

Are Personal Values of Importance in the Stigmatization of People With Mental Illness?

Ross MG Norman, PhD, CPsych¹; Richard Sorrentino, PhD²; Deborah Windell, BA³; Rahul Manchanda, MD, FRCPC⁴

Objectives: To investigate the relation of responses to the Schwartz Value Scale to preferred social distance to a person with either schizophrenia or depression. The influence of personal value priorities on discrimination has been investigated in several contexts, but seldom with reference to social distance towards those with mental illness.

Method: University students ($n = 200$) completed the Schwartz Value Scale, as well as a measure of beliefs about mental illness and preferred social distance with reference to a vignette describing a person with either schizophrenia or depression.

Results: Consistent with past findings, respondents indicated a preference for greater social distance for schizophrenia than depression, and beliefs about likelihood of socially inappropriate behaviour and danger were correlated with social distance. Self-transcendence value orientation was a significant independent predictor of preference for less social distance. These findings were not influenced by a social desirability bias.

Conclusions: Value orientation makes a significant contribution to the prediction of social distance towards those with mental illness. Evaluation of value-based interventions to reduce such discrimination appears warranted.

Can J Psychiatry 2008;53(12):848–856

Clinical Implications

- Preferred social distance to people with mental illness is related to diagnosis as well as beliefs about social appropriateness of their behaviour and potential danger.
- Personal value priorities make an independent contribution to the prediction of social distance to the mentally ill.
- Values-based appeals may prove effective in improving social reactions to those with mental illness.

Limitations

- Social reactions were assessed with reference to vignettes rather than actual people.
- The measure of social distance is based on stated behavioural intentions rather than actual behaviour.
- The findings should be replicated in other populations.

Key Words: stigma, depression, schizophrenia

People diagnosed with mental illness face many challenges in recovery and social reintegration. Although the intrinsic symptoms of such disorders can contribute to these difficulties, they are greatly compounded by the social stigma associated with mental illness.^{1–3}

Stigma refers to a socially widespread negative response to people who share a common devalued or thought-to-be spoiled identity. It often is conceptualized as consisting of stereotyped beliefs, prejudicial negative emotional reactions, and discriminatory behaviour.⁴ The behavioural component

is often assessed in terms of a preference for greater social distance towards those with the stigmatized identity.⁵ Most research on predictors of the social marginalization of people with mental illness has focused on the role of stereotyped beliefs about such illness.^{1,6,7} In general, however, interventions that have endeavoured to change specific beliefs about the nature of mental illness have had little impact on behavioural intention or behaviour.⁸⁻¹³

In our study, we focus on the role of personal value priorities as they relate to the stigmatization of mental illness. Values are defined as desirable trans-situational goals (expressed as preferable modes of conduct or end states of existence) that serve as guiding principles in people's lives; and it has been postulated that the relative priority that people assign to values strongly influence their behaviour in enduring and significant ways.¹⁴⁻¹⁶ Although value priorities have been found related to prejudice and openness to out-group contact in several contexts,¹⁷⁻²⁰ there has been little exploration of the potential role of values in stigmatization of people with mental illness. Recent papers have speculated that value priorities may be relevant to understanding cross-cultural differences in reactions to those with mental illness.^{21,22} An assessment of values along 3 dimensions (liberal, traditional, and modern)²³ has been included in population surveys in Germany.^{24,25} Angermeyer and Matschinger²⁴ report finding greater preferred social distance to people with mental illness to be associated with people having endorsed more traditional values (achievement, duty, and materialism) and having less attachment to liberal (equality, justice, and tolerance) or modern values (self-realization, hedonism, or postmaterialism). On the other hand, Schomerus et al²⁵ found no significant relations between the same measure of personal values and support for funding cuts for treatment of mental illness.

Particularly important for understanding the structure of values is the work of Schwartz and colleagues.^{14,26-28} They have identified 10 motivationally distinct values related to 3 basic and universal requirements for survival: meeting biological needs; coordinated social interaction; and the survival of groups.^{14,20} Such survival mechanisms have also been postulated to be fundamental factors in social stigmatization and ostracism.²⁹ There is evidence of a universal dynamic relation between the values related to these needs, with the pursuit of some sets of values (for example, achievement and power) being more likely to be consistent; whereas the simultaneous pursuit of others (for example, novelty and tradition) is more likely to be incompatible.^{14,30,31} The relative priority that a person gives to value sets, therefore, is predicted to be of considerable importance in determining other beliefs and behaviours.

The degree of compatibility or conflict between the pursuit of various values have been found to result in an overall structure

consisting of 2 orthogonal dimensions. The first is anchored by the pursuit of self-interests (personal success, authority, and wealth) versus concern for others (such as social justice, helpfulness, and equality). Self-enhancement values emphasize the desirability of achieving personal success through demonstrated competence, and attaining social status and control over others; whereas, self-transcendence values relate to protecting and enhancing the welfare of others. The second dimension is anchored by values related to conservatism (obedience, humility, and social order), compared with openness to change (an exciting life, creativity, and freedom). Conservatism values relate to the importance of self-control, respecting cultural traditions, and safety and stability in social relationships, in contrast to valuing personal autonomy, independence, and variety of experience. Consistent with the postulate that this value structure reflects priorities of universal human motives is the finding that the value structure appears to be cross-culturally consistent.^{27,30,31}

In our paper, we report the results of an investigation of the relation of the value dimensions of self-enhancement, compared with self-transcendence and conservatism, compared with openness to change to beliefs about and preferred social distance concerning the mental illnesses of depression and schizophrenia.

Methods

Participants

Participants ($n = 200$) were undergraduates at the University of Western Ontario in London who responded to advertisements to participate in the study on attitudes towards mental health issues. Participants were offered \$15 as compensation for their time. All participants signed an informed consent and the study protocol was approved by the relevant Ethics Board at the university. There were 90 men and 110 women in the sample, with a mean age of 21.5 years (SD 5.0 years).

Materials

Values

Values were assessed using the Schwartz Value Survey,¹⁴ which lists 57 value items, each followed by a short definition. The 57 items represent 10 underlying values (Table 1). Participants rated each value as a guiding principle in their own lives on a 9-point scale from -1 (opposed to my principles) to 7 (of supreme importance). The scale is asymmetrical to reflect the natural distribution of distinctions that people make when thinking about the importance of values.³⁰ Participants were instructed to initially read the entire list and choose the values that were of greatest and least importance to them and rate them accordingly, thereby providing anchors for the rest of the ratings. To control for differences in scale use between respondents, a deviation score was

Table 1 Definitions of motivational types of values

Power	Social status and prestige, control or dominance over people and resources (social power, authority, wealth)
Achievement	Personal success through demonstrating competence according to social standards (successful, capable, ambitious, influential)
Hedonism	Pleasure and sensuous gratification for oneself (pleasure, enjoying life)
Stimulation	Excitement, novelty, and challenge in life (daring, a varied life, an exciting life)
Self-direction	Independent thought and action-choosing, creating, and exploring (creative, freedom, independent, curious, choosing own goals)
Universalism	Understanding, appreciation, tolerance, and protection for the welfare of all people and for nature (broadminded, wisdom, social justice, equality, a world at peace, a world of beauty, unity with nature, protecting the environment)
Benevolence	Preservation and enhancement of the welfare of people with whom one is in frequent personal contact (helpful, honest, forgiving, loyal, responsible)
Tradition	Respect, commitment, and acceptance of the customs and ideas that traditional culture or religion provide the self (humble, accepting my portion in life, devout, respect for tradition, moderate)
Conformity	Restraint of actions, inclinations, and impulses likely to upset or harm others and violate social expectations or norms (politeness, obedient, self-discipline, honoring parents and elders)
Security	Safety, harmony, and stability of society, relationships, and self (family security, national security, social order, clean, reciprocation of favours)

calculated for each value rating centred on the individual's mean rating across all items.²⁶ This scale has been shown to have good internal and temporal reliability in samples from many countries.^{30,32} Scoring for self-enhancement value orientation was based on the average score for power and achievement motives; self-transcendence on the average of benevolence and universalism; conservatism on the average of security, conformity, and tradition; and openness to change is derived from the average of self-direction and stimulation.^{33,34}

Mental Illness Vignettes

We used 2 vignettes, one concerning a person suffering from schizophrenia and one concerning a person with depression. These vignettes had been prepared for an extensive population survey in Germany concerning reactions to mental illness.^{6,35,36} Each vignette concerned a hypothetical acquaintance, AB, and the symptoms described in the vignette fulfilled the Diagnostic and Statistical Manual of Mental Disorders' criteria for schizophrenia or depression as established by 5 experts in psychopathology. Aside from very minor wording changes to improve readability of the vignettes in English, the only substantial modifications of the vignettes were that the sex of the person described was randomly varied so that in about one-half of the cases the person was described as male and in the other half as female, and a final sentence was added providing a diagnosis so that respondents were responding to a combination of symptoms and diagnosis. Exactly one-half of the respondents received each of the

clinical vignettes concerning schizophrenia or depression; and for 101 respondents, the vignette concerned a female, and for 99 it referred to a male.

Because preferred social distance towards a person with a mental illness may at least partially reflect general preferences or habits not specific to mental illness, we also had subjects complete the social distance scale concerning a vignette describing a normal person, CD, of the same sex as AB. The responses to the normal vignette were always completed before the vignette describing depression or schizophrenia. The vignettes describing schizophrenia, depression, and the normal (healthy) comparison are in Figure 1.

Social Distance

As is typical of research on stigmatization of mental illness, preferred level of social distance was assessed by endorsement of specific behavioural intentions.⁵ We used slightly modified versions of 12 items adapted from the Bogardus Social Distance Scale.^{5,37} Respondents indicated on a 5-point scale (from "I certainly would" to "I certainly would not") the likelihood that they would speak to the person in the vignette if they passed each other on the street; have lunch with the person; do school work with the person; go to a party at the person's home; invite the person to their home; take a job where they would be working with that person; move into a home next door to the person; become a friend of the person; rent a room to the person; recommend the person for a job; support having their sibling or child marry the person; and trust the person to look after their child. Past research has

Figure 1 Vignettes**Vignette 1 Schizophrenia**

Imagine that you know the following about an acquaintance (AB) with whom you occasionally spend your leisure time.

In the past months, AB appears to have changed. More and more, AB has retreated from their friends and colleagues, up to the point of avoiding them. If someone managed to involve AB in a conversation, AB would only talk about whether some people have the natural gift of reading other people's thoughts. This question became AB's sole concern. In contrast with AB's previous habits, AB has stopped taking care of their appearance and looked increasingly untidy. At work, AB seemed absent-minded and frequently made mistakes. As a consequence, AB has already been summoned to their boss.

Finally, AB stayed away from work for an entire week without an excuse. Upon their return, AB seemed anxious and harassed. AB now reports being absolutely certain that people cannot only read other people's thoughts but also directly influence them. AB was, however, unsure who would steer AB's thoughts. AB also said that, when thinking, AB was continually interrupted. Frequently, AB would even hear those people talk to AB, and they would give AB instructions. Sometimes, they would also talk to each other and make fun of whatever AB was doing at the time. AB said that the situation was particularly bad at AB's apartment. At home, AB would really feel threatened, and would be terribly scared. Hence, AB had not spent the night at AB's place for the past week, but rather had hidden in hotel rooms and hardly dared to go out. AB has now sought professional help and was told AB appears to be suffering from schizophrenia.

Vignette 2 Major Depressive Disorder

Imagine that you know the following about an acquaintance (AB) with whom you occasionally spend your leisure time.

Within the past 2 months, AB has changed in nature. In contrast to previously, AB is down and sad without being able to give a concrete reason for feeling low. AB appears serious and worried. There is no longer anything that will make AB laugh. AB hardly ever talks, and if AB says something, AB speaks in a low tone of voice about the worries AB has with regard to AB's future. AB feels useless and has the impression AB does everything wrong. All attempts to cheer AB up have failed. AB lost all interest in things and is not motivated to do anything. AB complains of often waking up in the middle of the night and not being able to get back to sleep. By the morning, AB feels exhausted and without energy. AB says that AB encounters difficulty in concentrating on AB's job. Unlike before, everything takes AB a very long time to do. AB hardly manages AB's workload. As a consequence, AB has already been summoned to AB's boss. AB has now sought professional help and was told AB appears to be suffering from depression.

Vignette 3 Normal

Imagine that you know the following about an acquaintance (CD) with whom you occasionally spend your leisure time.

Over time, CD has not particularly changed in nature. Although CD has ups and downs like most people, CD is generally pretty normal in how CD's acts. CD is usually agreeable, and has a sense of humour. CD's ideas and beliefs do not seem strange and CD has a reasonable approach in thinking about issues. CD is usually comfortable interacting with other people. CD seems to have as much confidence in CD as most people do. CD's mood is generally good and CD is able to get on with the things in CD's life that need to be done. CD is able to do CD's work. While CD has unique characteristics and personality, people who know CD would think that CD is mentally and emotionally healthy.

Note: For simplicity, the terms AB or CD are used repeatedly in the above vignettes to replace relevant pronouns (for example, he/she, his/her) used in the vignettes. Copies of the actual vignettes can be obtained from the corresponding author.

demonstrated that such measures can predict significant variation in actual behaviour.³⁸ These items were completed by participants with response to the person in the normal vignette and either the person with schizophrenia or depression. Responses were averaged across items to provide a cumulative index with higher scores indicating greater social distance. The Cronbach's alpha coefficient for the social distance scale was 0.93.

Beliefs About Illness

Angermeyer and Matschinger⁶ and Hayward and Bright³⁹ identified 5 dimensions of belief as being of potential relevance to determining social distance towards those with mental illness. These were beliefs in likelihood of danger; socially inappropriate behaviour; personal responsibility for illness; talent or ability being associated with the illness; and treatment being effective. Given evidence that empathetic

behaviour towards another person can be influenced by perceived similarity,^{40,41} we also included items designed to assess the extent to which the symptoms of illness are believed to vary on a continuum with normal experience. Ten of the items used were adapted from Angermeyer and Matschinger⁶ and another 10 developed by the authors. Each item was on a 5-point scale from strongly agreed to strongly disagree. Subjects rated these beliefs with respect to the same illness as that characterizing the clinical vignette they read.

The results of a principal axis analysis with a promax rotation were consistent with the presence of the 6 factors described above. Scores on each of the 6 dimensions of belief were calculated using average scores for the relevant items, with higher scores indicating more negative beliefs about illness (greater danger, more socially inappropriate, greater personal responsibility, less continuity with normal, less talent

Table 2 Bivariate correlations with social distance

Variables	Correlation with social distance to ill person
Belief regarding danger	0.34 ^a
Belief regarding social inappropriateness	0.44 ^a
Belief regarding personal responsibility for illness	0.10
Belief regarding discontinuity with normal	0.19 ^b
Belief regarding no unusual talent and (or) intelligence	-0.05
Belief regarding treatment effectiveness	0.03
Self-transcendence value orientation	-0.42 ^a
Self-enhancement value orientation	0.27 ^a
Conservatism value orientation	0.18 ^c
Openness value orientation	-0.03
Preferred social distance to normal person	0.31 ^a
Diagnosis ^d	0.27 ^a
Social desirability	-0.16 ^c

Note: All scales were scored so that higher scores indicate more negative beliefs, greater social distance or high priority to the relevant value orientations.

^a $P < 0.001$; ^b $P < 0.01$; ^c $P < 0.05$

^d Score 0 = depression; 1 = schizophrenia

or intelligence, and less effectiveness of treatment). The alpha coefficients for the first 4 scales were respectable (from 0.74 to 0.83). However, the talent or intelligence and treatment effectiveness scales showed lower alpha coefficients of 0.48 and 0.57, respectively. Angermeyer and Matschinger⁶ also found lower internal consistency for these scales than for danger, attribution of responsibility, or social unpredictability. An assessment of the 2-week test-retest reliability of each of the scales was carried out using 20 respondents and all yielded reliability of 0.75 or greater.

Social Desirability

Concern has been expressed that responses to questions about mental illness may be influenced by a bias to present a socially desirable impression.^{5,42-44} To examine this possibility, we included the Crowne-Marlowe Social Desirability Scale.⁴⁵ This 33-item scale is designed to provide an index of a respondent's tendency to present a socially desirable impression through endorsing, as true, self-descriptions that are acceptable but improbable, or denying descriptions that are undesirable but probable.

Results

Effects of Sex

Sex of the respondent or the person represented in the vignette had no significant effect on preferred social distance to either the normal person or the person described as having a mental illness. Male respondents were more likely to believe in personal responsibility for the onset of illness ($t = 2.95$, $df = 198$, $P < 0.01$) and were rated higher on conservatism values ($t = 2.73$, $df = 198$, $P < 0.01$), but otherwise there were no significant sex differences on any belief or value ratings.

Prediction of Social Distance

Table 2 shows the bivariate correlations of each of the belief scales, value orientations, preferred social distance to the normal person, social desirability score, and diagnosis (presence of schizophrenia is treated as a dummy variable 1) with preferred social distance to the person depicted as having mental illness. It can be seen that greater belief in danger, social inappropriateness, and discontinuity with normal experience is associated with preference for greater social distance. Three of the value orientations also show significant correlations with social distance. Greater self-transcendence was associated with greater willingness to interact with the ill person while self-enhancement or conservatism value orientation was associated with preference for greater social distance.

When the ill person was portrayed as having a diagnosis of schizophrenia, respondents preferred greater social distance than when the diagnosis was depression. There was also a correlation between preferred social distance to the person portrayed in the normal vignette and social distance to the ill person. Finally, there was a modest, but significant, correlation between higher scores on social desirability and social distance.

To assess the extent to which each of the significant correlates of social distance in Table 2 makes an independent contribution to prediction of social distance, we entered them simultaneously into a multiple regression equation. To be a significant predictor in such an equation, a variable has to predict social distance independently of the other predictors.⁴⁶ Because the correlation between the self-transcendence and self-enhancement value orientations ($r = -0.73$) is sufficient to pose concerns about multicollinearity,⁴⁶ we elected to enter the self-transcendence value into the equation, but not self-enhancement. The results of this regression analysis are presented in Table 3. The combination of predictors accounted for 35% of the variance in preferred social distance with belief in social inappropriateness, self-transcendence value orientation, and preferred social distance to the normal person being independent

Predictors	Standardized β	<i>t</i>	<i>P</i>
Belief regarding danger	0.115	1.81	0.07
Belief regarding social inappropriateness	0.254	3.84	<0.001
Belief regarding discontinuity with normal	0.018	0.25	0.80
Self-transcendence value orientation	-0.253	3.93	<0.001
Conservatism value orientation	0.076	1.25	0.21
Social distance to normal person	0.208	3.50	<0.001
Diagnosis	0.126	1.77	0.08
Social desirability	-0.040	0.65	0.52
Adjusted $r^2 = 0.351$; $df = 8,191$			

predictors. Although belief concerning danger showed a highly significant bivariate relationship to preferred social distance, its role as an independent predictor in the regression equation did not quite reach conventional 2-tailed significance.

The reader might wonder about possible interactions between value orientation and beliefs in determining preferred social distance. Relevant interaction terms did not reach conventional levels of statistical significance. The interaction between conservation and beliefs in social inappropriateness approached significance ($\beta = -0.119$, $t = 1.76$, $df = 10\ 189$, $P = 0.08$), suggesting that those who placed more value on conformity and tradition were more influenced by beliefs about socially inappropriate behaviour on the part of people with depression or schizophrenia.

To assess the relative importance of the variables as predictors of social distance, we carried out a stepwise regression. In this procedure the variables are entered into the equation on the basis of their value in cumulatively predicting variance. The most important single predictor was belief about social inappropriateness, followed by self-transcendence value orientation, social distance to the normal person, and finally, diagnosis.

Discussion

Two aspects of our results replicate previous findings concerning preferred social distance towards people with mental illness. The first is the finding that amongst the beliefs about mental illness, it is beliefs about the likelihood of inappropriate social behaviour or danger that show the strongest relation to preferred social distance. Past research reports also implicate these as the aspects of stereotyped beliefs that are most predictive of personal behavioural intentions toward the mentally ill and the proportion of variance they account for in

population surveys is comparable to our findings.^{6,47,48} In addition, the finding that respondents generally preferred greater social distance to a person with schizophrenia, compared with someone with depression, also parallels past reports from several countries.^{21,35,49,50}

The finding of a correlation between behavioural intentions towards a person portrayed as normal and one with mental illness indicates that the latter at least partially reflect more general preferences concerning social distance. Such preferences are likely related to personal traits such as social anxiety and extraversion, as well as cultural factors. Our results demonstrate that while such general preferences do predict variance in social distance to those with mental illness, the influence of aspects of belief about mental illness and value orientation have an additional, independent impact on willingness to interact with people with mentally illness.

The self-transcendence value orientation was second only to belief in the likelihood of socially inappropriate behaviour in prediction of preferred social distance. In the structure of value systems that Schwartz and colleagues have demonstrated to have cross-cultural stability, self-transcendence, compared with self-enhancement, is considered to reflect a conflict between valuing acceptance of others as equals and concern for their welfare, compared with pursuit of one's own relative success and dominance over others.²⁰ Consistent with the hypothesis that self-transcendence, compared with self-enhancement, involves an incompatibility or conflict is our finding of a high negative correlation between the 2 value orientations. Further, while we elected, for statistical reasons, to only enter the self-transcendence orientation in our regression prediction of social distance, if we carry out the analysis using self-enhancement instead of self-transcendence then a comparable pattern of results is

obtained with the exception that higher self-enhancement is associated with greater social distance.

A limitation of this report is the use of a paper-and-pencil measure of social distance to a hypothetical person in a vignette. This methodology is frequently used in research concerning the stigmatization of mental illness.⁵ As noted earlier, there is evidence that measures of behavioural intention, such as used in our social distance measure, can predict significant variation in actual behaviour.³⁸ Nevertheless, we acknowledge the importance to more fully investigate the role of beliefs about mental illness and value priorities in predicting overt behaviour. As well, some might consider the use of university students to be a limitation. The response of such students are of interest and importance in their own right, particularly given that they are of an age and in a context where serious mental illness often comes to light. Our own work in the field of early identification and treatment of psychotic disorders leaves us convinced of the importance of the attitudes and behaviours of such populations for the detection of and recovery from such illnesses. It is also worth noting that in our sample the variance in social distance accounted for by specific beliefs about mental illness is very similar to that from a previous general population survey.^{6,48} In future, we intend to investigate the importance of personal values in predicting reactions to the mentally ill in other populations.

Our findings have a parallel in work concerning social distance and discriminatory behaviour towards other groups. It has been argued that valuing individual achievement can be associated with more racially discriminatory feelings and behaviour; while egalitarian or humanitarian ideals can serve as brakes on such reactions.^{17,51,52} Several studies have found that people who place greater priority on egalitarian values are less likely to express discriminatory reactions to other racial groups or those with a gay sexual orientation.^{17,53,54} There are strong parallels between the concept of egalitarian values and the self-transcendence value orientation as assessed in our study. The relation between such a value structure and discriminatory behaviour towards those with mental illness is likely to reflect such values being associated with greater feelings of sympathy leading to greater willingness for social contact; and (or) an active effort to avoid the psychological discomfort that could result from valuing social justice, equality, and helpfulness while ostracizing people with mental illness.

Most efforts to reduce behavioural discrimination towards those with mental illness implicitly use a model of changing beliefs about mental illness to change behaviour. As noted earlier, several such interventions have been found effective in changing beliefs, but have limited, if any, impact on behavioural intentions or behaviour.⁸⁻¹³ While the notion that changes in beliefs and attitudes determine behavioural

intentions has an appeal, there are circumstances in which the sequence is reversed.^{55,56} One illustration of the way in which behaviour can influence beliefs and attitudes is illustrated by evidence that behavioural contact with those with mental illness can, in some circumstances, result in changes in beliefs and attitudes.⁵⁷

How might values be used to induce changes in behaviour and reduce social distance? The functional approach to understanding behaviour suggests that our social responses can serve several purposes. The utilitarian functions are based on the personal costs and benefits associated with a particular response; the social adjustive functions relate to us responding in ways considered appropriate by different reference groups and the value expressive function refers to an attitude or behaviour serving the purpose of expressing important personal values.^{58,59} Consistent with the latter function, values theory postulates that by linking specific attitudes and behaviours to personal value priorities one can increase their centrality and the likelihood of people acting in a fashion consistent with them.^{16,20,60,61} This suggests the possible effectiveness of messages linking social support for the mentally ill to an individual's important personal values in bringing about actual behavioural change.

The most common value-based method of inducing behaviour change emphasizes the power of inducing a tension between one's self-concept and the values one holds. This is often referred to as values confrontation. In several contexts, it has been found that bringing to people's attention an inconsistency between a central part of their self-concept or aspirations (such as being a nonracist, a successful dieter, or a good teacher) and the priority they give to a personal value (such as freedom, equality, wisdom, or compassion) brings about a long-term change in value priorities and behaviour (joining a civil rights movement, losing weight, improving teaching skills).⁶²⁻⁶⁷ Mayville and Penn⁶⁸ briefly report an unsuccessful attempt to use this approach to increase willingness of business people to hire people with mental illness. The authors acknowledge that their induction of dissatisfaction was relatively weak, compared with more successful uses of this value discrepancy approach. Given the relation between value orientation and social distance we report here, there may well be rewards in further investigating such value-based interventions as a method for improving the social circumstance of people with mental illness.

Funding and Support

This research was supported by a grant from the Social Sciences and Humanities Research Council of Canada.

References

- Corrigan PW, Kleinlein P. The impact of mental illness stigma. In: Corrigan PW, editor. *On the stigma of mental illness: practical strategies for research and social change*. Washington (DC): American Psychological Press; 2005. p 11–44.
- Thornicroft G. *Shunned: discrimination against people with mental illness*. Oxford (GB): Oxford University Press; 2006.
- United States Department of Health and Human Services. *Mental health: a report of the Surgeon General*. Rockville (MD); 1999.
- Corrigan P, Markowitz FE, Watson A, et al. An attribution model of public discrimination towards persons with mental illness. *J Health Soc Behav*. 2003;44(2):162–179.
- Link BG, Yang LH, Phelan JC, et al. Measuring mental illness stigma. *Schizophr Bull*. 2004;30(3):511–541.
- Angermeyer MC, Matschinger H. The stereotype of schizophrenia and its impact on discrimination against people with schizophrenia: results of a representative survey in Germany. *Schizophr Bull*. 2004;30:1049–1061.
- Link BG, Phelan JC. Conceptualizing stigma. *Ann Rev Sociol*. 2001;27:363–385.
- Gaebel W, Baumann AE. Interventions to reduce the stigma associated with severe mental illness: experiences from the open the doors program in Germany. *Can J Psychiatry*. 2003;48(10):657–662.
- Paykel ES, Hart D, Priest RG. Changes in public attitudes to depression during the Defeat Depression Campaign. *Br J Psychiatry*. 1998;173:519–522.
- Pinfold V, Huxley P, Thornicroft G, et al. Reducing psychiatric stigma and discrimination—evaluating an educational intervention with the police force in England. *Soc Psychiatry Psychiatr Epidemiol*. 2003;38(6):337–344.
- Pinfold V, Toulmin H, Thornicroft G, et al. Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *Br J Psychiatry*. 2003;182:342–346.
- Rosen A, Walter G, Casey D, et al. Combating psychiatric stigma: an overview of contemporary initiatives. *Aust Psychiatry*. 2000;8:19–26.
- Schulze B, Richter-Werling M, Matschinger H, et al. Crazy? So what! Effects of a school project on students' attitudes towards people with schizophrenia. *Acta Psychiatr Scand*. 2003;107(2):142–150.
- Schwartz SH. Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. In: Zanna M, editor. *Advances in experimental social psychology*. Vol 25. Orlando (FL): Academic Press; 1992. p 1–65.
- Kluckhohn C. Values and value-orientations in the theory of action: an exploration in definition and classification. In: Parson T, Shils E, editors. *Toward a general theory of action*. Cambridge (GB): Harvard University Press; 1951:388–433.
- Rokeach M. *The nature of human values*. New York (NY): Free Press; 1973.
- Biernat M, Vescio TK, Theno SA, et al. Values and prejudice: toward understanding the impact of American values on outgroup attitudes. In: Seligman C, Olson JM, Zanna MP, editors. *The psychology of human values: the Ontario symposium*. Vol 8. Hillsdale (NJ): Lawrence Erlbaum; 1996.
- Haddock G, Zanna MP, Esses VM. Assessing the structure of prejudicial attitudes: the case of attitudes toward homosexuals. *J Pers Soc Psychol*. 1993;65:1105–1118.
- Pratto F, Sidanius J, Stallworth LM, et al. Social dominance orientation: a personality variable predicting social and political attitudes. *J Pers Soc Psychol*. 1996;67:741–763.
- Schwartz SH. Value priorities and behavior: applying a theory of integrated value systems. In: Seligman C, Olson JM, Zanna MP, editors. *The psychology of human values: the Ontario symposium*. Vol 8. Hillsdale (NJ): Erlbaum; 1996. p 1–24.
- Griffiths KM, Nakane Y, Christensen H, et al. Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry*. 2006;6:21.
- Yang LH, Kleinman A, Link BG, et al. Culture and stigma: adding moral experience to stigma theory. *Soc Sci Med*. 2007;64(7):1524–1535.
- Maag G. Zur erfassung von werten in der umfrageforschung: ein empirischer beitrag zur neu konzeptionalisierung und operationalisierung [The assessment of value orientations in survey research: an empirical contribution to its conceptualization and operationalization]. *Z Soziol*. 1989;18:313–323. German.
- Angermeyer MC, Matschinger H. Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany. *Psychol Med*. 1997;27(1):131–141.
- Schomerus G, Matschinger H, Angermeyer MC. Preferences of the public regarding cutbacks in expenditure for patient care: are there indications of discrimination against those with mental disorders? *Soc Psychiatry Psychiatr Epidemiol*. 2006;41(5):369–377.
- Bardi A, Schwartz SH. Values and behavior: strength and structure of relations. *Pers Soc Psychol Bull*. 2003;29(10):1207–1220.
- Schwartz SH. Basic human values: their content and structure across countries. In: Tamayo A, Porto JB, editors. *Valores e comportamento nas organizacoes*. Petropolis (BR): Vozes; 2005. p 21–25. Spanish.
- Schwartz SH. Basic human values and theory: measurement and applications. *Rev Fr Soc*. 2006;47:929–968.
- Kurzban R, Leary MR. Evolutionary origins of stigmatization: the functions of social exclusion. *Psychol Bull*. 2001;127(2):187–208.
- Schwartz SH, Bardi A. Value hierarchies across cultures: taking a similarities perspective. *J Cross Cult Psychol*. 2001;32:268–290.
- Schwartz SH, Bilsky W. Toward a theory of the universal content and structure of values: extensions and cross-cultural replications. *J Pers Soc Psychol*. 1990;58:878–891.
- Schmitt MJ, Schwartz SH, Steyer R, et al. Measurement models for the Schwartz Values Inventory. *Eur J Psychol Assess*. 1993;9:107–121.
- Roccas S. Identification and status revisited: the moderating role of self-enhancement and self-transcendence values. *Pers Soc Psychol Bull*. 2003;29(6):726–736.
- Struch N, Schwartz SH, van der Kloot WA. Meanings of basic values for women and men: a cross-cultural analysis. *Pers Soc Psychol Bull*. 2002;28:16–28.
- Angermeyer MC, Matschinger H. Public beliefs about schizophrenia and depression: similarities and differences. *Soc Psychiatry Psychiatr Epid*. 2003;38(9):526–534.
- Angermeyer MC, Matschinger H. Causal beliefs and attitudes to people with schizophrenia. Trend analysis based on data from two population surveys in Germany. *Br J Psychiatry*. 2005;186:331–334.
- Bogardus ES. Social distance and its origins. *J Appl Sociol*. 1925;9:216–226.
- Armitage CJ, Conner M. Efficacy of the theory of planned behaviour: a meta-analytic review. *Br J Soc Psychol*. 2001;40(Pt 4):471–499.
- Hayward P, Bright JA. Stigma and mental illness: a review and critique. *J Ment Health*. 1997;6(4):345–354.
- Batson CD, Lishner DA, Cook J, et al. Similarity and nurturance: two possible sources of empathy for strangers. *Basic Appl Soc Psychol*. 2005;27:15–25.
- Batson CD, Sager K, Garst E, et al. Is empathy due to self-other merging? *J Pers Soc Psychol*. 1997;73:495–509.
- Alexander LA, Link BG. The impact of contact on stigmatizing attitudes toward people with mental illness. *J Ment Health*. 2003;12:271–289.
- Haghighat R. A unitary theory of stigmatization: pursuit of self-interest and routes to destigmatization. *Br J Psychiatry*. 2001;178:207–215.
- Haghighat R. The development of an instrument to measure stigmatization: factor analysis and origin of stigmatization. *Eur J Psychiatry*. 2005;19:144–154.
- Crowne DP, Marlowe D. A new scale of social desirability independent of psychopathology. *J Consult Psychol*. 1960;24:349–354.
- Tabachnick BG, Fidell LS. *Using multivariate statistics*. 4th ed. Boston (MA): Allyn and Bacon; 2001.
- Martin J, Pescosolido BA, Tuck SA. Of fear and loathing: the role of disturbing behavior, labels, and causal attributions in shaping public attitudes toward people with mental illness. *J Health Soc Behav*. 2000;41:208–223.
- van 't Veer JT, Kraan HF, Drosseart SHC, et al. Determinants that shape public attitudes towards the mentally ill: a Dutch public study. *Soc Psychiatry Psychiatr Epidemiol*. 2006;41:310–317.
- Crisp AH, Gelder MG, Rix S, et al. Stigmatization of people with mental illnesses. *Br J Psychiatry*. 2000;177:4–7.
- Pescosolido BA, Monahan J, Link BG, et al. The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *Am J Public Health*. 1999;89(9):1339–1345.
- Dutton DG. Tokenism, reverse discrimination, and egalitarianism in interracial behavior. *J Soc Issues*. 1976;32:93–107.
- Feldman S. Economic self-interest and mass belief systems. *Am J Pol Sci*. 1983;26:446–466.
- Gaertner SL, Dovidio JF. The aversive form of racism. In: Dovidio JF, Gaertner SL, editors. *Prejudice, discrimination and racism*. Orlando (FL): Academic Press; 1986.
- Katz I, Hass RG. Racial ambivalence and American value conflict: correlational and priming studies of dual cognitive structures. *J Pers Soc Psychol*. 1988;55:893–905.
- Ben DJ. *Beliefs, attitudes and human affairs*. Belmont (CA): Brook Cole; 1970.
- Olson JM, Stone J. The influence of behavior on attitudes. In: Albarracín D, Johnson BT, Zanna MP, editors. *The handbook of attitudes*. Mahwah (NJ): Lawrence Erlbaum Associates Publishers; 2005. p 223–271.
- Couture SM, Penn DL. Interpersonal contact and the stigma of mental illness: a review of the literature. *J Ment Health*. 2003;12(3):291–305.
- Katz D. *The functional approach to the study of attitudes*. Public Opin Q. 1960;24:163–204.
- Smith MB, Bruner JS, White RW, editors. *Opinions and personality*. New York (NY): Wiley; 1956.
- Ostrom TM, Brock TC. Cognitive bonding to central values and resistance to a communication advocating change in policy orientation. *J Exp Res Pers*. 1969;4:42–50.
- Murray SL, Haddock G, Zanna MP. On creating value-expressive attitudes: an experimental approach. In: Seligman C, Olson JM, Zanna M, editors. *The psychology of values: the Ontario symposium*. Vol 8. Hillsdale (NJ): Lawrence Erlbaum; 1996.
- Ball-Rokeach SJ, Rokeach M, Grube JW, editors. *The great American values test*. New York (NY): Free Press; 1984.

63. Greenstein T. Behavior change through value self-confrontation: a field experiment. *J Pers Soc Psychol.* 1976;34(2):254–262.
64. Grube JW, Mayton DM, Ball-Rokeach SJ. Inducing changes in values, attitudes, and behaviors: belief system theory and the method of value self-confrontation. *J Soc Issues.* 1994;50:153–173.
65. Rokeach M. Long-range experimental modification of values, attitudes and behavior. *Am Psychol.* 1971;26:453–459.
66. Rokeach M, McLellan DD. Feedback on information about the values of self and others as determinants of long-term cognitive and behavioral change. *J Appl Soc Psychol.* 1972;2:236–251.
67. Schwartz SH, Inbar-Saban N. Value self-confrontation as a method to aid in weight loss. *J Pers Soc Psychol.* 1988;54(3):396–404.
68. Mayville E, Penn DL. Changing societal attitudes toward persons with severe mental illness. *Cogn Behav Pract.* 1998;5:241–253.

Manuscript received November 2007, revised, and accepted April 2008.

¹Professor, Departments of Psychiatry and Epidemiology and Biostatistics, University of Western Ontario, London, Ontario.

²Professor, Department of Psychology, University of Western Ontario, London, Ontario.

³Research Coordinator, Prevention and Early Intervention Program for Psychoses, London Health Sciences Centre, London, Ontario.

⁴Professor, Department of Psychiatry, University of Western Ontario, London, Ontario; Physician Leader, Prevention and Early Intervention Program for Psychoses, London Health Sciences Centre, London, Ontario.

Address for correspondence: Dr R Norman, Prevention and Early Intervention Program for Psychoses, London Health Sciences Centre, Room 114A–392 South Street, London, ON N6A 4G5; rnorman@uwo.ca

Résumé : Les valeurs personnelles ont-elles de l'importance dans la stigmatisation des personnes souffrant de maladie mentale?

Objectifs : Étudier la relation des réponses à l'échelle de valeurs de Schwartz avec la préférence d'une distance sociale d'une personne souffrant de schizophrénie ou de dépression. L'influence des priorités des valeurs personnelles sur la discrimination a été étudiée dans plusieurs contextes, mais rarement en se référant à la distance sociale de ceux qui souffrent de maladie mentale.

Méthode : Des étudiants d'université ($n = 200$) ont répondu à l'échelle de valeurs de Schwartz, ainsi qu'à une mesure des croyances sur la maladie mentale et la distance sociale préférée, relativement à un scénario décrivant une personne souffrant soit de schizophrénie, soit de dépression.

Résultats : Conformément aux résultats passés, les répondants ont indiqué une préférence pour une distance sociale accrue pour la schizophrénie et la dépression, et les croyances sur la probabilité d'un comportement socialement inconvenant et d'un danger étaient corrélées avec la distance sociale. La valeur d'autotranscendance était un prédicteur indépendant significatif de la préférence de moins de distance sociale. Ces résultats ne sont pas influencés par un biais de désirabilité sociale.

Conclusions : L'échelle des valeurs contribue significativement à la prédiction de la distance sociale envers ceux qui souffrent de maladie mentale. L'évaluation d'interventions fondées sur les valeurs visant à réduire cette discrimination semble nécessaire.