which members should strive to climb. Thus, those at the top of society 'naturally' have more power and privileges. This is contradictory in 'horizontal' cultures where people more readily expect societal equality and, if a resource needs to be divided, it should be done as equally as possible. To this author's knowledge, no previous study has directly assessed these UK-based groups' value orientations before. Hofstede (2008) has assessed UK individualism levels but his assessment does not separate English values from UK values, nor does it measure vertical-horizontal orientations. Therefore, although the data collected in this study was unique, its findings still form

a basis for comparison with previous research which have assessed such value orientations in these cultures' home countries.

The survey findings revealed that the American group was highly individualistic and vertical in structure. The white-English group was also individualistic although less so, and instead more horizontally inclined. The Greek/Greek Cypriot group was generally collectivistic although the prevalence of this value-orientation was lower than the prevalence of individualism in both the white-English and, especially, American groups. Further, the Greek/Greek Cypriots scored almost identically in the measure of vertical and horizontal orientation. The Chinese group was also collectivistic as well as slightly more vertical in structure. These findings are generally supported by previous research and provide further illumination on these cultures' value orientations, and may be useful on a policy and clinical level. Furthermore, the quantitative results also showed evidence of both value systems within each group. This corroborates the idea that Triandis (2006) and other researchers are keen to emphasise: that all people from any culture can apply values from individualistic and collectivistic systems depending on the situation and context, even though in general their culture may be more heavily dependent on drawing from one of the particular value systems. The same philosophy can be applied to vertical and horizontal value-systems, for which this study's survey results also support. The implication of this is that it is inaccurate to assume that, for example, people from an individualistic culture will always act or think individualistically. While the probability that an individualistic action/cognition is increased, particularly if the individual comes from an urban, affluent, socially liberal and modern geographical region, such black and white assumptions are too uncompromising and simplistic.

An additional set of findings were revealed in the qualitative arm of the study. Specifically, the analysis intimated that a range of antecedents, attributes and consequences are related to individualism and collectivism, many of which have been extensively previously documented, such as independence (an attribute of individualism) and interdependence (an attribute of collectivism), while others, such drug misuse and social isolation (consequences of individualism), could benefit from future research (see section 6.4).

Associated with the above aim was the exploration of whether and how acculturation affects the individualism-collectivism paradigm; an area of research that has been previously identified as lacking in evidence (Triandis, 2001) and in need of further research. The results showed that vertical-horizontal individualism-collectivism scores for this study's American group were similar to the scores of Americans sampled from the United States in previous research. However, the Chinese and Greek/Greek Cypriot groups held values that were less collectivistic than those previously documented in their home countries. Globalisation and successful acculturation are argued to have impacted these two groups' cultural values. In terms of acculturation, the qualitative analysis suggested that the speed of migrants' acculturation to a new host culture depends on (a) the length of migration time; (b) the migrant's affection towards their native culture; and (c) the migrant's affection towards their host culture. Also of note is how similar or different a migrant's native and host cultures are. These are factors that government policy-makers should consider when they are examining what increases the prospects for successful integration. A tool that measures such factors in new migrants could highlight

potential acculturation barriers which could then be addressed. On the other hand, globalisation may be eroding many of the Chinese and Greek/Greek Cypriot traditional values, particularly within younger people living in urban areas. However, despite value changes in these two groups, they remain in general collectivist cultures, mainly due to their levels of traditionalism. As Triandis (2006, p215) states: "traditional cultures are anchored on their soil, their language, and their religion, which they take very seriously. Traditional cultures see globalization as destroying the family (Stern, 2003), and as the 'enemy of God.' The reaction in such cultures is to want to preserve their national boundaries and culture (language, religion)." Thus, for migrants who come from a culture that is steeped in rich history and hold many cultural traditions, cultural value transition is likely to be relatively slow and take generations to have significant effect, particularly if the migrant holds strong affection to their native culture and/or little affection to the new host culture.

6.3 Policy and clinical recommendations

There are a number of practice and policy recommendations that are based on the study's findings:

6.3.1 Policy recommendations

- Anti-stigma campaigns that increase mental health knowledge and understanding should continue as research suggests that this is a key method of decreasing stigmatising attitudes. Anti-stigma campaigns should be culturally (and

linguistically) appropriate and sensitive in order to effectively access and serve cultural groups, particularly collectivist and 'closed' communities.

- Anti-stigma campaigns should include the following information:
    - Who to contact for help and support;
    - That services are discreet and treat people with complete confidentiality and respect (this is particularly important for those from 'high surveillance' collectivist cultures);
    - Evidence that professional services can help treat mental health problems;
    - Data explaining why experiencing mental illness should not be considered shameful or something to hide;
    - The specifics about various major forms of mental illness and potential negative impacts they can each have without treatment.
    - That mental illness can be understood from a scientific perspective (this is particularly important for cultures that lack a scientific, evidence-based view of mental illness);
- Organisations should develop initiatives which provide individuals and communities opportunities to come in contact with people who suffer from mental illness in safe and constructive environments.
- For closed and collectivist communities/cultures which are difficult to access, in-group, second-generation members and local community groups who are trusted and should be involved in the delivery of anti-stigmatising initiatives.
- The mass media have an important role to play in educating the public and influencing attitudes. Therefore, they should report mental illness in a fair, objective, and informative manner.

- In order to smoothen the acculturation process for new migrants, the Home Office should fund evidenced-based methods to assess and promote (a) knowledge of the migrants' own culture; and (b) knowledge of the host culture, and (c) migrants' level of affection for the host culture

6.3.3 Clinical recommendations

- A patient's culture needs to be competently assessed and understood in order to provide sensitive, appropriate, and culturally competent mental (and general) healthcare to the patient and his/her family.
- Practitioners should be trained to understand cross-cultural value systems, and how such value systems significantly impact on mental health attitudes. Cultural training should include the following:
  - An understanding and knowledge about vertical-horizontal-individualism-collectivism value paradigms;
  - They should be made aware that mental illness stigma could be prevalent and pervasive in collectivist cultures, particularly when their culture is more horizontal than vertical;
  - They should be made aware that in collectivistic cultures, the patient and his/her in-group values and attitudes may be more traditional, conservative, and consequently more stigmatising of mental illness. However, they should also understand that this will not always be the case, particularly if the patient is from an urbanised, liberal, and/or affluent geographical and social background.

o They should be made aware that the reverse is the case in individualistic cultures: that the probability of attitudes and values being modern, liberal, and non-stigmatising is increased, but not necessarily so, particularly if the patient and his/her in-group are from rural, conservative, and poor geographical and social backgrounds.

6.4 Future research

This study provides the platform for the development of several potentially important future research projects. Perhaps the most important trigger for new research this study has made is the introduction of the relationship between individualism-collectivism and mental health attitudes. As this is the first time this paradigm has been applied in this way, future research is needed to continue to develop our understanding and significance of this paradigm's role. According to this study's findings, the indication is that the paradigm has most explanatory significance within highly individualistic or collectivistic cultures, and therefore research should begin with examining if this is true, why it is true, and what further implications towards our understanding of mental illness stigma these have. Quantitative research studies should ideally be conducted using randomised methods to ensure for accurate general population representativeness which this study lacked.

As culture is a primary factor in what influences one's attitudes and beliefs, it would also be interesting to explore whether there are explanatory links between mental health attitudes and Hofstede's (2008) other cultural value dimensions, such as masculinity-femininity, uncertainty avoidance, long-term orientation, and power

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distance. Indeed, the latter has already been indicated in this study to link with vertical cultures, and there may be other important links to establish.

Further, the interrelated roles of community surveillance, ruralism/urbanism, conservatism/liberalism, and traditionalism/modernism in understanding mental health stigma would benefit from further examination. This study's qualitative examination of these themes could strongly benefit from a larger, in-depth qualitative study that specifically examines such ideas. A quantitative examination would be as equally useful since this could objectively establish whether there are any statistically significant links between these themes.

Finally, this study's qualitative analysis of the antecedents, attributes, and consequences of individualism flagged up some interesting ideas which, to this author's knowledge, have not previously been directly researched. Specifically, the associations between individualism and substance misuse, social isolation, loneliness, and obesity could strongly benefit from future research. Additionally, the psychosocial effects of failing to meet the demands and expectations of an individualist or collectivist culture need examination as, according to this study's initial indications, these can be potentially damaging to the extent where a mental health problem could be triggered.

6.5 Study limitations and critical considerations

There are a number of important study limitations that are important for the reader to consider when thinking critically about this study. Perhaps the most important

limitation was the implementation of non-randomised methods within the quantitative survey. This led to collecting general population data that was not representative and therefore lacking in generalisability. This means that any inferences made about the meaning of the data can only appropriately be applied internally, and that generalisations and assumptions made to the wider UK-based white-English, American, Greek/Greek Cypriot, and Chinese populations must be tentative, Any such assumptions about native American, Greek/Greek Cypriot, and/or Chinese culture that are based on the quantitative survey findings could be particularly criticised, since this data at best only reflects UK-based migrants who have at least to some degree become acculturated to UK-life. Further, any assumptions made about the American culture based on this study's survey data must only be in reference to white-Americans who are of European descent and are from eastern, urbanised States. Similarly, this data best reflects urbanised white-English, Greek/Greek Cypriot and Chinese populations. Non-proportionate quota sampling was used thus any claims of generalisability cannot be made (Trochim, 2001). Further, the snowball sampling method used in this study is known to be particularly low in generalisability (Punch, 2005) since it introduces bias and reduces the likelihood that the sample will represent a good cross-section from the population.

There are other areas of potential criticism. Both the survey sample sizes and qualitative interviewee numbers could be criticised for being small, particularly since this study is in direct reference to very large populations. The choice of utilising Triandis' vertical/horizontal/individualism/collectivism measurement tool could also be scrutinised since there are only few studies that have concretely tested its level of internal reliability, although Triandis himself has previously stated that no

individualism/collectivism measurement tool, including his own, has been proven to be entirely satisfactory. Taylor and Dear's (1981) 'Community Attitudes towards Mental Illness' survey tool could be criticised for being too old and therefore questionable in terms of current-day use, although to date the author is not aware of a preferable measure. Another problem with this tool is the use of the term 'mental illness' which is general and does not tap into the attitudes of specific mental illnesses which are wide-ranging and fundamentally dissimilar. Although attempts were consistently made to make participants think about mental illness in general when completing the questionnaire, it is possible that the Chinese and Greek/Greek Cypriot groups, hampered by their lack of knowledge in this area, were either not fully aware what they were assessing, or thinking about a specific disorder, such as schizophrenia. This could partially explain why their CAMI scores were more negative than the American and white-English participants.

Furthermore, upon reflection, it may have been beneficial to have also conducted a qualitative interview pilot. This is because such a process may have highlighted the importance of traditionalism/modernism, conservatism/liberalism, and ruralism/urbanism; factors which could have been additional key measurable variables to include within the quantitative survey questionnaire. These variables would have likely increased overall regression model power and provided extra credence to their overall importance between the links of individualism/collectivism and mental illness stigma. Acculturation may have also been more accurately measured, since the qualitative themes relating to migration could have been also been potentially transformed and implemented for quantitative measurement. Another methodological improvement would have been the use of respondent validation. This

involves cross-checking the emerging findings with the interviewees themselves to enable interviewees' reactions to further refine explanations and establish a level of correspondence in findings. This would have been a useful and practical additional technique to increasing qualitative rigour.

According to Mays and Pope (2000), the potential effects of personal characteristics such as age, sex, social class and professional status on the data collected and on the 'distance' between the researcher and those researched should always be highlighted and discussed, particularly in qualitative research. Therefore, it is also important to cite my own potential research biases which could have increased subjectivity, lowered objectivity, and impaired overall research exploratory accurateness. One important factor includes the fact that I am a second generation, UK-born Greek/Greek Cypriot. I am also married to a first generation American-born woman. Further, my sister-in-law is a first-generation Chinese UK-migrant and as such I have a high level of direct personal contact with each of the cultures sampled in this study. These circumstances have undoubtedly shaped my beliefs on what data to expect, and what the meaning of the quantitative and, especially, qualitative data analysis implies. However, in line with a reflexive approach, measures were taken during each stage of the research process to ensure that my objectivity was not threatened. The starting point was to acknowledge such potential dangers and thereafter seek ways to overcome them. Thus, at all stages, I attempted to keep an open mind about the meaning of the data while suspending personal beliefs and past professional and research experiences (since I have previously conducted research in mental illness, stigma, and culture). This was augmented over time, practice, and through conversations with critical experts such as my supervisors and other close aides.

Hammersley and Atkinson (1995) also advise that in order to avoid over-identification and over-rapport with the population being studied, the researcher should aim to adopt a marginal position of simultaneous 'insider/outsider', and be intellectually poised between familiarity and strangeness. This was a technique that I also adopted which provided me with enough social and intellectual distance to ensure objectivity during the sampling and analysis procedures even though close contact was being made with each cultural group. Thus, the strategies I employed to reduce the danger of such biases were: awareness, reflexivity, and use of research advice, my research supervisors, and several informal mentors. Further, I believe that accurately representing social truth, whilst being cognisant of its complexity, should be the foremost and primary goal of any good researcher, and this is best achieved when conducted in a manner that is rigorous, moral, and ethical. These were values and principles which I employed throughout this study.

6.6 Brief conclusion

This study represents the first time that individualism-collectivism has been examined as a potential explanatory factor for mental health stigma. It also marks the first attempt at measuring the vertical-horizontal-individualism-collectivism value orientations of UK-based white-English, American, Greek/Greek Cypriot, and Chinese cultural groups. Further, it provides a contemporary, multi-method, in-depth examination of mental health attitudes, knowledge, and experience levels in these cultures. This was also the first time a UK-based American sample has been examined in the latter areas. The findings are extensive and wide-ranging, although perhaps most critically highlight the importance of culture in determining and understanding

attitudes towards mental illness. If these findings and their implications are considered

by anti-stigma policy-makers and relevant health-care professionals, their

understanding of mental health stigma can be advanced, and, as a result, the damage

and prevalence of such stigma can, hopefully, continue to be reduced.

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APPENDICES

Appendix 1: Participant information sheet

<u>**May 2004, version 1.2**</u>

<u>**'Stigma towards mental health problems'**</u>

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

<u>**What is the purpose of this study?**</u>

I intend to study whether different cultures living in the UK view people with mental health problems differently. Understanding how different cultures view people with mental health problems is extremely important as it helps health-care professionals understand how o be more culturally sensitive and skilled when working with both patients and their families.

<u>**Why have I been chosen?**</u>

You have been chosen as you are a person from a white-English, Greek/Greek-Cypriot, American or Chinese culture living in the UK. I will be aiming to recruit approximately 50-75 other people from each culture – that's 200-300 people in total.

<u>**Do I have to take part?**</u>

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked again to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason.

<u>**What will happen to me if I take part?**</u>

You will be asked to complete a questionnaire that should not last longer than 10 minutes. You may choose to complete this questionnaire in private or with my assistance at a place of your choice. A translated questionnaire is also available if you prefer.

After completing the questionnaire I will ask whether you would be interested in taking part in a one-to-one in-depth interview about your views on people with mental health problems. If you do not wish to take part, then you will be thanked for your cooperation in completing the questionnaire.

What do I have to do?

Completing a questionnaire involves writing by hand answers to questions. There are two types of questions: 1. 'Open-ended questions' where a question is open for you to answer in any way or detail you prefer and; 2. 'Multiple-choice questions' where you will be given a selection of set answers to questions to choose from. You do not have to complete all the questions, although it would be far more helpful for me if you did. The completion of the questionnaire can be done at any place you prefer with or without my assistance. If you chose to complete the questionnaire in private, please answer your questions alone without any help from your friends of family. This is because I am interested in your responses, and I do not wish for your responses to be influenced by anyone else.

If you choose to take part in a one-to-one interview, I will arrange a time, day and venue that suits you best. The interview should be conducted in a quiet undisturbed area. Although there is no set length for the interview I do not foresee an interview lasting more than two hours. However, you may withdraw from the interview at any time and without giving a reason. If you consent to it, the interview will be audio-recorded. I will later transcribe the recording and analyse the data. All of your responses will remain completely anonymous. However, I will ask you whether it is ok to use anonymous quotations of your interview within the write-up of my study. You may choose to decline this at any time and without giving a reason.

What are the possible benefits to taking part?

The main aim of this study is to further the knowledge and understanding of how people from different cultures view people with mental health problems. This will allow health-care professionals to be better able to work in a culturally sensitive and skilled manner.

Will taking part in this study be kept confidential?

All information that is collected about you during the course of this study will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of this research study?

The study will be completed and written-up by 2009 at the latest. There is a possibility that I will publish some of aspects of the study before 2009. If you wish, I can contact you when any results are published with details of how to obtain a copy. Just to reiterate, you will not be identified in any report or publication.

Who has reviewed the study?

This study has been reviewed by the Middlesex University School of Health and Social Sciences Health Studies Ethics Sub-Committee. This was done to ensure that all aspects of this study are ethical and do not pose any risk or harm to any person involved.

Contact for further information

You may contact me at anytime about this study.

My contact details are: My supervisor's contact
details are:

Chris Papadopoulos,   Dr John Foster,
Middlesex University,   Middlesex University,
Enfield Campus,   Enfield Campus,
Middlesex,   Middlesex,
EN3 4SA   EN3 4SA

Tel: 020 8411 6817   Tel: 020 8411 2656

Email: c.papadopoulos@mdx.ac.uk   j.foster@mdx.ac.uk

Thank you for reading!

Appendix 2: Participant consent form

<u>Consent Form</u>

Stigma towards mental health problems

By Chris Papadopoulos

1. I confirm that I have read and understand the information sheet dated May 2004 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to take part in the above study

4. I agree to be audio-recorded if I participate in a follow-up interview

Name of participant: Name of researcher:

Signature: Signature:

Date: Date:

Appendix 3: Ethical approval letter

School of Health and Social Sciences
The Archway Campus
Furnival Building
10 Highgate Hill
London N19 5LW

Chris Papadopoulos

06.07.04

Dear Chris

'*Stigma towards mental health problems: an individualism collectivism cross-cultural comparison*'.

The ethics subcommittee (Health Studies) considered your application on the 29th June. On behalf of the committee, I am pleased to inform you that your application has been approved. However, please note that the committee must be informed if any changes in the protocol need to be made at any stage.

I wish you all the very best with your project. The committee will be delighted to receive a copy of the final report.

Yours sincerely

Professor (I)Rena Papadopoulos
Chair of Ethics Sub-committee (Health Studies)

Appendix 4: Qualitative interview schedule

QUESTION 1: Tell me about your culture – how would you describe and define it?

For this question, I shall attempt to explore the interviewee's view of their culture including what they think are the fundamental values of their culture. If necessary, I shall use all or some of the following probes:

- How would you describe/define your culture?
- Can you tell me which values are important in your culture?
- Are unusual behaviours seen as ok?
- Do people in your culture usually attempt to depend on each other or get by on their own?
- What is your family like?
- If you had a piece of important and truthful information about yourself to tell your family, but it might upset or anger them, would you say it? why?
- Think about something you enjoy doing. Would you stop doing this activity if your partner or other family member told you to stop doing it for the good of the group (e.g. to save money?)

QUESTION 2: How has living away from your native country affected you?

I will next explore whether and how acculturation has affected their cultural identity. If necessary, I shall use all or some of the following probes:

- Do you still feel 100% American/Chinese/Greek etc?

QUESTION 3: How is mental illness generally viewed in your culture?

Is it stigmatised or normalised? If necessary, I shall use all or some of the following probes:

- How does the media portray MI in your culture? why?
- How would a family react if someone became mentally ill?
- Do you think that people with a MI can get married as easily as someone else?
- How would you community react if they heard someone was having treatment for a MI? How does this effect the person with MI, and his/her family?
- (non white-English question) What do you think about immigrants from your culture trying to get mental health care in the UK?
- How would your community feel if there were mental health group homes in their neighbourhoods?
- Do people know a lot about MI in your culture?
- Do people have a lot of contact with MI in your culture?
- What kinds of slang labels are linked to MI in your culture? (e.g. crazy, psycho etc)

QUESTION 4: Why do you think mental illness is viewed in this way in your culture?

I will here explore if the I-C dimension links with mental health stigma, and what the other underlying cultural reasons for stigma are. If necessary, I shall use all or some of the following probes:

- What do you think causes these views of MI in your culture?
- Do you think that the values of your culture have anything to do with causing these views?
- Do you think that there are differences in views between poorer and richer people in your culture?
- Do you think that there are differences in views between people who have had more or less education in your culture?

QUESTIONNAIRE: MENTAL HEALTH PROBLEMS

Thank you for agreeing to complete this questionnaire. The data that will be gathered from this survey will help us to understand some of the many complex issues around the notion of **attitudes** towards people with mental illness. This questionnaire is completely anonymous. Any reporting of the data will be done in such a way that none can be assigned to a particular individual. **Please answer the questions honestly and do not be influenced by what other people around you say.** There are no right or wrong answers and this is not a test – I simply wish to know your views. If there are any questions you feel are too sensitive to answer, please circle them. Please return this questionnaire to Chris Papadopoulos.

SECTION 1 - Background information

1. How old are you?_____

2. What is your sex?　　　　Male
　　　　　　　　　　　　　Female

3. What is your ethnicity?

_____

4. Where were you born? (Please specify country)

_____

5. How many years have you lived in England?

_____

6. Where were you educated?
　　　　England
　　　　Other (please state)

_____

7. If you were educated in **England**, please state your educational level:

　　　Primary School
　　　Secondary School
　　　(GCSE or leaving certificate)
　　　A level
　　　College (BTec/HNC/HND)
　　　University (Degree)
　　　Postgraduate
　　　Other (specify) _____

8. If you were educated in **a different country**, please state your educational level:

_____

9. What is your first language?

_____

10. What is your occupation?

_____

11. What is your religion?

_____

12. How religious do you consider yourself to be?
　　　　　　Extremely religious
　　　　　　Quite religious
　　　　　　Not very religious
　　　　　　Atheist/Agnostic
　　　　　　Other (please state)

_____

13. What is your marital status?

　　　　　　Single
　　　　　　Married
　　　　　　Cohabiting
　　　　　　Divorced/Separated
　　　　　　Widowed

PLEASE TURN TO THE NEXT PAGE

SECTION 2 – Questionnaire 1 The following consists of a list of statements in which you have to tick the response that you **MOST** agree with.

		Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
14.	There are sufficient existing services for the mentally ill.					
15.	Mentally ill patients need the same kind of control and discipline as a young child.					
16.	Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.					
17.	The mentally ill are a burden on society.					
18.	Anyone with a history of mental problems should be excluded from entering parliament.					
19.	As far as possible, mental health services should be provided through community based facilities.					
20.	There is something about the mentally ill that makes it easy to tell them from normal people					
21.	Most women who were once patients in a mental hospital can be trusted as babysitters.					
22.	Less emphasis should be placed on protecting the public from the mentally ill.					
23.	The mentally ill should not be denied their individual rights.					
24.	The mentally ill should not be given any responsibility.					
25.	Mental hospitals are an outdated means of treating mentally ill.					
26.	Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great.					
27.	A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.					
28.	Local residents have good reason to resist the location of mental health services in their neighbourhood.					

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
29.	Locating mental health services in residential neighbourhoods does not endanger local residents.					
30.	Mental illness is an illness like any other.					
31.	No one has the right to exclude the mentally ill from their neighbourhood.					
32.	We need to adopt a far more tolerant attitude toward the mentally ill in our society.					
33.	Virtually anyone can become mentally ill.					
34.	The mentally ill are far less of a danger than most people suppose.					
35.	We have a responsibility to provide the best possible care for the mentally ill.					
36.	The mentally ill have for too long been the subject of ridicule.					
37.	One of the main causes of mental illness is a lack of self-discipline and will power.					
38.	More tax money should be spent on the care and treatment of the mentally ill.					
39.	It is best to avoid anyone who has mental problems.					
40.	The best way to handle the mentally ill is to keep them behind locked doors.					
41.	Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.					
42.	The mentally ill should be isolated from the rest of the community.					
43.	The best therapy for many mental patients is to be part of a normal community.					
44.	I would not want to live next door to someone who has been mentally ill.					
45.	The mentally ill don't deserve our sympathy.					

	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
46. Mental patients should be encouraged to assume the responsibilities of normal life.					
47. Mental health facilities should be kept out of residential neighbourhoods.					
48. The mentally ill should not be treated as outcasts of society.					
49. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.					
50. It is frightening to think of people with mental problems living in residential neighbourhoods.					
51. Increased spending on mental health services is a waste of tax money.					
52. Locating mental health facilities in a residential area downgrades the neighbourhood.					
53. As soon as a person shows signs of mental disturbance he should be hospitalised.					

SECTION 3 – Other questions

54. Do you know the names of any types of mental illness? Yes No

55. If yes, please state a maximum of three names (please try to state the name of the illness, not the symptoms)

_____

_____

_____

56. Do you know what 'learning disabilities' means?

Yes No

57. If yes, what is it?

_____

_____

58. Do you think there is a difference between mental illness and people with learning disabilities?

Yes No

59. If yes, what is it?

_____

_____

_____

60. Can you tell that somebody has mental illness?

Yes No Sometimes

61. If yes or sometimes, how?

_____

62. What do you think are the main causes of mental illness? (please state a maximum of three causes)

_____

_____

_____

63. Do you think mental illness can be passed down in families?

           Yes   No

64. If a friend or neighbour of yours was showing signs of mental illness, who would you contact for help?

_____

_____

65. Do you know of any sort of treatment there is for mental illness?

           Yes   No

66. If yes, please state these treatments.

_____

_____

67. Where did you get most of your information about mental illness?

_____

_____

68. Have you ever visited a psychiatric hospital?

           Yes   No

69. Have you ever worked with people with mental health problems?

           Yes   No

70. If yes, please state the type of work

_____

_____

The following questions are very sensitive. Please remember that the information gathered is completely anonymous and dealt with in the strictest confidence.

71. Do you know somebody who has/had mental illness?

           Yes   No

72. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms) (If no, please skip to question 74)

_____

_____

73. What is your relationship with them?

_____

74. How close to you would you consider this person?

           Extremely close
           Quite close
           Not very close
           Distant
           Very distant

75. Have you ever suffered from any mental illness?

           Yes   No

76. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms)

_____

_____

_____

Please follow this scale when answering each question:

1	2	3	4	5	6	7	8	9
I Strongly disagree				Unsure				I Strongly agree

77. I prefer to be direct and forthright when I talk with people_____

78. My happiness depends very much on the happiness of those around me_____

79. I would do what would please my family, even if I detested that activity_____

80. Winning is everything_____

81. One should live one's life independently of others_____

82. What happens to me is my own doing_____

83. I usually sacrifice my self-interest for the benefit of my group_____

84. It annoys me when other people perform better than I do_____

85. It is important for me to maintain harmony within my group_____

86. It is important to me that I do my job better than others_____

87. I like sharing little things with my neighbours_____

88. I enjoy working in situations involving competition with others_____

89. We should keep our aging parents with us at home_____

90. The well-being of my co-workers is important to me_____

91. I enjoy being unique and different from others in many ways_____

92. If a relative were in financial difficulty, I would help within my means_____

93. Children should feel honoured if their parents receive a distinguished award_____

94. I often do "my own thing" _____

95. Competition is the law of nature_____

96. If a co-worker gets a prize I would feel proud_____

97. I am a unique individual_____

98. To me, pleasure is spending time with others

99. When another person does better than I do, I get tense and aroused_____

100. I would sacrifice an activity that I enjoy very much if my family did not approve of it_____

101. I like my privacy_____

102. Without competition it is not possible to have a good society_____

103. Children should be taught to place duty before pleasure_____

104. I feel good when I cooperate with others_____

105. I hate to disagree with others in my group_____

106. Some people emphasise winning; I am not one of them_____

107. Before taking a major trip, I consult with most members of my family and many friends_____

108. When I succeed, it is usually because of my abilities_____

PLEASE TURN TO THE NEXT PAGE

To better understand the complex issues on the attitudes and understanding of mental health problems, I hoping to conduct a series of one-to-one in-depth interviews some time in the not-to distant future. If you would be willing be take part in an interview, I will arrange for a time, day and venue that suits you best. The interview should be conducted in a quiet undisturbed area. Although there is no set length for the interview I do not foresee an interview lasting more than two hours. However, you may withdraw from the interview at any time and without giving a reason. If you consent to it, the interview will be audio-recorded. I will later transcribe the recording and analyse the data. All of your responses will remain completely anonymous. If you are willing to participate, I will take down your name and contact information on a separate file. Please remember that in the manner of confidence and sensitivity, I will not be able to identify you with this questionnaire.

Would you be interested in taking part?

Yes   No

Finally, in order for a large amount of the questionnaires to be handed out, it would be extremely beneficial if you could possibly provide me with 3 or so people, perhaps with a similar background to you, who I could contact to also complete these questionnaires.

1. Name & address & phone number

_____

_____

2. Name & address & phone number

_____

_____

3. Name & address & phone number

_____

_____

YOU FOR YOUR PARTICIPATION

IN THIS SURVEY. YOUR CONTRIBUTION IS GREATLY APPRECIATED.

Contact information:
My contact details are: Mr Chris Papadopoulos, Middlesex University, Enfield Campus, EN3 4SA. Tel: 020 8411 6817. Email address: c.papadopoulos@mdx.ac.uk

My supervisor's contact details are: Dr John Foster, Middlesex University, Enfield Campus, EN3 4SA. Tel: 020 8411 2656. Email address: j.foster@mdx.ac.uk

If you have any other comments on any aspect of this study, please feel free to express them here:

_____

_____

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_____

QUESTIONNAIRE: MENTAL HEALTH PROBLEMS

Thank you for agreeing to complete this questionnaire. The data that will be gathered from this survey will help us to understand some of the many complex issues around the notion of **attitudes** towards people with mental illness. This questionnaire is completely anonymous. Any reporting of the data will be done in such a way that none can be assigned to a particular individual. **Please answer the questions honestly and do not be influenced by what other people around you say.** There are no right or wrong answers and this is not a test – I simply wish to know your views. If there are any questions you feel are too sensitive to answer, please circle them. Please return this questionnaire to Chris Papadopoulos.

SECTION 1 - Background information

1. How old are you?_____

2. What is your sex?   Male
                            Female

3. What is your ethnicity?

_____

4. Where were you born? (Please specify country)

_____

5. How many years have you lived in England?

_____

First generation American
Someone who was born in America from American parents and subsequently moved to live in England.

Second Generation American
Someone who was born and grew up in England and whose parents are first generation American.

Third generation American
Someone who was born and grew up in England and whose parents are second generation American.

---

6. Where were you educated?
                England
                America
                Other (please state)

_____

7. If you were educated in **England**, please state your educational level:

        Primary School
        Secondary School
        (GCSE or leaving certificate)
        A level
        College (BTec/HNC/HND)
        University (Degree)
        Postgraduate
        Other (specify) _____

8. If you were educated in **a different country**, please state your educational level:

_____

9. What is your first language?

_____

10. What is your occupation?

_____

11. What is your religion?

_____

12. How religious do you consider yourself to be?
Extremely religious   Quite religious
Not very religious   Atheist/Agnostic
Other (please state)   _____

13. What is your marital status?
Single   Married   Cohabiting
Divorced/Separated   Widowed

SECTION 2 – Questionnaire 1 The following consists of a list of statements in which you have to tick the response that you **MOST** agree with.

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
14.	There are sufficient existing services for the mentally ill.					
15.	Mentally ill patients need the same kind of control and discipline as a young child.					
16.	Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.					
17.	The mentally ill are a burden on society.					
18.	Anyone with a history of mental problems should be excluded from entering parliament.					
19.	As far as possible, mental health services should be provided through community based facilities.					
20.	There is something about the mentally ill that makes it easy to tell them from normal people					
21.	Most women who were once patients in a mental hospital can be trusted as babysitters.					
22.	Less emphasis should be placed on protecting the public from the mentally ill.					
23.	The mentally ill should not be denied their individual rights.					
24.	The mentally ill should not be given any responsibility.					
25.	Mental hospitals are an outdated means of treating mentally ill.					
26.	Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great.					
27.	A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.					
28.	Local residents have good reason to resist the location of mental health services in their neighbourhood.					

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
29.	Locating mental health services in residential neighbourhoods does not endanger local residents.					
30.	Mental illness is an illness like any other.					
31.	No one has the right to exclude the mentally ill from their neighbourhood.					
32.	We need to adopt a far more tolerant attitude toward the mentally ill in our society.					
33.	Virtually anyone can become mentally ill.					
34.	The mentally ill are far less of a danger than most people suppose.					
35.	We have a responsibility to provide the best possible care for the mentally ill.					
36.	The mentally ill have for too long been the subject of ridicule.					
37.	One of the main causes of mental illness is a lack of self-discipline and will power.					
38.	More tax money should be spent on the care and treatment of the mentally ill.					
39.	It is best to avoid anyone who has mental problems.					
40.	The best way to handle the mentally ill is to keep them behind locked doors.					
41.	Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.					
42.	The mentally ill should be isolated from the rest of the community.					
43.	The best therapy for many mental patients is to be part of a normal community.					
44.	I would not want to live next door to someone who has been mentally ill.					
45.	The mentally ill don't deserve our sympathy.					

		Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
46.	Mental patients should be encouraged to assume the responsibilities of normal life.					
47.	Mental health facilities should be kept out of residential neighbourhoods.					
48.	The mentally ill should not be treated as outcasts of society.					
49.	Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.					
50.	It is frightening to think of people with mental problems living in residential neighbourhoods.					
51.	Increased spending on mental health services is a waste of tax money.					
52.	Locating mental health facilities in a residential area downgrades the neighbourhood.					
53.	As soon as a person shows signs of mental disturbance he should be hospitalised.					

SECTION 3 – Other questions

54. Do you know the names of any types of mental illness?   Yes   No

55. If yes, please state a maximum of three names (please try to state the name of the illness, not the symptoms)

_____

_____

_____

56. Do you know what 'learning disabilities' means?

                Yes   No

57. If yes, what is it?

_____

_____

58. Do you think there is a difference between mental illness and people with learning disabilities?

                Yes   No

59. If yes, what is it?

_____

_____

_____

60. Can you tell that somebody has mental illness?

Yes   No   Sometimes

61. If yes or sometimes, how?

_____

_____

62. What do you think are the main causes of mental illness? (please state a maximum of three causes)

_____

_____

_____

63. Do you think mental illness can be passed down in families?

              Yes   No

64. If a friend or neighbour of yours was showing signs of mental illness, who would you contact for help?

_____

_____

65. Do you know of any sort of treatment there is for mental illness?

              Yes   No

66. If yes, please state these treatments.

_____

_____

67. Where did you get most of your information about mental illness?

_____

_____

68. Have you ever visited a psychiatric hospital?

              Yes   No

69. Have you ever worked with people with mental health problems?

              Yes   No

70. If yes, please state the type of work

_____

_____

The following questions are very sensitive. Please remember that the information gathered is completely anonymous and dealt with in the strictest confidence.

71. Do you know somebody who has/had mental illness?

              Yes   No

72. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms) (If no, please skip to question 74)

_____

_____

73. What is your relationship with them?

_____

74. How close to you would you consider this person?

              Extremely close
              Quite close
              Not very close
              Distant
              Very distant

75. Have you ever suffered from any mental illness?

              Yes   No

76. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms)

_____

_____

_____

Please follow this scale when answering each question:

1   2   3   4   5   6   7   8   9
I Strongly   Unsure   I Strongly
disagree   agree

77. I prefer to be direct and forthright when I talk with people_____

78. My happiness depends very much on the happiness of those around me_____

79. I would do what would please my family, even if I detested that activity_____

80. Winning is everything_____

81. One should live one's life independently of others_____

82. What happens to me is my own doing_____

83. I usually sacrifice my self-interest for the benefit of my group_____

84. It annoys me when other people perform better than I do_____

85. It is important for me to maintain harmony within my group_____

86. It is important to me that I do my job better than others_____

87. I like sharing little things with my neighbours_____

88. I enjoy working in situations involving competition with others_____

89. We should keep our aging parents with us at home_____

90. The well-being of my co-workers is important to me_____

91. I enjoy being unique and different from others in many ways_____

92. If a relative were in financial difficulty, I would help within my means_____

93. Children should feel honoured if their parents receive a distinguished award_____

94. I often do "my own thing" _____

95. Competition is the law of nature_____

96. If a co-worker gets a prize I would feel proud_____

97. I am a unique individual_____

98. To me, pleasure is spending time with others

99. When another person does better than I do, I get tense and aroused_____

100. I would sacrifice an activity that I enjoy very much if my family did not approve of it_____

101. I like my privacy_____

102. Without competition it is not possible to have a good society_____

103. Children should be taught to place duty before pleasure_____

104. I feel good when I cooperate with others_____

105. I hate to disagree with others in my group_____

106. Some people emphasise winning; I am not one of them_____

107. Before taking a major trip, I consult with most members of my family and many friends_____

108. When I succeed, it is usually because of my abilities_____

To better understand the complex issues on the attitudes and understanding of mental health problems, I hoping to conduct a series of one-to-one in-depth interviews some time in the not-to distant future. If you would be willing be take part in an interview, I will arrange for a time, day and venue that suits you best. The interview should be conducted in a quiet undisturbed area. Although there is no set length for the interview I do not foresee an interview lasting more than two hours. However, you may withdraw from the interview at any time and without giving a reason. If you consent to it, the interview will be audio-recorded. I will later transcribe the recording and analyse the data. All of your responses will remain completely anonymous. If you are willing to participate, I will take down your name and contact information on a separate file. Please remember that in the manner of confidence and sensitivity, I will not be able to identify you with this questionnaire.

Would you be interested in taking part?

Yes   No

Finally, in order for a large amount of the questionnaires to be handed out, it would be extremely beneficial if you could possibly provide me with 3 or so people, perhaps with a similar background to you, who I could contact to also complete these questionnaires.

1. Name & address & phone number

_____

_____

2. Name & address & phone number

_____

_____

3. Name & address & phone number

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_____

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If you have any other comments on any aspect of this study, please feel free to express them here:

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_____

QUESTIONNAIRE: MENTAL HEALTH PROBLEMS

Thank you for agreeing to complete this questionnaire. The data that will be gathered from this survey will help us to understand some of the many complex issues around the notion of **attitudes** towards people with mental illness. This questionnaire is completely anonymous. Any reporting of the data will be done in such a way that none can be assigned to a particular individual. **Please answer the questions honestly and do not be influenced by what other people around you say.** There are no right or wrong answers and this is not a test – I simply wish to know your views. If there are any questions you feel are too sensitive to answer, please circle them. Please return this questionnaire to Chris Papadopoulos.

SECTION 1 - Background information

1. How old are you?_____

2. What is your sex?   Male
                            Female

3. Where were you born? (Please specify country)_____

4. How many years have you lived in England?
_____

5. What is your ethnicity?
Greek Cypriot   Greek

6. If you are of Greek/Greek Cypriot ethnicity, which of the following best describes yourself (**please use the table below for definitions**):

                First generation
                Second generation
                Third generation
Greek/Greek Cypriot with one parent who is not Greek/Greek Cypriot

First generation Greek/Greek Cypriot
Someone who was born in Greece or Cyprus from Greek/Greek Cypriot parents and subsequently moved to live in England.
Second Generation Greek/Greek Cypriot
Someone who was born and grew up in England and whose parents are first generation Greek/Greek Cypriots.
Third generation Greek/Greek Cypriot
Someone who was born and grew up in England and whose parents are second generation Greek/Greek Cypriots

7. Where were you educated?
England   Greece/Cyprus

8. If you were educated in **England**, please state your educational level:
        Primary School
        Secondary School (GCSE or leaving certificate)
        A level
        College (BTec/HNC/HND)
        University (Degree)
Other (specify) _____

9. If you were educated in **Greece or Cyprus**, please state your educational level:
Primary School
Secondary School (leaving certificate)
College certificate
University certificate
Other(specify)_____

10. What is your first language?
_____

11. What is your occupation?
_____

12. What is your religion?
_____

13. How religious do you consider yourself to be?   Extremely religious
                Quite religious
                Not very religious
                Atheist/Agnostic
        Other (please state)
        _____

14. What is your marital status?
Single   Married   Cohabiting
Divorced/Separated   Widowed

SECTION 2 – Questionnaire 1 The following consists of a list of statements in which you have to tick the response that you **MOST** agree with.

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
15.	There are sufficient existing services for the mentally ill.					
16.	Mentally ill patients need the same kind of control and discipline as a young child.					
17.	Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.					
18.	The mentally ill are a burden on society.					
19.	Anyone with a history of mental problems should be excluded from entering parliament.					
20.	As far as possible, mental health services should be provided through community based facilities.					
21.	There is something about the mentally ill that makes it easy to tell them from normal people					
22.	Most women who were once patients in a mental hospital can be trusted as babysitters.					
23.	Less emphasis should be placed on protecting the public from the mentally ill.					
24.	The mentally ill should not be denied their individual rights.					
25.	The mentally ill should not be given any responsibility.					
26.	Mental hospitals are an outdated means of treating mentally ill.					
27.	Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great.					
28.	A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.					
29.	Local residents have good reason to resist the location of mental health services in their neighbourhood.					

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
30.	Locating mental health services in residential neighbourhoods does not endanger local residents.					
31.	Mental illness is an illness like any other.					
32.	No one has the right to exclude the mentally ill from their neighbourhood.					
33.	We need to adopt a far more tolerant attitude toward the mentally ill in our society.					
34.	Virtually anyone can become mentally ill.					
35.	The mentally ill are far less of a danger than most people suppose.					
36.	We have a responsibility to provide the best possible care for the mentally ill.					
37.	The mentally ill have for too long been the subject of ridicule.					
38.	One of the main causes of mental illness is a lack of self-discipline and will power.					
39.	More tax money should be spent on the care and treatment of the mentally ill.					
40.	It is best to avoid anyone who has mental problems.					
41.	The best way to handle the mentally ill is to keep them behind locked doors.					
42.	Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.					
43.	The mentally ill should be isolated from the rest of the community.					
44.	The best therapy for many mental patients is to be part of a normal community.					
45.	I would not want to live next door to someone who has been mentally ill.					
46.	The mentally ill don't deserve our sympathy.					

	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
47. Mental patients should be encouraged to assume the responsibilities of normal life.					
48. Mental health facilities should be kept out of residential neighbourhoods.					
49. The mentally ill should not be treated as outcasts of society.					
50. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.					
51. It is frightening to think of people with mental problems living in residential neighbourhoods.					
52. Increased spending on mental health services is a waste of tax money.					
53. Locating mental health facilities in a residential area downgrades the neighbourhood.					
54. *As soon as a person shows signs of mental disturbance he should be hospitalised.*					

SECTION 3 – Other questions

55. Do you know the names of any types of mental illness?   Yes   No

56. If yes, please state a maximum of three names (please try to state the name of the illness, not the symptoms)

_____

_____

57. Do you know what 'learning disabilities' means?

                    Yes   No

58. If yes, what is it?

_____

_____

59. Do you think there is a difference between mental illness and people with learning disabilities?

                    Yes   No

60. If yes, what is it?

_____

_____

_____

61. Can you tell that somebody has mental illness?

Yes   No   Sometimes

62. If yes or sometimes, how?

_____

_____

393

63. What do you think are the main causes of mental illness? (please state a maximum of three causes)

_____

_____

_____

64. Do you think mental illness can be passed down in families?

          Yes   No

65. If a friend or neighbour of yours was showing signs of mental illness, who would you contact for help?

_____

_____

65. Do you know of any sort of treatment there is for mental illness?

          Yes   No

66. If yes, please state these treatments.

_____

_____

67. Where did you get most of your information about mental illness?

_____

_____

68. Have you ever visited a psychiatric hospital?

          Yes   No

69. Have you ever worked with people with mental health problems?

          Yes   No

70. If yes, please state the type of work

_____

_____

The following questions are very sensitive. Please remember that the information gathered is completely anonymous and dealt with in the strictest confidence.

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          Yes   No

72. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms) (If no, please skip to question 74)

_____

_____

73. What is your relationship with them?

_____

74. How close to you would you consider this person?

          Extremely close
          Quite close
          Not very close
          Distant
          Very distant

75. Have you ever suffered from any mental illness?

          Yes   No

76. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms)

_____

_____

_____

Please follow this scale when answering each question:

1	2	3	4	5	6	7	8	9
I Strongly disagree				**Unsure**				**I Strongly agree**

77. I prefer to be direct and forthright when I talk with people_____

78. My happiness depends very much on the happiness of those around me_____

79. I would do what would please my family, even if I detested that activity_____

80. Winning is everything_____

81. One should live one's life independently of others_____

82. What happens to me is my own doing_____

83. I usually sacrifice my self-interest for the benefit of my group_____

84. It annoys me when other people perform better than I do_____

85. It is important for me to maintain harmony within my group_____

86. It is important to me that I do my job better than others_____

87. I like sharing little things with my neighbours_____

88. I enjoy working in situations involving competition with others_____

89. We should keep our aging parents with us at home_____

90. The well-being of my co-workers is important to me_____

91. I enjoy being unique and different from others in many ways_____

92. If a relative were in financial difficulty, I would help within my means_____

93. Children should feel honoured if their parents receive a distinguished award_____

94. I often do "my own thing" _____

95. Competition is the law of nature_____

96. If a co-worker gets a prize I would feel proud_____

97. I am a unique individual_____

98. To me, pleasure is spending time with others

99. When another person does better than I do, I get tense and aroused_____

100. I would sacrifice an activity that I enjoy very much if my family did not approve of it_____

101. I like my privacy_____

102. Without competition it is not possible to have a good society_____

103. Children should be taught to place duty before pleasure_____

104. I feel good when I cooperate with others_____

105. I hate to disagree with others in my group_____

106. Some people emphasise winning; I am not one of them_____

107. Before taking a major trip, I consult with most members of my family and many friends_____

108. When I succeed, it is usually because of my abilities_____

395

To better understand the complex issues on the attitudes and understanding of mental health problems, I hoping to conduct a series of one-to-one in-depth interviews some time in the not-to distant future. If you would be willing be take part in an interview, I will arrange for a time, day and venue that suits you best. The interview should be conducted in a quiet undisturbed area. Although there is no set length for the interview I do not foresee an interview lasting more than two hours. However, you may withdraw from the interview at any time and without giving a reason. If you consent to it, the interview will be audio-recorded. I will later transcribe the recording and analyse the data. All of your responses will remain completely anonymous. If you are willing to participate, I will take down your name and contact information on a separate file. Please remember that in the manner of confidence and sensitivity, I will not be able to identify you with this questionnaire.

Would you be interested in taking part?

Yes   No

Finally, in order for a large amount of the questionnaires to be handed out, it would be extremely beneficial if you could possibly provide me with 3 or so people, perhaps with a similar background to you, who I could contact to also complete these questionnaires.

1. Name & address & phone number

_____

_____

2. Name & address & phone number

_____

_____

3. Name & address & phone number

_____

_____

**YOU FOR YOUR PARTICIPATION
IN THIS SURVEY. YOUR CONTRIBUTION IS
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Contact information:
My contact details are: Mr Chris Papadopoulos, Middlesex University, Enfield Campus, EN3 4SA. Tel: 020 8411 6817. Email address: c.papadopoulos@mdx.ac.uk

My supervisor's contact details are: Dr John Foster, Middlesex University, Enfield Campus, EN3 4SA. Tel: 020 8411 2656. Email address: j.foster@mdx.ac.uk

If you have any other comments on any aspect of this study, please feel free to express them here:

_____

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_____

Appendix 5d: Quantitative survey questionnaires (English for Chinese version)

QUESTIONNAIRE: MENTAL HEALTH PROBLEMS

Thank you for agreeing to complete this questionnaire. The data that will be gathered from this survey will help us to understand some of the many complex issues around the notion of **attitudes** towards people with mental illness. This questionnaire is completely anonymous. Any reporting of the data will be done in such a way that none can be assigned to a particular individual. **Please answer the questions honestly and do not be influenced by what other people around you say.** There are no right or wrong answers – I simply wish to know your views. If there are any questions you feel are too sensitive to answer, please circle them. Please return this questionnaire to Chris Papadopoulos.

SECTION 1 - Background information

1. How old are you?_____

2. What is your sex?   Male
                           Female

3. What is your ethnicity?
_____

4. Where were you born? (Please specify country)   _____

5. How many years have you lived in England?
_____

6. If you are of Chinese ethnicity, which of the following best describes yourself (see table)
        First generation
        Second generation
        Third generation
        Chinese with one parent
        who is not Chinese

First generation Chinese
Someone who was born in China from Chinese parents and subsequently moved to live in England.

Second Generation Chinese
Someone who was born and grew up in England and whose parents are first generation Chinese

Third generation Chinese
Someone who was born and grew up in England and whose parents are second generation Chinese

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7. Where were you educated?
        England
        China
        Other (please state)
_____

8. If you were educated in **England**, please state your educational level:
        Primary School
        Secondary School
        A level
        College (BTec/HNC/HND)
        University (Degree)
        Postgraduate
        Other (specify) _____

9. If you were educated in **China**, please state your educational level:
        Preschool education
        Primary school
        Secondary
        University (degree)
        Postgraduate
        Other (specify) _____

10. If you were educated in **a different country**, please state your educational level:
_____

11. What is your first language?
_____

12. What is your occupation?
_____

13. What is your religion?
_____

14. How religious do you consider yourself to be?
Extremely religious   Quite religious
Not very religious   Atheist/Agnostic
Other (please state)   _____

15. What is your marital status?
Single   Married   Cohabiting
Divorced/Separated   Widowed

SECTION 2 – Questionnaire 1 The following consists of a list of statements in which you have to tick the response that you **MOST** agree with.

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
16.	There are sufficient existing services for the mentally ill.					
17.	Mentally ill patients need the same kind of control and discipline as a young child.					
18.	Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.					
19.	The mentally ill are a burden on society.					
20.	Anyone with a history of mental problems should be excluded from entering parliament.					
21.	As far as possible, mental health services should be provided through community based facilities.					
22.	There is something about the mentally ill that makes it easy to tell them from normal people					
23.	Most women who were once patients in a mental hospital can be trusted as babysitters.					
24.	Less emphasis should be placed on protecting the public from the mentally ill.					
25.	The mentally ill should not be denied their individual rights.					
26.	The mentally ill should not be given any responsibility.					
27.	Mental hospitals are an outdated means of treating mentally ill.					
28.	Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great.					
29.	A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.					
30.	Local residents have good reason to resist the location of mental health services in their neighbourhood.					

		Strongly agree	Agree	Neutral	Disagree	*Strongly Disagree*
31.	Locating mental health services in residential neighbourhoods does not endanger local residents.					
32.	Mental illness is an illness like any other.					
33.	No one has the right to exclude the mentally ill from their neighbourhood.					
34.	We need to adopt a far more tolerant attitude toward the mentally ill in our society.					
35.	Virtually anyone can become mentally ill.					
36.	The mentally ill are far less of a danger than most people suppose.					
37.	We have a responsibility to provide the best possible care for the mentally ill.					
38.	The mentally ill have for too long been the subject of ridicule.					
39.	One of the main causes of mental illness is a lack of self-discipline and will power.					
40.	More tax money should be spent on the care and treatment of the mentally ill.					
41.	It is best to avoid anyone who has mental problems.					
42.	The best way to handle the mentally ill is to keep them behind locked doors.					
43.	Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.					
44.	The mentally ill should be isolated from the rest of the community.					
45.	The best therapy for many mental patients is to be part of a normal community.					
46.	I would not want to live next door to someone who has been mentally ill.					
47.	The mentally ill don't deserve our sympathy.					

	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
48. Mental patients should be encouraged to assume the responsibilities of normal life.					
49. Mental health facilities should be kept out of residential neighbourhoods.					
50. The mentally ill should not be treated as outcasts of society.					
51. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.					
52. It is frightening to think of people with mental problems living in residential neighbourhoods.					
53. Increased spending on mental health services is a waste of tax money.					
54. Locating mental health facilities in a residential area downgrades the neighbourhood.					
55. *As soon as a person shows signs of mental disturbance he should be hospitalised.*					

SECTION 3 – Other questions

56. Do you know the names of any types of mental illness?   Yes   No

57. If yes, please state a maximum of three names (please try to state the name of the illness, not the symptoms)

_____

_____

_____

58. Do you know what 'learning disabilities' means?

                    Yes   No

59. If yes, what is it?

_____

_____

60. Do you think there is a difference between mental illness and people with learning disabilities?

                    Yes   No

61. If yes, what is it?

_____

_____

_____

62. Can you tell that somebody has mental illness?

          Yes   No   Sometimes

63. If yes or sometimes, how?

_____

_____

64. What do you think are the main causes of mental illness? (please state a maximum of three causes)

_____

_____

_____

65. Do you think mental illness can be passed down in families?

          Yes   No

66. If a friend or neighbour of yours was showing signs of mental illness, who would you contact for help?

_____

_____

67. Do you know of any sort of treatment there is for mental illness?

          Yes   No

68. If yes, please state these treatments.

_____

_____

69. Where did you get most of your information about mental illness?

_____

_____

70. Have you ever visited a psychiatric hospital?

          Yes   No

71. Have you ever worked with people with mental health problems?

          Yes   No

72. If yes, please state the type of work

_____

_____

The following questions are very sensitive. Please remember that the information gathered is completely anonymous and dealt with in the strictest confidence.

73. Do you know somebody who has/had mental illness?

          Yes   No

74. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms) (If no, please skip to question 74)

_____

_____

75. What is your relationship with them?

_____

76. How close to you would you consider this person?

          Extremely close
          Quite close
          Not very close
          Distant
          Very distant

77. Have you ever suffered from any mental illness?

          Yes   No

78. If yes, what was/is the problem? (please try to state the name of the illness, not the symptoms)

_____

_____

_____

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Please follow this scale when answering each question:

1 2 3 4 5 6 7 8 9
I Strongly   Unsure   I Strongly
disagree   agree

79. I prefer to be direct and forthright when I talk with people_____

80. My happiness depends very much on the happiness of those around me_____

81. I would do what would please my family, even if I detested that activity_____

82. Winning is everything_____

83. One should live one's life independently of others_____

84. What happens to me is my own doing_____

85. I usually sacrifice my self-interest for the benefit of my group_____

86. It annoys me when other people perform better than I do_____

87. It is important for me to maintain harmony within my group_____

88. It is important to me that I do my job better than others_____

89. I like sharing little things with my neighbours_____

90. I enjoy working in situations involving competition with others_____

91. We should keep our aging parents with us at home_____

92. The well-being of my co-workers is important to me_____

93. I enjoy being unique and different from others in many ways_____

94. If a relative were in financial difficulty, I would help within my means_____

95. Children should feel honoured if their parents receive a distinguished award_____

96. I often do "my own thing" _____

97. Competition is the law of nature_____

98. If a co-worker gets a prize I would feel proud_____

99. I am a unique individual_____

100. To me, pleasure is spending time with others

101. When another person does better than I do, I get tense and aroused_____

102. I would sacrifice an activity that I enjoy very much if my family did not approve of it_____

103. I like my privacy_____

104. Without competition it is not possible to have a good society_____

105. Children should be taught to place duty before pleasure_____

106. I feel good when I cooperate with others_____

107. I hate to disagree with others in my group_____

108. Some people emphasise winning; I am not one of them_____

109. Before taking a major trip, I consult with most members of my family and many friends_____

110. When I succeed, it is usually because of my abilities_____

To better understand the complex issues on the attitudes and understanding of mental health problems, I hoping to conduct a series of one-to-one in-depth interviews some time in the not-to distant future. If you would be willing be take part in an interview, I will arrange for a time, day and venue that suits you best. The interview should be conducted in a quiet undisturbed area. Although there is no set length for the interview I do not foresee an interview lasting more than two hours. However, you may withdraw from the interview at any time and without giving a reason. If you consent to it, the interview will be audio-recorded. I will later transcribe the recording and analyse the data. All of your responses will remain completely anonymous. If you are willing to participate, I will take down your name and contact information on a separate file. Please remember that in the manner of confidence and sensitivity, I will not be able to identify you with this questionnaire.

Would you be interested in taking part?

Yes   No

Finally, in order for a large amount of the questionnaires to be handed out, it would be extremely beneficial if you could possibly provide me with 3 or so people, perhaps with a similar background to you, who I could contact to also complete these questionnaires.

1. Name & address & phone number

_____

_____

2. Name & address & phone number

_____

_____

3. Name & address & phone number

_____

_____

YOU FOR YOUR PARTICIPATION IN THIS SURVEY. YOUR CONTRIBUTION IS GREATLY APPRECIATED.

Contact information:
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My supervisor's contact details are: Dr John Foster, Middlesex University, Enfield Campus, EN3 4SA. Tel: 020 8411 2656. Email address: j.foster@mdx.ac.uk

If you have any other comments on any aspect of this study, please feel free to express them here:

_____

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