

A Comparative Sociological Investigation of the Conceptions and Perceptions of Mental Health and Illness in Arica, Chile and Rome, Italy

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Abstract

This comparative study aimed to discover the principal factors that influence the perceptions of citizens in Arica, Chile and Rome, Italy toward mental illness.

Specifically, the study aimed to investigate how these perceptions affect the societal acceptance of mentally ill individuals and to identify potential sources of stigma.

In both cities, mental health services exist for free use by citizens, but stigma makes the use of these services and the acceptance of those who use them somewhat taboo. Past studies on the topic of mental health stigma have investigated the barriers to accessing mental health services (Acuña & Bolis 2005), the inception and effects of Basaglia's Law (Tarabochia 2011), strategies to combat stigma (López et al. 2008) and images of mental illness in the media (Stout, Villeagas & Jennings 2004).

To discover Aricans' opinions on mental health and illness, personal interviews were administered to five mental health professionals, and a 20-question survey was administered to 131 members of the general population. In Rome, 27 subjects answered an 18-question survey as well as an interview, and 12 professionals participated in narrative interviews. From these interviews and surveys, the lack of economic, structural and human resources to effectively manage mental health programs was gleaned. Moreover, many participants identified how stigma infringed upon the human rights of those with mental illnesses and opined that they were barely accepted in society.

Conclusions drawn were that stigma stems from multiple concurrent sources, and strategies to reduce it must align with each society's unique needs. Stigma prevents people from caring for their mental health and from integrating those with mental illness.

Key words: *mental health, stigma, mental illness, Basaglia's Law and human rights*

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Introduction

If the mind dictates our every step in life, it would thus be logical to place a high value on a healthy mind and to go to great lengths to guarantee its stability. Mental illness is a topic that has historically been shrouded with a strong stigma, and it still has not gained widespread acceptance as a legitimate disease in many parts of the world, including Chile and Italy. Along with stigma, come prejudice, discrimination and human rights violations against people suffering from mental illnesses. Mental health is often the forgotten specialty in medicine, so exploring why this case is a reality can shed light on possible ways to change this situation.

Defining stigma proves to be complex and variable, as investigators either provide a general dictionary definition or provide their own conceptualization of the term. Erving Goffman views stigma as intrinsically tied to the divulgence, inadvertent or not, of personal information as social information. He conceptualizes it as “a pervasive two-role social phenomenon in which every individual participates in both roles,” due to the fluid, rather than concrete, nature of interaction (Goffman 138). This interaction can cause “performers of each role [to] withdraw from contact with the other as a means of adjustment; each may feel that he is not fully accepted by the other; each may feel that his own conduct is being watched too closely—and be correct in this feeling” (Goffman 133). This social information can then be transposed to encompass entire groups of individuals who associate together, thus propagating the stigma, “The issue is that in certain circumstances, the social identity of those an individual is with can be used as a source of information concerning his own social identity, the assumption being that he is

what the others are” (Goffman 47). Because the average person would not willingly choose to be marginalized, he or she will marginalize others to bolster his or her own sense of normalcy, “The very anticipation of such contacts can of course lead normals and the stigmatized to arrange life so as to avoid them” (Goffman 13).

The results of this stigma can be rather grave, having “a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health and life itself” (Link & Phelan 2001). Based upon societal opinions, as well as economic and political power of those in control, stigma arises from a “connection between labels (human differences) and stereotypes (negative attributes)” (Link & Phelan 2001). For this reason, stigmatizing attributes can lose much of their force over time—it takes power to stigmatize. The key terms linked to stigma are stereotypes, which are negative beliefs towards a certain group (ex. dangerousness, incompetence, weakness of character), prejudices, which represent an agreement between beliefs and negative emotional reactions (ex. rage, fear) and discrimination, which is the behavioral response to prejudice (ex. avoidance, refusal of employment, withholding help) (Corrigan & Watson 2002).

With these terms in mind, this comparative study was constructed to decipher the reasons for existing mental health perceptions in Arica, Chile and Rome, Italy, and how those perceptions affect the valuation of mental health and of people suffering from mental illness. Venturing to Chile and then Italy was a unique experience to explore two cultures firsthand, rather than solely through classroom study, to embark upon independent mental health stigma research about the intersection of the brain and society, and to further comprehend the inequities entrenched within the health care system. The

researcher sought to tackle the disparities in comprehension, options, access and quality of care within the field of mental health and to find reasonable solutions to some of these problems.

To understand how mental health systems function today, both at the medical and social levels, one must study the background of the country in question. Chile and Italy both have staunch Catholic, conservative traditions that have promoted a pervasive cultural religiosity. The first half of this study was conducted in Arica, Chile in the fall of 2011 as part of the study abroad program School of International Training Chile: Public Health, Traditional Medicine and Community Empowerment. It was not originally conceived as a comparative study, but the results were compelling enough to incite further research. With the researcher pursuing a Combined Spanish & Italian Studies major, Italy was a logical choice as the second country of study. However, the deeper motivation was that Italy has a unique history with mental health and illness, being the first country to have legally abolished mental institutions in 1978. The country was a pioneer in its depiction of mental illness as a systemic problem with roots within society and not solely within the organic matter of the mind. However, studies show that the stigma linked to mental illness did not disappear along with the physical institutions. Thus, in both countries, the aim was to explore the way members of each society think about mental health and illness today, as well as to determine the principal factors that influence their perceptions of mental illness.

Chile suffered a period of dictatorship and terror under Augusto Pinochet from 1973 to 1990, and this period arguably influenced the types and prevalence of mental illness that pervade within its borders today. Prior to 1973, Chile embarked upon a road

to socialism under President Salvador Allende in 1970, when the government began to nationalize farms, factories and education with ENU, or *Escuela Nacional Unificada* [Unified National School]. However, with the constitutionality of this legislation in question, the Right and the Left political parties vilified each other to the point that military officers stepped in to revolt against the government. In 1973, the United States intervened on behalf of the Right and the military, and the military's siege of the presidential palace drove President Allende to commit suicide (Collier & Sater 352-58).

Following this tragic series of events, General Pinochet assumed power with an iron fist. Completely dismantling any hope of a democratic government, he closed down Congress, banned all political parties, imposed nighttime curfews, shut down left-wing media and put military personnel in charge of important national institutions (Collier & Sater 259). Not only did he stage an overhaul of the democratic process, but he also went to the extreme of arbitrarily arresting, imprisoning, raiding, surveilling, intimidating, abducting, detaining, torturing, exiling and executing left-wing activists and *allendistas* (Allende supporters) in torture-centers and detention camps. Spearheading these horrors was Pinochet's secret police force, the DINA, or *Dirección de Inteligencia Nacional* [Directorate of National Intelligence], which carried out most of the terroristic acts that Pinochet ordered (Collier & Sater 360).

In addition to physical violence, Pinochet implemented rigid economic policies that rocked the nation. With his permission, neo-liberal Chilean economists, named the Chicago Boys, drastically cut economic spending in an attempt to erase state intervention in the economic affairs of the country. By 1975, the GDP had fallen to one-seventh of its pre-1973 value (Collier & Sater 365). The rapid shift from nationalization to privatization

caused the Chilean economy to implode in a recession that restructured traditional forms of employment to short-term labor and seasonal shifts, while also restructuring social strata (Collier & Sater 374). To maintain his power, Pinochet met every protest movement launched by labor unions or grassroots organizations with firm repression (Collier & Sater 382). His reign was the longest of any Chilean president, lasting seventeen years, when he finally had to concede to Patricio Aylwin, who won in democratic elections in 1990. Under his reign of terror, more than 200,000 people were tortured, imprisoned or otherwise abused, 1 million people were exiled and at least 2,200 died or mysteriously disappeared, which together represent nearly 10% of the population at the time (Sagaris 1995). Chile's Rettig Report and the National Corporation for Reconciliation and Reparation actually cited a higher figure of 2,095 people murdered and 1,102 missing between September 11, 1973 and March 11, 1990 due to Pinochet's repressive government (Fernandez 2002).

Just five years after Pinochet relinquished power, the Chilean economy bounced back, as did political stability, but mental health issues abounded. Understandably, the horrors of the dictatorship induced trauma in many of the affected Chilean citizens. Some immediate effects included alcohol and drug abuse, family violence and depression (Sagaris 1996). Studies showed that in 1995, Chile ranked third in the world for child abuse and alcoholism, while 25% of women reported experiencing spousal abuse and 33% reported experiencing psychological abuse (Sagaris 1996). According to Dr. Alberto Minoletti, who was exiled to Canada by Pinochet, the coup of 1973 shook the core of society, bringing "social reforms that threatened the country's ruling elite and those who depended on it" (Sagaris 1996). The shift in societal order frightened and depressed

Chileans, leaving many hopeless enough to turn to alcohol. Additionally, anxiety and drug abuse increased, with 11% of Chilean adults self-medicating with benzodiazepines and children experimenting with both legal and illegal drugs at ever-younger ages (Sagaris 1996). Today, the national commission of exonerated and released political victims of Pinochet works to guarantee the health and human rights of all affected by the military regime through PRAIS, which stands for *Programa de Reparación en Atención Integral en Salud y Derechos Humanos* [Reparation Program for Integral Healthcare Attention and Human Rights]. Established in 1991, PRAIS is a health insurance plan conceived by the Chilean state to provide some sort of retribution to the victims of political repression.

With PRAIS, beneficiaries receive free access to public healthcare, including examinations, medical consultations, hospitalization, surgeries and medication (Prais y Derechos Humanos 2007). Particularly interesting is its focus on mental healthcare. PRAIS pays special attention to psychiatric treatment, individual or family psychotherapy and psychological care. Although people cannot always detect physical scars of past abuse, terror victims often suffer from flashbacks, nightmares, feeling socially disconnected, loss of social status, constant fear and loss of trust in others, which can all induce mental health problems. According to sociologist Marta Lagos, two-thirds of Chileans “believe other people don’t offer their true opinions during conversations” because of an attenuated fear of speaking out during Pinochet’s regime (Sagaris 1996). PRAIS covers fathers, mothers, siblings, children and grandchildren of victims of Chile’s dictatorial period (identified by both the National Commission for Truth and Reconciliation and the National Corporation of Reparation and Reconciliation), people

who have worked in the protection of human rights of the aforementioned individuals for at least ten years and additional victims identified by the National Commission on Political Imprisonment and Torture (Prais y Derechos Humanos 2007).

In a telling quote, Dr. Maria Luisa Cordero, a psychiatrist and former president of the Chilean Mental Health Association, described her country post-Pinochet, “Chile has become a country of people who live in the present, with no plans for the future and a blacked-out past” (Sagaris 1996). In Chile’s case, the past definitely affected the present condition of its citizens, so it is important to acknowledge this past when talking about stigma and mental illness. The 2002 Chilean Study on the Prevalence of Psychiatric Pathologies shows that 36% of the population over 15 years of age has had a psychiatric disorder at some point in their lifetime (Ministerio de Salud 2010). The country’s four principal mental disorders are agoraphobia (11.1%), major depression (9%), dysthymia (8%) and alcohol dependency (6.4%) (Minoletti & Zaccaria 2005).

As for Italy’s history with mental health and illness, 1978 was a defining year. Before 1978, psychiatric institutions known as asylums were the standard treatment centers for mental illness. In that era, only psychiatrists blessed with a “special power” were allowed to come into contact with people with mental illness, and they did so in closed off spaces in an effort to prevent contamination of others by these patients (Pittalis 2010). These psychiatrists employed antiquated methods to treat patients as objects of investigation rather than as human beings deserving of effective treatment (Villa 1985). In opposition to this type of psychiatry, even as he served as the director of the main asylum in Gorizia, Dr. Franco Basaglia pushed for the reintegration of mental health departments into the general medical service, an end to gender-based separation of

patients, an end to the unscientific and invalid labels used by psychiatrists to separate patients (like “agitated”, “corrupt”, “calm” and “dangerous”), the abolition of physical restraint devices and integration of mental healthcare externally to the community (Villa 1985). The traditional psychiatry that Basaglia dismantled operated in complete opposition to Article 5 of The Universal Declaration of Human Rights, “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment” (United Nations 1948). Through Law 180, the focus of mental health treatment shifted from pure medicalization headed by power-hungry psychiatrists to collaborative, therapeutic strategies that encouraged shared responsibility among healthcare providers (Villa 1985).

After the passing of Law 180 and of the financial acts of 1995 and 1996, “which required regional districts to finally dismantle 67 still active mental hospitals,” a new system was established to care for the 78,000 patients who had been institutionalized up to 1978 (Maone & Rossi 2002). To replace the asylums, the Department of Mental Health (*Dipartimento di Salute Mentale – DSM*), consisting of 226 Local Health Units (*Aziende Sanitarie Locali – ASL*), was created to encompass all public psychiatric facilities for adults in Italy's twenty-one regional districts (Maone & Rossi 2002). With the DSM, people can receive treatment from mental health centers (*Centro di Salute Mentale – CSM*), psychiatric wards in general hospitals (*Servizio Psichiatrico di Diagnosi e Cura – SPDC*), private or public day hospitals for short- to medium-term care, and private or public intermediate facilities like non-hospital residential facilities (Maone & Rossi 2002). Although conditions in mental institutions were frequently deplorable, the quality of today's mental health services still leave something to be desired in terms of providing comprehensive care and education to patients about their illnesses. The Italian Center of

Social Investigation (CENSIS) conducted the nation's first inquiry about psychiatric care in 1984, but both Italian and foreign professionals are still unconvinced about the superiority of community-based care due to “the lack of a systematic monitoring of post-reform community-based services” since 1984 (Maone & Rossi 2002).

Studies show that 18.3% of Italians have suffered from a mental disorder during their lifetime (24.4% of females and 11.6% of males) (De Girolamo et al. 2006). These disorders break down into non-psychotic disorders—including anxiety disorders (generalized anxiety, panic attacks, different phobias, obsessive-compulsive disorder and post-traumatic stress disorder), affective disorders (major depression and dysthymia) and alcohol abuse and/or dependency—and psychotic disorders—including schizophrenia, bipolar disorder and mania (De Girolamo et al. 2006). The country’s five most frequent psychiatric disorders are affective disorders (11.2%), anxiety disorders (11.1%), major depression (10.1%), phobias (5.7%) and dysthymia (3.4%) (De Girolamo et al. 2006). Therefore, the majority of people with mental illness suffer from mild psychological disturbances, though society tends to magnify the more severe disorders, like schizophrenia, which affect less than 1% of the population (Ministero della Salute 2006). Often times, these graver disorders cease to be regarded as illnesses; instead, they become associated with deviant personality traits that sick individuals endure for their lifetimes (Pittalis 2010).

This research is important because despite research showing that mental illness affects a significant percentage of both Chile and Italy’s populations, mental illness still exists as a marginalizing condition. People with mental illnesses are just that—people—who deserve to be treated with the same respect as their fellow citizens. If the roots of

people's stigma can be uncovered and addressed, the long-needed reversal of discrimination and injustice that mentally ill individuals face every day could finally come to fruition.

Objectives—Chile

General Objective: To determine the principal factors that influence the perceptions of adults towards mental illness in Arica, Chile.

Specific Objective 1: To comprehend how the perceptions of Aricans influence their valorization of mentally ill individuals.

Specific Objective 2: To investigate how Aricans' perceptions affect the way they take care of their mental health.

Specific Objective 3: To uncover mental health professionals' opinions of the ramifications of mental health perceptions and mental healthcare structure on those suffering from mental illness.

Specific Objective 4: To identify possible sources of stigma that surrounds mental illness.

Objectives—Italy

General objective: To investigate the perceptions of Italian citizens about mental health and illness, especially in light of Basaglia's revolutionary Law 180.

Specific Objective 1: To detect differences in perceptions of adults who lived during and after the era of asylums, including how their perceptions influence their valorization of those with mental illnesses as productive members of society.

Specific Objective 2: To investigate how Italians' perceptions of mental illness affect the

way they take care of their mental health.

Specific Objective 3: To uncover mental health professionals' opinions of the ramifications of mental health perceptions and mental healthcare structure on those suffering from mental illness.

Specific objective 4: To identify possible sources of stigma against mental illness in Italy.

Literature Review

Although similarities can be drawn between Chilean and Italian cultural traditions, especially in terms of religion and relative demographic homogeneity excluding recent years, the paths both countries have taken towards approaching society's attitudes towards mental health treatment reveal important distinctions. In Chile, mental health stigma was infrequently studied until the last decade. Due to historical associations of mental illness with violence, unpredictable behavior and mental retardation, multiple erroneous linkages between mental illness and negative characteristics of those who bear them pervade (Acuña & Bolis 2005). Researchers have approached the subject of mental health stigma from multiple angles, with each one revealing a new layer of just how extensive stigma is. By elucidating the problems associated with stigma in this multifaceted fashion, researchers enable the compilation of broad analysis on the topic of mental health and illness.

First and foremost, it is necessary to define the terms *mental health* and *stigma*. According to the Chilean government, mental health is a state of equilibrium between a person and his or her surroundings of interpersonal relationships, from the most intimate spaces like the family, to larger spaces like the community (Gobierno de Chile 2010).

Therefore, taking care of one's mental health is not the sole responsibility of the individual with the disorder, but rather, it is the combined responsibility of that person, his or her family, the community, the government, the places of work and study and the media (Gobierno de Chile 2010). However, not everyone accepts this responsibility in Chile or in Arica, specifically. The exact definition of *stigma* is elusive because "there is a debate about the definition and the utility of the stigma concept and none of the conceptualizations should be viewed as definitive" (Link, Yang, Phelan & Collins 2004). For example, Goffman has his own ideas as previously described, Jones and his colleagues believe in six dimensions of stigma being "concealability, course, disruptiveness, aesthetics, origin and peril," and Link and Phelan break stigma down into the co-occurrence of labeling, stereotyping, cognitive separating, emotional reactions, status loss/discrimination (expectations), status loss/discrimination (experience), structural discrimination and behavioral responses to stigma (Link et al. 2004).

In Italy, the history surrounding the country's rapport with mental health is quite complex. On May 13th, 1978, the Italian government passed Basaglia's Law, also known as *La Legge 180*, mandating provision of medical treatment for people suffering from mental illness and effectively ordering the closure of all of its psychiatric institutions (Federazione Italiana per la Salute Mentale 2011). Franco Basaglia, a prominent psychiatrist and neurologist, spearheaded this law because he did not agree with the standard practices in the mental health system of his time. He pushed forward the anti-psychiatry movement to combat the violent ideas, solutions and explanations for mental illness given by traditional psychiatry, which included the lack of rights for patients, forced electroshock and the control and confiscation of rights in those institutions

(Federazione Italiana per la Salute Mentale 2011). The law established some key changes from the archaic law of 1904: involuntary hospitalization could only be obligated for a maximum of a week and was contingent upon thorough medical examinations, all asylums were closed down and no new ones were to be created, and local health centers and short-stay hospital wards were to take care of psychiatric treatments (Tarabochia 2011). From that year forward, the treatment methods for those suffering from mental illness drastically transformed, but society's attitudes towards these individuals, including the stigmas it held, have persevered.

Franco Basaglia's reform of Italy's mental health system was not aimed only at “a successful dismantling of the old disciplinary psychiatry, which was based on a purely organic treatment of mental illness confined within the closed space of the asylum,” but also at impeding the progression of “psychiatry that makes extensive use of psychopharmacology, psychiatrizes all forms of psychological suffering, [and] reduces the human psyche to its organic correlative” (Tarabochia 2011). This traditional psychiatry represented negative biopolitics, as it did not take into account societal and experiential events that could contribute to psychiatric disorders. Mental illness is real and complex, as “humans cannot define their own nature outside of a given social context and without a relation to the other” (Tarabochia 2011). Therefore, Basaglia wished to create a positive social context in which ex-mental patients could thrive, and he urged the formation of a community that “forsakes its paradigms of immunization, of defense against the loss of individuality that is inherent in the very fact of belonging to a community” (Tarabochia 2011). Psychiatry morphed from a medical specialty doctors dealt with in institutionalized terms to a statewide issue brought into the consciousness of

all citizens. This change was necessary because as Foucault explained in his 1974-75 discourse *Abnormal*, disciplinary “psychiatry evolved into a general instance of the defense of society against the dangers that threaten it from within” (Tarabochia 2011). A society at war with itself is a society divided. For this very reason, Basaglia supported the spread of mental health consciousness into the community, “The asylum is no longer within the walls. Rather, it is to be found in our everyday life” (Tarabochia 2011). He truly sought to break down the lopsided psychiatrist-patient power relations in favor of an affirmative biopolitical psychiatry that fostered life in a “utopian community of human beings who have [...] accepted their lack and their need for the other” (Tarabochia 2011).

Despite Basaglia's laudable goals, there were inherent problems in a transition to community-based mental health care. In scaling community attitudes toward the mentally ill, it was found that “in both America and Canada, the move toward community-based health care has caused extensive neighborhood opposition” (Taylor & Dear 1981). When selecting the physical locations for community mental health facilities, it was important to address the following: “the geographical incidence of mental illness and its ecological correlates,” “the utilization and accessibility of mental health services,” “the aftercare problems of patients discharged from psychiatric hospitals,” “neighborhood opposition,” and “the community support system for the mentally disabled and other service-dependent populations” (Taylor & Dear 1981). In Italy's new post-1978 mental health care system, psychiatrists were forced to develop a relationship with their patients as independent human beings, which was logical in theory but in practice, it provided “limited guidance for the anti-institutional psychiatrist about how to help the psychologically suffering people” (Tarabochia 2011).

Interestingly enough, the degree of cohesion of the neighborhood prior to the entry of individuals dealing with mental illness was shown to affect the way they were treated, “Facilities with the highest level of integration tend to be in neighborhoods with low social cohesion. On the other hand, social integration tends to be lower in highly cohesive neighborhoods, which tend to close ranks against the incursion of the mentally ill” (Taylor & Dear 1981). In terms of demographics, married and widowed groups were less sympathetic towards community-based mental health care, most likely due to the advanced age of the participants and the young children in the home, while individuals with higher educational status were more sympathetic (Taylor & Dear 1981). Similarly, those who had used mental health services in the past or who had friends or relatives who had used those services were also sympathetic to integration of people with mental illness in their neighborhood, demonstrating how familiarity to mental illness can positively affect perceptions (Taylor & Dear 1981). Thus, stigma often exists due to a lack of understanding of mental health and illness.

One team of researchers referred to stigma as a highly discrediting attribute or a characteristic held by a person that is related in the society’s consciousness as a negative stereotype towards the person and the overall devaluation of the person (López et al. 2008). These themes of perception and consciousness of society were extremely important and relevant to the present study. Instead of relying on social evaluations to restrict rights or privileges of people suffering from mental illnesses, “disabilities that lead to judgments of incompetence and restriction of rights must be measurable using reliable and valid tools” (Corrigan, Markowitz & Watson 2004). After all, stigma is generally arbitrary, “Stigma management is an offshoot of something basic in society, the

stereotyping or ‘profiling’ of our normative expectations regarding conduct and character” (Goffman 51).

Another formal definition of *stigma* proposed that the diagnosis of mental illness and the behaviors that accompany this diagnosis stir up negative attitudes and attitudes of refusal in those without mental illness (Azienda Socio Sanitaria d'Italia 2011). These attitudes have a certain degree of arbitrariness to them, as “society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories” (Goffman 2). Stigma towards people with mental illness represents a clear discrepancy between virtual identity that society gives a person and that individual’s real identity (Cariola 2004). In engaging this discrepancy between an individual’s virtual and actual identities, Goffman explains, “This discrepancy, when known about or apparent, spoils his social identity it has the effect of cutting him off from society and from himself so that he stands a discredited person facing an unaccepting world” (19). Furthermore, people use their erroneous valuations of another’s social identity, “along with everything else that can be associated with him” to construct a personal identification of that person (Goffman 65). To clarify, social identity refers to how others view an individual, while personal identity refers to how an individual decides to present himself or herself by controlling information divulged. These misplaced identities are breeding beds of stigma, and are thus pertinent to the objective of the current study to ascertain what value people place on their fellow citizens suffering from mental illness.

The societal element overrides the biological element in determining the desirability of an attribute. In other words, stigma can be used “to refer to an attribute that

is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed” (Goffman 3). This relationship is based on society's expectations of what is normal versus what an individual presents as his or her reality, meaning, “a stigma, then, is really a special kind of relationship between attribute and stereotype” (Goffman 4). Basaglia strongly believed in this relation-based nature, “It is only in the possibility of opposing himself to the external world that the subject can succeed in affirming himself” (Tarabochia 2011). After all, human nature dictates a relationship with others in order to set a standard for a relationship with oneself. By devaluing those with mental illness through stigmatization, society fosters the public labeling of the former as incurable, dirty, dangerous and violent (Pittalis 2010). Furthermore, it leads these individuals to isolate themselves and to become distrustful of others, hostile or anxious by responding with aggression or extreme reclusion from mainstream society (Cariola 2004).

Corrigan's study on attribution theory details how society makes attributions about others' mental illnesses. He seeks to investigate how emotions play a role in attitudes towards mental illness, especially examining “the role of emotional responses in mediating the effects of attributions on helping and rejecting responses” (2003). This study also examines the relative importance of “beliefs about responsibility (attribution hypothesis) or fear (danger appraisal hypothesis),” as well as the role of familiarity with mental illness in determining helping and rejecting responses (2003). The findings that information about dangerousness, controllability of illness and familiarity with the illness all affect the emotional responses of the individuals, and consequently, their attributions of mental illness made it clear that those three factors should be investigated in further

detail to determine the perceptions of Italians about mental illness (the Chilean study was performed prior to location of this source) (Corrigan 2003). Moreover, an American study showed that with a greater degree of familiarity to the person seeking mental health care, people were “considerably less rejecting than those with more distant relations, perhaps because the label had come to take on new meaning as a consequence of their greater familiarity” (Link, Cullen, Frank & Wozniak 1987). On the other hand, Goffman found that although “the whole problem of managing stigma is influenced by the issue of whether or not the stigmatized person is known to us personally,” knowing someone with a mental illness does not necessarily decrease stigma (55). As he explains, “One must go on to see that familiarity need not reduce contempt. For example, normals who live adjacent to settlements of the tribally stigmatized often manage quite handedly to sustain their prejudices” (53).

Corroborating the belief that “stigma defines people in terms of some distinguishing characteristic and devalues them as a consequence,” a 2004 study aimed “to describe the relationship of stigma with mental illness, psychiatric diagnosis, treatment and its consequences of stigmas for the individual” (Dinos, Stevens, Serfaty, Weich & King 2004). This study identified and separated the different types of mental disorders to determine the degree of stigma associated with psychotic versus non-psychotic ones, which is valuable in analyzing the nuances of and level of discrepancy in a society’s stigma. The results showed that “people with psychosis or drug dependence were most likely to report feelings and experiences of stigma and were most affected by them, [while] those with depression, anxiety and personality disorders were more affected by patronizing attitudes and feelings of stigma even if they had not experienced

any overt discrimination” (Dinos et al. 2004). This distinction revealed two subcategories of stigma as “subjective feelings of stigma, even in the absence of any discrimination and stigma in the context of overt discrimination” (Dinos et al. 2004). A key research point that was replicated in the study in Rome was the investigation of levels of “anxiety about how to manage information regarding illness and whether to disclose it or not to friends, family and prospective employers” (Dinos et al. 2004).

This anxiety is understandable given a study showing that 44% of family members polled opined that people with schizophrenia should not get married, 33% opined that the law should permit the spouse of someone with schizophrenia to obtain a divorce more expeditiously and 49% opined that those with schizophrenia should not have children (Magliano, Fiorillo, De Rosa, Malangone & Maj 2004a). Such blatant disregard of citizens’ basic rights by their own family members showed how crippling, widespread and deep-reaching discomfort with mental illness could be.

In another study, a community survey on the causes and effects of schizophrenia showed that 536 individuals believed that patients with schizophrenia were unpredictable, while 457 people thought they were not (Magliano et al. 2004b). The researchers examined the socio-demographic profile of the interviewees, and the results showed that when comparing the “unpredictable” group to the “not unpredictable” group, the former included more people lay people (41% vs. 21%), more people with a lower education level, and less mental health professionals (15% vs. 27%) (Magliano et al. 2004b). Thus, people with less education, especially about mental illness, tended to hold the stigmatized perception of individuals with mental illness as unpredictable. Moreover, only 16% of the 536 from the “unpredictable” group believed that schizophrenic patients could recover

completely, while 26% of the other group held this view (Magliano et al. 2004b). Finally, 42% of the 536 thought that schizophrenic individuals should not get married, compared to only 16% of the other group (Magliano et al. 2004b). These results demonstrated how the negative perceptions of Italians towards people with schizophrenia influenced their valuation of the competencies and civil rights of those individuals. Therefore, these questions were used in the survey of the current investigation in Italy to see to what degree the results might reproduce themselves.

In a study by Fabrizio Starace about the perception of young adults between the ages of 16 and 20 towards mental illness, the principle results of the question, “What is the image associated with people affected by mental illness” were “*un matto, un pazzo, un folle,*” which all loosely translate to “a crazy person” (Ministero della Salute 2004). The study showed that some subjects thought that mental illness was an effect of magic or the evil eye, while asserting that those with mental illness were more violent than those without it (Ministero della Salute 2004). Positively, even though 72% claimed to be barely or not at all informed about mental illness, 84% expressed interest in learning more, suggesting the real possibility of change (Ministero della Salute 2004). Studying varying perceptions within and between age groups was thus salient to the current investigation to determine if societal perceptions were changing or remaining constant.

Lack of knowledge can be a powerful barrier to accessing mental health services, resulting in exclusion of an entire subset of people. Acuña & Bolis found that when society perceived someone with a mental illness as a disruptive element in medical facilities, that person was less disposed to seek the medical care he or she needed (2005). Moreover, the negative valuation of those suffering from mental illness for multiple

reasons, such as their minimal contribution to the community in terms of economic productivity or reproductive value, placed them on the lowest rung of priorities when they attempted to seek medical attention (Acuña & Bolis 2005). This reality is deeply troubling because it confirms that even medical professionals harbor prejudices that cause them to ignore the needs of their stigmatized patients. In one particular study, Byrne and Heyman found that nurses' "definitions of work priorities and their own perceptions of their patients had a strong influence on the nature and quality of communication with patients" (Roe, Joseph & Middleton 2010). In the interaction of community nurses with the caregivers of elderly individuals with depression, collaboration helped achieve individual goals and results, accenting "the significant influence service providers' priorities and their perceptions of clients' social situation and needs have on the nature and quality of care they provide" (Roe et al. 2010). Providers played a huge role in the way patients viewed themselves, which also influenced the potential for recovery. Their interaction could be described as "a moving sphere in which the individual parties involved are continuously evaluating and interpreting their actions in light of the actions of the other" (Roe et al. 2010). Stigma from medical professionals was not explicitly investigated in the current research, but both the general public and mental health professionals interviewed mentioned its occurrence, which highlighted the importance of exploring patient-doctor and doctor-doctor interactions to reduce stigmatization of patients, mentioned it.

In a previously referenced study by Magliano et al., the researchers investigated the beliefs about schizophrenia held by the general public, mental health professionals and relatives of patients (2004a). This multilayered subject approach greatly contributed

to the framework of the methodology used in the current comparative study. Magliano et al. found that 35% of the general public, 2% of professionals and 17% of parents believed that people with schizophrenia could recover completely (2004). Additionally, only 9% of professionals stated that those with schizophrenia could hold a job as successfully as any other person (Magliano et al. 2004a). These low percentages from professionals could suggest discriminatory attitudes on the part of medical practitioners, or at least their low level of confidence in current treatment techniques in mental health. Also tellingly, discriminatory practices by these professionals, such as paternalism, pedagogy, abandoning patients and failure to exercise responsibility in taking care of those who could not care for themselves revealed improper medical conduct based upon ideals of stigma (Ferrara 2009). Clearly, stigma was not confined only to those without knowledge of mental health and illness. For this reason, it was extremely important to interview mental health professionals in the comparative study to get a more complete view of the societal stigma.

Understandably, not all medical professionals are experts on mental health, especially those in primary care. However, Sepúlveda argued that since primary care provides the essential medical attention that is universally accessible to the community, it is arguably the most important level at which to reduce stigma towards the sick (Sepúlveda 2005). For the successful integration of these patients, mental health specialists must supervise primary care providers and work closely with them in a system of references and counter-references (Sepúlveda 2005). The 4747 Decree by the Pan-American Health Organization defined *reference* as one healthcare provider sending patients to another provider for attention or diagnostic complementarity, and it defined

counter-reference as the response that the receiving provider gives to the original provider (Vásquez 2008). In addition to an effective referral system between primary and secondary healthcare, Funk et al. believed, “Mental health specialists [...] must be made available to primary care staff to give advice and guidance on the management and treatment of people with mental disorders” (2008). Their bottom line was that in order to serve patients adequately and to reduce cases of stigmatization, primary care staff members should be “trained to identify, treat and manage the majority of cases of mental disorders” (Funk et al. 2008). Similarly, Acuña & Bolis maintained that through education and empowerment of personnel at the primary care level, stigma might be decreased (2005).

In Saldivia, Vicente, Kohn, Rioseco & Torres’s study of the use of mental health services in Chile, a factor intertwined with the concept of access, “approximately 61.5% of the respondents who met the criteria for a psychiatric disorder in the past year did not receive mental health care” (2004). Additionally, only “13 percent of the respondents with a psychiatric disorder received specialized mental health services, and more than 70 percent of those with severe mental illness [...] did not receive care from mental health specialists” (Saldivia et al. 2004). These statistics elucidated the negative effects that direct barriers to healthcare access, such as regional inequities, as well as indirect barriers, such as mental health stigma, could have on a patient’s quality of health (Saldivia et al. 2004). The ways in which this exclusion appears are key in the specific objective of determining the opinions of mental health professionals on the ramifications of citizens’ perceptions about mental illnesses.

Systemic barrier to access also exists in other parts of the world, as stigma and

discrimination are often entrenched in structural systems. For example, discriminatory factors like “policies of private and governmental institutions that *intentionally* restrict the opportunities of people with mental illness and policies of institutions that yield *unintended consequences* that hinder the options of people with mental illness” all bar access to treatment (Corrigan, Markowitz & Watson 2004). These top-down systems of stigma dissemination lent themselves to investigation in the present study to pinpoint possible sources of stigma in both Chile and Italy. These discriminatory factors were further analyzed in the present investigation to clarify the power of the media to portray certain groups in a stigmatizing light and the effects of governmental policies on quality of care in private and public mental health services in Italy. These structural issues complicated the ease in resolving stigma, “Structural models also challenge the effectiveness of such individual-focused anti-stigma strategies, such as education and contact, and instead suggest that radical social policies like those embodied in affirmative action are necessary” (Corrigan, Markowitz & Watson 2004).

Furthermore, in determining the correct course of action to reduce stigma, one must keep in mind the pervasive power of the stigma, whose reduction often results “not in the acquisition of fully normal status, but in a transformation of self from someone with a particular blemish into someone with a record of having corrected a particular blemish” (Goffman 9). For example, ex-mental patients “are sometimes afraid to engage in sharp interchanges with a spouse or employer because of what a show of emotion might be taken as a sign of” (Goffman 15). As measured in a series of vignettes, the label of “ex-mental patient” often activated beliefs that “play a potent role in determining levels of social rejection,” and prejudice and discrimination could be sustained long after

attenuation of a patient's acute mental health problems (Link et al. 1987). The stigma was so strong that some patients gave up insurance benefits so that their mental disorder would not be discovered (Link et al. 1987).

An additionally troubling result of stigma towards mental illness is the patient's auto-stigmatization. Corrigan & Watson found that some people with psychiatric disorders submitted themselves to stereotypes, prejudice and discrimination in response to the stereotypes, prejudices and discrimination imposed upon them by society (2002). Stereotypes in self-stigmatization manifested themselves in negative beliefs about oneself, such as one's dangerousness, incompetence and weak character (Corrigan & Watson 2002). Prejudice in self-stigmatization manifested itself in conforming to beliefs and/or emotional reactions like low self-esteem, uncertainty about one's own capacity and shame (2002). Finally, discrimination in self-stigmatization manifested itself in the response to the prejudice, such as lack of taking advantage of work and housing opportunities and the refusal to seek help (2002).

It is quite interesting to consider self-stigmatization because this phenomenon represents how society can affect those suffering from mental illness to the point of distorting the way they esteem themselves. The point of view of individuals struggling with mental illness is invaluable in understanding the ramifications of stigma. In a study of the perceptions of stigma from the point of view of individuals with schizophrenia, the subjects listed their most frequent experiences of stigmatization in the following order: negative attitudes and prejudices from the community (28.8%), lack of understanding (18.6%), exclusion from social life and loss of friends, family members and colleagues (16.9%), exclusion from the workplace and academic institutions (8%), erroneous

information (7.5%), quality of mental health services (7.5%), self-stigma (7.5%) and negative representations furnished by the media, particularly the relationship between schizophrenia and violence (6.5%) (Buizza, Bertocchi, Rossi & Pioli 2005). Although self-stigmatization was not directly tied to the present study, as patients were not interviewed, it remained an important piece of the puzzle of dissecting the construction of stigma.

In an attempt to reduce this stigma, researchers have posited various suggestions. According to Pittalis, to guarantee greater accessibility to mental health services for patients and their families, to inform them clearly about their illness, to answer their needs adequately, to provide a better quality psychiatric and rehabilitative treatment based on scientific evidence and to promote social policies like insertion of people with mental illness into the workforce without reducing their social function, one must go above and beyond informative campaigns (Pittalis 2010). More specifically, López et al. believed that the answer rests in strategies like protest, education and social contact that have yet to work on a widespread level mainly due to the ineffective administration of the potential solution (López et al. 2008). Most of these suggestions were explored in the current comparative study.

Finally, another important study in developing the current investigation addressed mental health stigma among asylum seekers and refugees. This study touched on human rights issues with a list of yes or no questions, such as “People with mental health problems should have the same rights as anyone else” and “I would be happy for someone with a mental health problem to marry into my family” (Quinn, Shirjeel, Siebelt & Donnelly et al. 2011). The researcher selected which questions from Quinn et al.’s

study to include in a yes/no survey for the general population in Rome in order to identify and propose ways to lessen stigma's power to limit the rights of those with mental illness.

As a whole, all the studies described above provided valuable antecedents to continue to the themes of the current investigation. The multiple conceptualizations of stigma allowed for inclusion of the various frames of reference from which stigma was studied in this researcher's study.

Methodology—Chile

This research was conducted in November 2011 in Arica, Chile using a qualitative, realist epistemology. This type of study included elements of both a relativistic, constructivist ontology and positivism. The former allowed for the subjectivity of participants' realities by acknowledging that there is not "a single unitary reality apart from our perceptions. Since each of us experiences from our own point of view, each of us experiences a different reality" (Krauss 760). Relativistic constructivism ontology posits, "All research is essentially biased by each researcher's individual perceptions" (Krauss 760). However, validity could be established through other means. Individuals were not so unique that their opinions could not be aggregated and categorized in both quantitative and qualitative modes of analysis. Thus, elements of positivism were also apparent. Positivists see science as a way to "understand the world well enough so that it might be predicted and controlled [...] positivists believe in empiricism, the idea that observation and measurement are at the core of the scientific endeavor" (Krauss 760). The philosophical paradigm of a realist epistemology that was

employed in this study combined both positivism and relativistic constructivism to consider that multiple perceptions existed, which could create a wedge between people's perceptions and reality. Realism was the best option because of it is "value cognizant; conscious of the values of human systems and of researchers," which allows for a complementary existence of quantitative and qualitative research methods to procure the most meaning in accordance to the specific topic of interest (Krauss 761).

The questions for the study were initially formulated on September 21st, with further revisions made up to November 4th, when the research officially began. The researcher's advisor, Ester López, is the director of the public mental health system in Arica, and she agreed to oversee the project on September 14th. She helped to discuss the themes of the study, to refine the questions of investigation and to plan when and where to conduct interviews. The collection of data occurred from November 4th to 14th. The time of study lent itself positively to insightful observation of behavior because of the "adequate time to become thoroughly familiar with the milieu under scrutiny" for the two months prior to beginning the interviews, although the one-time interviews did not give participants "the time to become accustomed to having the researcher around" (Mays & Pope 111).

The design of this experiment was non-experimental because there was no deliberate manipulation of independent or dependent variables. The phenomena and subjects of study were observed in their natural environment. Within this classification, the study was transversal descriptive because the data was collected during one singular time period (November 4th – November 14th), and the opinions of the Arican adults were procured in a descriptive manner.

The population of study was adults in Arica, Chile, which included people with and without mental illness. The first of two samples was non-probabilistic because it was a random selection of 131 adults. Although care was taken not to produce a sample consisting exclusively of one gender or one age group, the non-probabilistic selection worked because “statistical representativeness is not a prime requirement when the objective is to understand social processes” (Mays & Pope 110). The sample group was not intended to be representative of the population at large, but rather to be indicative of the specific opinions of the participants interviewed that would lend insight into some perceptions of mental health and stigma in Arica, Chile.

For this sample, a 5 to 15- minute survey of 20 open, closed and categorical questions was administered as the instrument of data collection. Oral interviews, in which the researcher posed the questions and filled in the participants’ answers, were employed as the technique of data collection. To guarantee the rights of the participants, the researcher read them the informed consent form, assuring them of the voluntary nature of the survey and of the confidentiality of their identities in the analysis of their responses. Each participant had the opportunity to sign the form, thus agreeing to be interviewed and/or agreeing that the interview could be audio recorded. This method of access represented “overt access based on informing subjects and getting their agreement” (Silverman 2004). The chronology of the administration of the interviews was as follows:

- November 4th: 3 adults in the plaza at the intersection of Maipú and Vicuña Mackenna Streets and 7 adults at an open-air market
- November 5th: 20 adults at Chinchorro Beach
- November 6th: 26 adults at Park Brazil

-November 7th: 14 adults at the family health clinic Remigio Sapunar and 20 adults in downtown Arica.

-November 8th: 23 adults at the family health clinic Víctor Bertín Soto

-November 9th: 18 adults in the emergency room of the Regional Hospital Juan Noé

This sample was established through the method of saturation sampling.

Therefore, the surveys were concluded once the participants' responses began to repeat themselves. Due to the subjective nature of the determination of this point, the method contained some element of arbitrariness. However, efforts were taken to engage a diverse group of individuals, in terms of age, gender and location approached, in order to enhance the reliability of the saturation point. This sampling method worked for a small sample in a qualitative study because the results were confined to the sample and not extrapolated to the general public. The sample was not representative of the 190,000 inhabitants of Arica. Additionally, the fieldwork was described in detail to ensure that other researchers could inspect the evidence independently.

The design of analysis for the surveys was the creation of a database and graphs and tables on Microsoft Excel to analyze the trends of responses to each question. This database consisted of a compilation of participants' answers to all the questions (open, closed and categorical), in order to effectively determine the frequency of each response. Significant segments of the discourse that went beyond answering the question directly were also included as part of a narrative analysis.

The second sample of this study was a non-probabilistic sample of experts, and it consisted of five mental health professionals from the Ambulatory Psychiatry and Mental

Health Teams (*Equipos de Psiquiatría y Salud Mental Ambulatoria – ESSMA*) and one family health clinic (*Centro de Salud Familiar - CESFAM*). A 1 to 1½- hour interview based on 20 questions was administered orally as both the instrument and technique of data collection. The instrument was not fixed, meaning that the interviewee guided the direction of the interview, with different questions being posed as necessary. To guarantee the rights of the participants, the professionals were provided with an informed consent form, which they read and signed before beginning the interview. This form stated that they agreed to be interviewed, agreed that the interview be audio recorded and agreed that their name be used in the written project. The chronology of the interviews was as follows:

- November 4th: Natalia Pérez, occupational therapist, ESSMA Norte
- November 4th: Antonia Varas, social worker, ESSMA Sur
- November 10th: Dr. Cristian Osorio, psychiatrist, ESSMA Sur
- November 11th: Carla Quiroz, psychologist, ESSMA Sur
- November 14th: Maritza Acosta, psychologist, CESFAM Víctor Bertín Soto

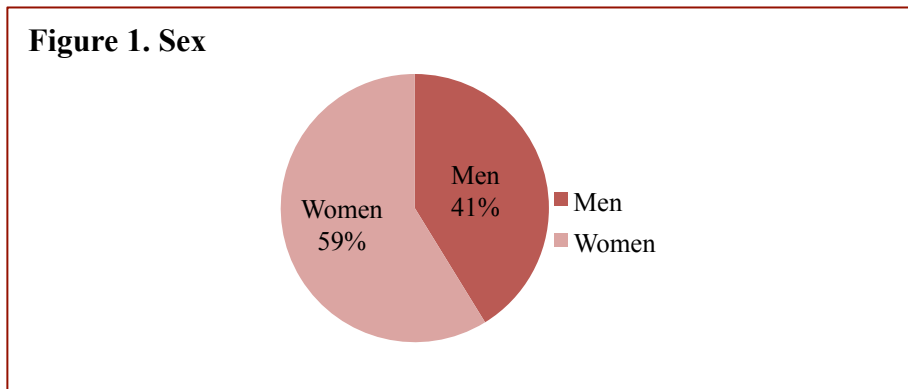
The design of analysis for the expert interviews was the meticulous transcription of each audio-recorded interview—which was double-checked with native speakers—and the revision of the answers to understand their points of views on the functioning of the mental health system in Arica. In the data analysis, a software system was not used to analyze the content of interview transcriptions, thus a computerized coding frame was not developed. Instead, the transcriptions and analysis were obtained manually to familiarize the researcher thoroughly with the details of each interview. Due to the small number of professionals interviewed, it was possible to “analyze such data singlehandedly and use

ways of classifying and categorizing the data which emerge from the analysis and remain implicit” (Mays & Pope 110). This analysis of the narratives allowed for the determination of similarities and differences between the professionals’ answers with a reliable degree of conclusions drawn.

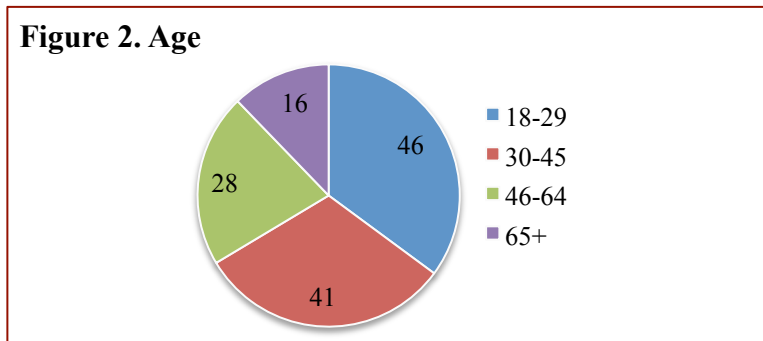
Results & Discussion—Chile

I. General Population Surveys

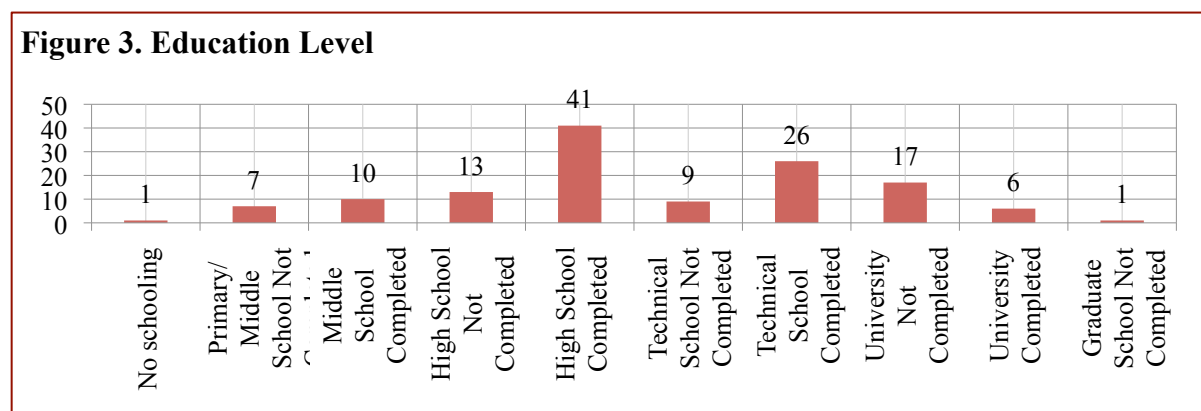
From the 131 surveys and the 5 interviews administered, the responses were very telling of the participants’ views on mental health and illness in Arica and in Chile. One main goal of this investigation was to obtain a comprehensive range of gender, age, level of education and health insurance to avoid collecting a homogeneous data sample.



There were 77 women and 54 men in the sample. The percentage of each is demonstrated in the chart above. As Chile is a very much patriarchal society that has not yet reached an equitable distribution of men and women in the workforce, it was not surprising that more women than men were available to be interviewed during working hours.

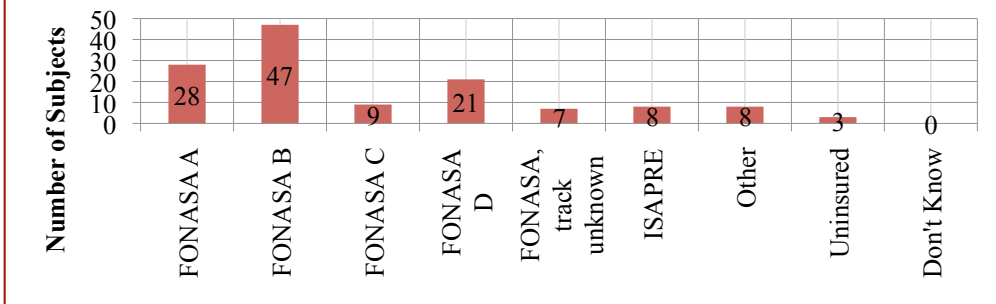


For diversity purposes, it was important to obtain responses from a sample of subjects covering a wide range of ages. There were 46 subjects from 18-29 years, 41 from 31-45 years, 28 from 46-64 years and 16 subjects 65 years or older.



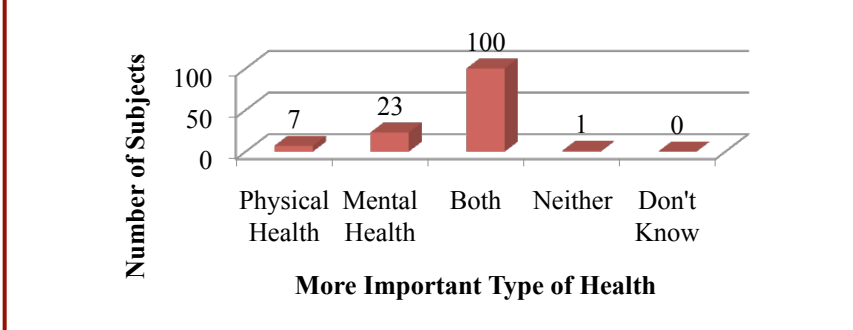
For the education level, the majority of subjects had completed high school (41 subjects) and technical school (26 subjects). Only 1 subject had received no schooling, 1 participant had advanced to graduate level studies, and no subject had completed a graduate level education (everywhere outside of North America, graduate level is called post-graduate level). This system can be confusing because in Chile, students receive a degree in a professional field, such as law or medicine, upon completion of university, so those with a completed university degree have an education that is on par to American students pursuing non-Ph.D graduate studies.

Figure 4. Health Insurance Provider



With respect to health insurance, the majority of subjects held FONASA B (47) and FONASA A (28), which are public health insurance tracks for citizens of the lowest socioeconomic brackets (FONASA – *Fondo Nacional de Salud*; National Health Fund). FONASA D serves the top socioeconomic sectors publicly, while ISAPRE is private health insurance. Included in the “Other” category were PRAIS, FOSAFE (*Fondo de Salud Familiar del Ejército* – medical fund for army families) and CAPREDENA (*Caja de Previsión de la Defensa Nacional* – fund for the armed forces). It would have been informative to inquire more about the intersection of mental illness and human rights violations to the PRAIS holders, but broaching the topic of Pinochet appropriately would have required an additional level of coaching that the researcher did not receive. In any case, given that nobody stated not knowing his or her insurance provider, all subjects at least understood the importance of knowing what health insurance they had.

Figure 5. More Important Type of Health



In response to the question about the relative importance of physical and mental health, 100 subjects selected “both,” 23 selected “mental health,” 7 selected “physical health” and the only person who selected “neither” was the one participant who had received no formal education. Because 123 out of 131 subjects, or 93.9%, stated their belief in the equal or greater importance as opposed to physical health, they showed a positive valuation of mental health. The World Health Organization (WHO) has promoted this idea of the integral nature of health since 1948, when the organization recognized integral health as a state of physical, mental and social well-being (Funk et al. 2008).

Table 1. Ways To Take Care of One’s Mental Health

| Way You Take Care of Your Mental Health | Number of Subjects |
|--|---------------------------|
| Talk to your family and friends about your worries | 66 |
| Relax and rest | 63 |
| Try to avoid drugs and alcohol | 41 |
| Do physical exercise to reduce stress | 40 |
| Speak with a mental health professional | 19 |
| Do not take care of your mental health | 7 |
| Solve your problems alone | 2 |
| Read | 2 |
| Take care of the house | 2 |
| Play Sudoku | 1 |
| Go out on walks | 1 |
| Write and exercise your mind | 1 |
| Go to the beach to follow the red flowers | 1 |
| Listen to music | 1 |
| Block out your problems | 1 |

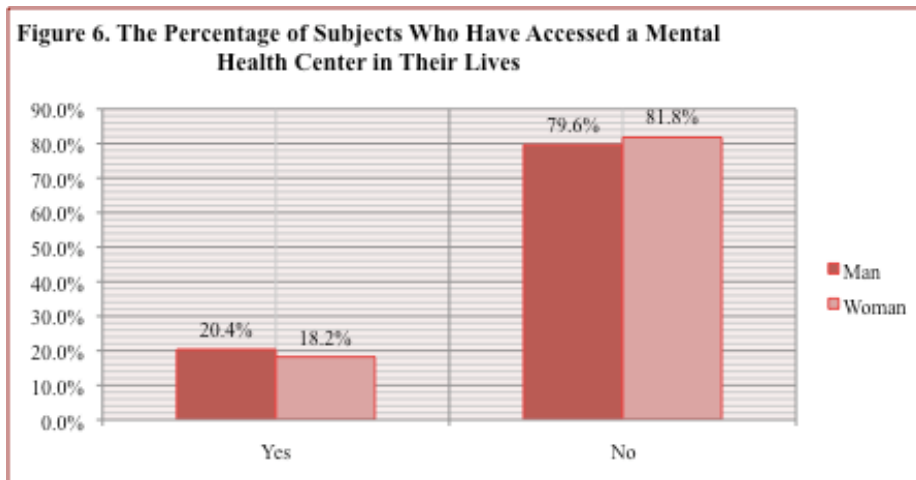
There were varied responses from subjects about how they took care of their mental health. The subjects could choose more than one option, and the most frequent response was “talk to family and friends” (66 responses). This answer demonstrated the importance of strong family ties to calm one’s worries. Following this response was “relax and rest” (63), “try to avoid drugs and alcohol” (41) and “do physical exercise to reduce stress” (40). Subjects’ ability to make the connection between drugs and alcohol

and mental illness showed knowledge of some triggers of psychiatric disorders. However, only 19 people chose “speak to a mental health professional,” suggesting that seeking help at a mental health center was not prevalent or culturally accepted among the subject pool, for reasons yet to be determined. Of the 10 subjects who chose “other,” they gave methods including “read,” “listen to music” and “exercise your mind”.

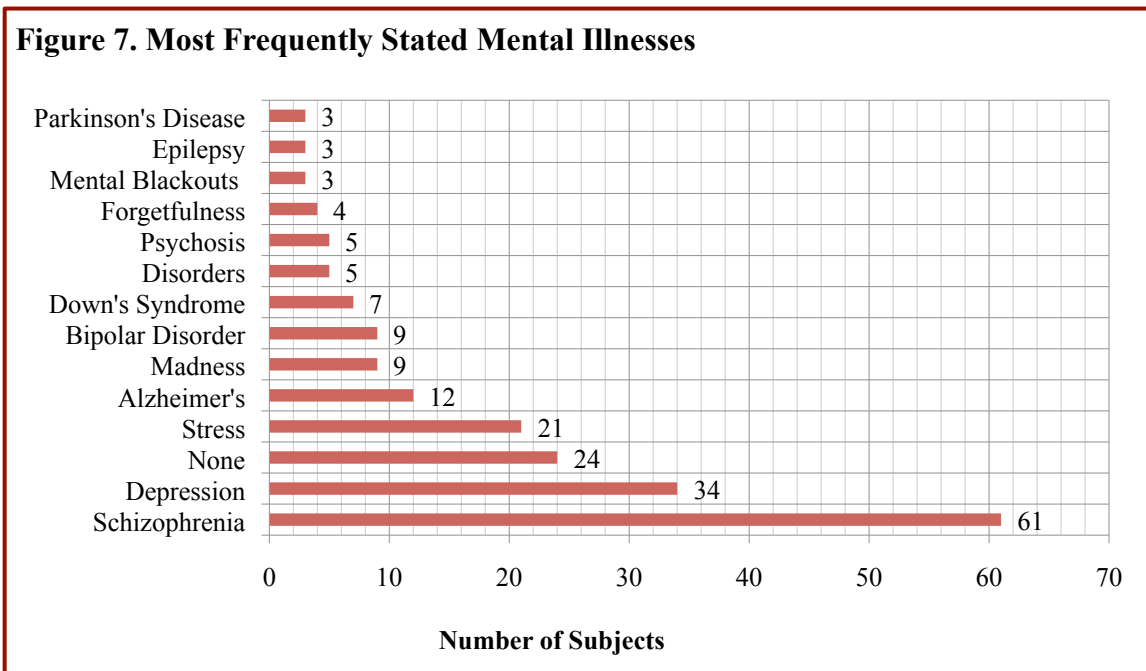
Table 2. Participants Who Do Not Take Care of Their Mental Health

| Participant | Sex | Age | Education Level | Health Insurance |
|-------------|-------|-------|--------------------------------|------------------|
| 1 | Man | 18-29 | High School Completed | FONASA B |
| 2 | Man | 18-29 | High School Completed | FONASA C |
| 3 | Man | 46-64 | High School Completed | FONASA D |
| 4 | Woman | 18-29 | Technical School Not Completed | FONASA C |
| 5 | Woman | 30-45 | High School Completed | FONASA B |
| 6 | Woman | 30-45 | University Completed | ISAPRE |
| 7 | Woman | 46-64 | Middle School Completed | FONASA D |

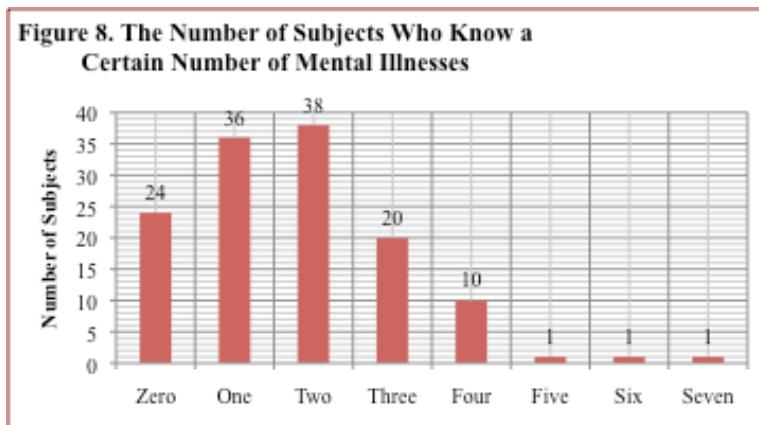
Recognition of the importance of integral health could explain why only 7 subjects stated not doing anything to take care of their mental health. Of these 7 participants, the group included 3 men and 4 women, subjects from 18 to 64 years of age, education levels of middle school completed, high school completed, technical school not completed and university completed and health insurance providers FONASA B, C, D and ISAPRE. This demographic information indicated that the decision not to take care of one’s mental health was not limited to any one gender, age, education level or type of medical insurance. Thus, other factors must be at play in making this decision.



Along with the theme of taking care of one’s mental health in a medical center, 25 people responded that “yes” they had visited a mental health center in their lives, and 106 people responded “no.” As suggested by the subjects’ responses to how they took care of their mental health, accessing mental health centers for medical attention was either not a common occurrence or it was not spoken about in public. The results were analyzed between sexes, and the percentages were rather similar, with 20.4% of men and 18.2% of women responding “yes,” and 79.6% of men and 81.8% of women responding “no”. It was interesting that the decision to seek treatment or not was evenly split between the sexes because the portrayal of men in a *machista* society is that of an individual, who must keep his problems enclosed. As this sample group was not representative of the larger population, having around 80% of the people not having visited a mental health center could either be a consequence of the individuals not having mental health problems chosen or it could represent a failure to access available mental health centers.



When the participants had to name all of the mental illnesses they knew, they collectively named 57 illnesses. This long list would initially suggest that the subjects had a vast knowledge of mental illnesses. However, 24 participants could not name even one illness, and some asked for the definition of *mental illness* before answering. Moreover, various people could not name a specific illness, so they tried to describe one instead. These failures to name one mental illness without any prompting indicated a lack of knowledge of the topic. Schizophrenia and depression were the most frequently named illnesses, with 61 and 34 responses, respectively. The illnesses that only one or two participants named included domestic violence, obsessive compulsive disorder, autism, Asperger’s syndrome, mental retardation, bulimia, anorexia, delirium of persecution, people who see illusions and hallucinations, neuronal deterioration, physical cerebral trauma, mental weakness, aggressive people, and “*cuando uno cambia de parecer*” [when one changes his/her mind].



To analyze this distribution of knowledge of mental illnesses, the graph above was created. It illustrates how many people named a certain number of mental illnesses. 24 participants could not name any, 36 named one, 38 named two, 20 named three, 10 named four, 1 named five, 1 named six and 1 named seven. The fact that only 33

individuals could name more than two mental illnesses was also indicative of a lack of exposure to or knowledge of mental health. Most of the subjects struggled to come up with a response other than schizophrenia or depression, which although being the most prevalent disorders in Arica, do not cover the wide breadth of illnesses that do exist. Interestingly, some subjects could not name psychiatric disorders when asked, but they brought them up in stories later on in their interviews. One person mentioned anxiety disorders in another part of the survey, but not in response to this question, suggesting that he did not make the connection between those disorders being psychiatric ones. Similarly, a woman asserted that she had been suffering from depression, but she did not name depression as a mental illness. This occurrence could indicate mere forgetfulness or maybe a lack of recognition that what they were mentioning classified as mental illness.

Table 3. Education Level of Those Who Could Not Name Any Mental Illness

| Education Level | Number of Subjects | Percentage of this Education Level that Did Not State Any Mental Illness |
|-------------------------------------|---------------------------|---|
| No Schooling | 1 | 100% |
| Primary/Middle School Not Completed | 1 | 14% |
| Middle School Completed | 4 | 40% |
| High School Not Completed | 5 | 39% |
| High School Completed | 8 | 19.50% |
| Technical School Not Completed | 2 | 22.20% |
| Technical School Completed | 1 | 3.80% |
| University Not Completed | 1 | 5.90% |
| Graduate School Not Completed | 1 | 100% |
| TOTAL | 24 | |

The above table was created to determine whether subjects' level of formal education had any influence in their inability to name any mental illness. Every educational group except for "university completed" was represented. In the group with no level of formal education, the one individual who could not name any illness represented 100% of that group. For "middle school not completed", the one participant represented 14.3% of the group. For "middle school completed", the 4 participants

represented 40% of the group. The 5 participants from “high school not completed” represented 38.5% of the group. The 8 participants from “high school completed” represented 19.5% of the group. The 2 participants of “technical school not completed” represented 22.2% of the group. The one participant with complete technical studies represented 3.8% of the group. The one participant from “university not completed” represented 5.9% of the group, and the one participant from “graduate school not completed” represented 100% of the group. This wide variety of education levels insinuated that formal education did not have a significant correlation with knowledge of mental health, as this topic was not taught extensively taught in Chilean schools.

Table 4. Most Frequently Named Mental Health Centers

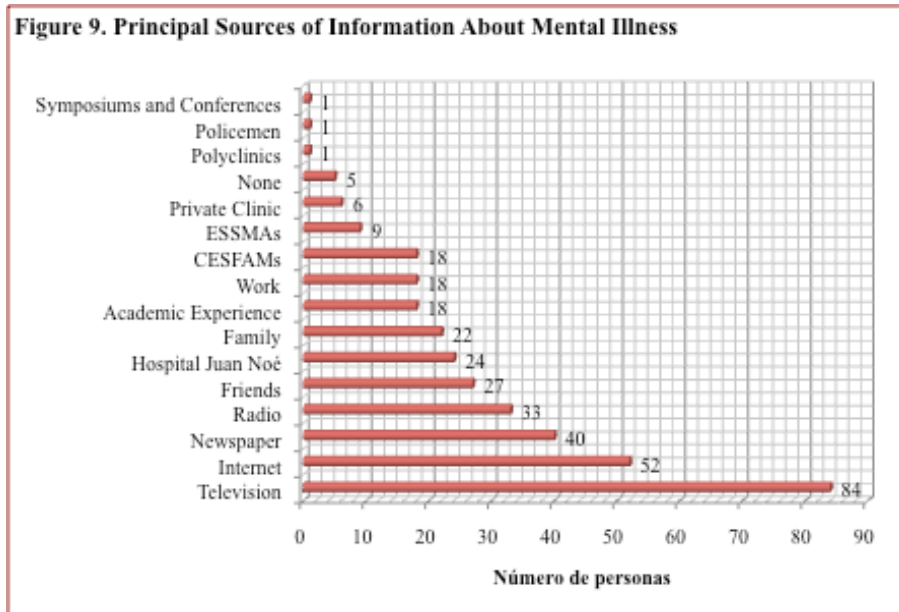
| Mental Health Centers in Arica | Number of Subjects |
|---|--------------------|
| None | 64 |
| Juan Noé Hospital | 27 |
| CESFAMs (primary care centers) | 13 |
| ESSMAs (specialized mental health centers) | 10 |
| Santo Domingo Clinic | 5 |
| San José Clinic | 3 |
| Psychiatrists | 3 |
| San Agustín Clinic | 2 |
| Asylum Hospital | 2 |
| Psychologists | 2 |
| ESM | 2 |
| On Calle 11 de septiembre, in the Camilo Henríquez Neighborhood | 2 |

When the participants had to name all of the mental health centers in Arica that they knew, the most frequently named centers were “none” (64), the Hospital Juan Noé (27), family health clinics (13) and the ESSMAs (10). The centers that were only named by one person were COSAM — *Centro Comunitario de Salud Mental* [Community Center for Mental Health], COSAN (does not exist), the private clinic Megasalud, the Mutual life insurance company, polyclinics, psychologists in high schools and universities, the Olivo de Azapa (not a mental health center), APEDIM (support group for parents of mentally ill children), SERNAC (National Service for the Consumer),

Alcoholics Anonymous and “there aren’t any”. The inability of 64 participants to name even one mental health center in Arica revealed a glitch in effective communication between those centers and the community. The ESSMAs are the largest presence in terms of public health centers in the city, yet only 10 people named them, suggesting a failure to engage the community-at-large about the resources available to them. However, the incorrect acronym ESM was most likely an attempt to reproduce the actual name of the institutions. Likewise, COSAN may have been an attempt to name COSAM, but there is no COSAM in Arica. Also, it was unclear why the “Olivo de Azapa” and “SERNAC” were named, as they have no connection to the healthcare field. Finally, the 40 people who named the hospital and CESFAMs as mental health centers signified a lack of clarity on the difference between a primary care center with a psychologist and an actual specialized mental health center.

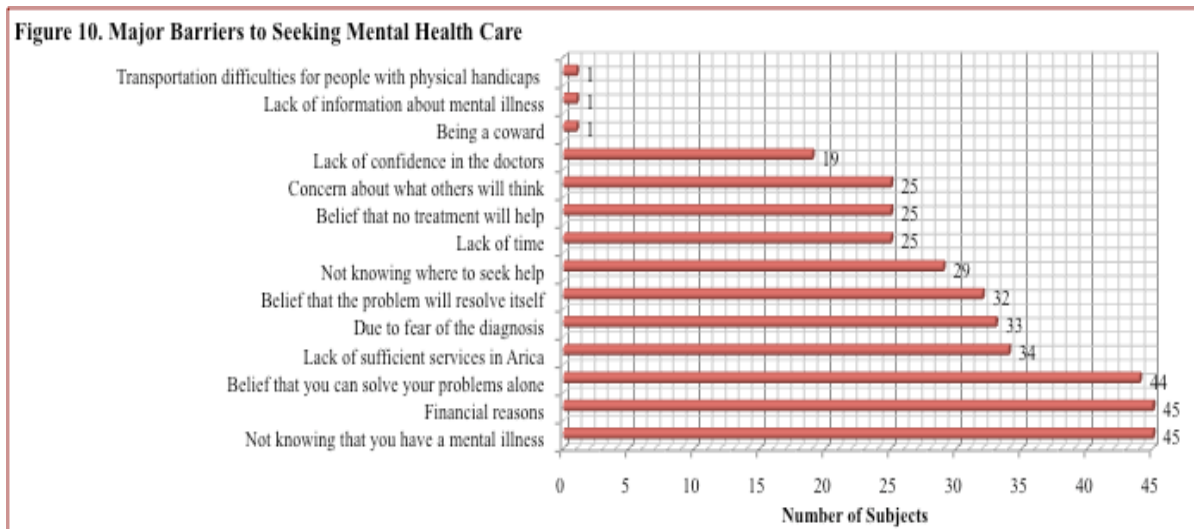
Despite not being able to name many mental health centers, the subjects still recognized the necessity of those centers. 92% declared that mental health centers were necessary, 4% said they were sometimes necessary, 3% admitted not knowing whether they were necessary or not, and 1% negated their necessity. One participant emphasized that these centers were necessary due to a high consumption of cocaine, alcohol, non-prescription pills and marijuana in Arica. The only person who said they were not necessary had had a negative experience in a mental health center. When asked about the efficacy of these centers, 43% said “yes,” 35% said “sometimes,” 18% said “I don’t know” and 5% said “no.” One person said that sometimes they are effective, but only in accordance to the level of family support afforded to the patient. This discrepancy between the perception of necessity and efficacy of the centers implied distrust in the

healing capabilities of the treatments offered by the centers. One could suppose that this distrust influenced subjects' decision not to seek treatment for mental health problems.



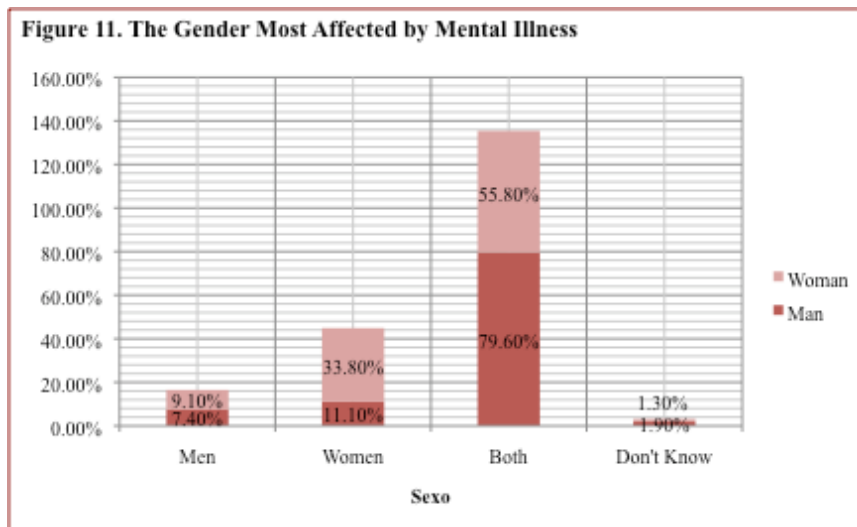
To understand the grounds upon which subjects formulated their opinions, the researcher asked them which sources they received the majority of their information on mental health from, and they could select more than one response. The most frequently selected responses were television (84), the Internet (52), newspapers (40), the radio (33), friends (27), Hospital Juan Noé (24) and family (22). Three subjects provided their own options of symposiums and conferences (1), policemen (1) and polyclinics (1). A potential problem with the heavy emphasis on media sources was that the media portrays people with mental illness in three prototypic manners: as homicidal maniacs, as adult individuals with childlike behaviors and as free, creative spirits (López et al. 2008). These unrepresentative prototypes, along with personal opinions of friends and family members, could have greatly misinformed individuals. As for the hospital response, general doctors can provide valuable information, but if they are not specialized in mental

health, they cannot serve as the most accurate source of information for the promotion and education of the population on the topic of mental health and illness. Therefore, the sources of information for the majority of these subjects were problematic in terms of accuracy.



In terms of the most important barriers to seeking professional help, participants could select more than one response. The three most frequently selected responses were “not knowing that one has a mental illness” (45), “for financial reasons” (44) and “the belief that the person can solve the problem on his/her own” (44). The 45 subjects who cited ignorance of possessing a mental illness as a barrier pointed to the difficulty of detecting mental health problems held by oneself. However, the 44 subjects who cited financial reasons implied that they did not understand how to receive mental health care according to their health insurance provider since the majority of the subjects in the study held FONASA A and B insurance. With this insurance, mental health consultation in the public sector is completely free, and it is relatively cheap for all other providers. The 44 subjects who cited belief in being able to resolve a problem by one’s self demonstrated, once more, the low tendency to talk about one’s problems and seek professional help.

Moreover, the 34 subjects who cited the lack of mental health services as a major barrier suggested that a lack of information could be the problem, rather than a lack of services, because many subjects were not able to name the mental health resources available in Arica. The least selected option, except for “other,” was “lack of confidence in the medical team” (19). The “other” responses were “due to being a coward” (1), “lack of information about mental health” (1) and “transportation difficulties for people with physical handicaps” (1). Similarly, in Saldivia et al.’s 1992-1997 study, the strongest reasons for not seeking mental health care were the belief that the problem would resolve itself, the belief that one could solve the problem alone, financial reasons and the way the diagnosis was provided. Therefore, Saldivia et al.’s results coincided rather closely with the present study’s results. These similarities suggested that ideas held by Chileans about seeking out help for mental illness have not changed much in the last fifteen years.



In terms of the role of gender in susceptibility to mental illness, the majority of participants believed that “both” sexes had the same risk of suffering from a mental illness, followed by “women,” “men,” and “I don’t know”. More women (9.1%) than men (7.4%) opined that men were more at risk, more women (33.8%) than men (11.1%)

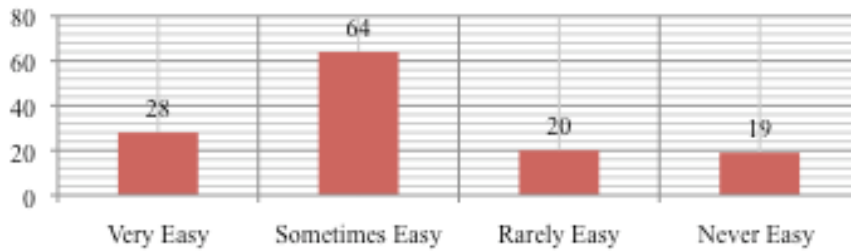
opined that women were more at risk, and more men (79.6%) than women (55.8%) opined that both sexes were equally at risk. Men tended to think of the sexes on equitable terms, at least with regard to mental health, but women made distinctions between the two. Those who claimed that women were more inclined to have a mental illness cited the following reasons [translated from Spanish]: they are the ones who worry more about everything, women have more stress than men, women are crazy and I don't understand them, they have to deal with more pressures from the family, husbands make them crazy, women are more weak of character, and women are more easily depressed. In general, these reasons demonstrate the feminine viewpoint that women have more pressure to bear in society due to their role in taking care of the family. The reasons for selecting men were women are stronger and more solid, men consume alcohol and drugs, men are stronger so they cannot control their character, men have less mental strength, men have more worries, and men are more closed off [translated from Spanish]. Clearly, men were less likely to name themselves as the primary sufferers from mental illness, maybe due to the pressure to uphold society's *machista* culture. However, a belief in the dependence upon the individual, rather than gender, in determining propensity for mental illness was the main explanation for choosing "both." Specific reasons included: economic problems affect everyone, I have seen as many violent women as men, we are human beings, and we function equally, both work and both have to take care of the home, mental illness is hereditary, and it depends on the specific life experiences one goes through [translated from Spanish].

Table 5. Segments of the Population Most Likely To Have a Mental Illness

| Segments of the Population Most Likely to Have a Mental Illness | Number of Subjects |
|--|---------------------------|
| The poorest/Those with scarce resources | 10 |
| People who consume drugs and alcohol | 10 |
| Youth/Adolescents | 6 |
| People who work | 5 |
| People in the streets | 5 |
| Adults | 5 |
| Children | 5 |
| The elderly | 3 |
| In areas where there is no medical attention | 2 |
| Those who have more problems | 2 |
| People with heredity for mental illness | 2 |
| Unprotected people | 1 |
| Uneducated people | 1 |
| People who live in tiny villages | 1 |
| People who live in the valleys | 1 |
| People in Arica are very despotic | 1 |
| Relatives | 1 |
| The disabled | 1 |
| Those who suffer from love pains | 1 |
| People in the most vulnerable sectors | 1 |
| Weak people | 1 |
| Those who have babies at an old age | 1 |
| Women | 1 |
| Drunk old men | 1 |
| Middle class | 1 |
| Don't know | 1 |
| Delinquents | 1 |
| Those with a lot of money | 1 |

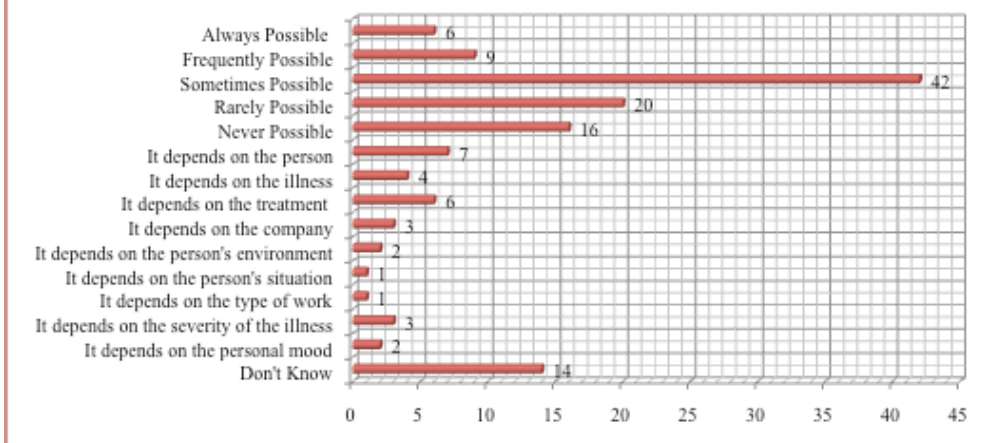
57 of 131 people also opined that there were other segments of the population that tended to suffer more from mental illness. The most frequently stated groups were: those with scarce [economic] resources (10), people who consume drugs and alcohol (10) and youth (6). The opinions of 26 participants that the most vulnerable segments of the population were the poorest people, drug addicts and alcoholics, and youth coincided with scientific studies. From 2000-2010, Chile's National Plan for Mental Health and Psychiatry prioritized its attention on children and school-aged adolescents with attention disorders and people with alcohol and drug dependency (Minoletti & Zaccaria 2005). Additionally, another study found that mental disorders contributed to the increase in the level of poverty (Acuña & Bolis 2005).

Figure 12. Ease in Identifying People with Mental Illness

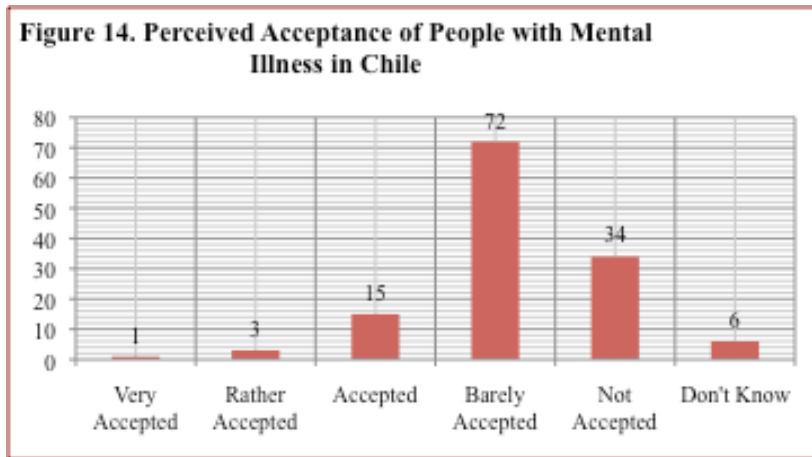


Subjects also gave their opinions on how easy it was to distinguish mentally ill individuals from healthy ones. 64 people said it as “sometimes easy,” 28 said it was “very easy,” 20 said it was “rarely easy” and 19 said it was “never easy.” Three people elaborated that it was “very easy” to detect individuals suffering from mental illness due to personal years of experience, their manner of moving and carrying themselves, and the way in which they expressed themselves and spoke. The opinion of half of the sample that it was sometimes easy to tell whether someone had a mental health problem signified an awareness of the spectrum of mental illnesses—some are immediately notable and others are more subtle. However, the context of those claiming that it was very easy to tell whether someone had a mental illness often erroneously referred to individuals who were also homeless or to extreme cases of those who wandered the streets talking to themselves. Furthermore, it was notable that although the majority of the subjects believed that it was “very easy” or “sometimes easy” to tell that a person had a mental illness, 45 subjects also cited the greatest obstacle to seeking treatment as “not knowing that one has a mental illness”. This inconsistency denoted that people tended to identify mental health problems in others, but they could not accept that they themselves might suffer from the same condition.

Figure 13. Potential of People with Mental Illness to Complete Tasks in Workforce



Additionally, participants provided their opinions on the potential for individuals suffering from mental illness to succeed in the workforce. The most frequent response was it was “sometimes possible” (42), and the least selected response was that it was “always possible” (6). Thus, the subjects did not display much confidence in the abilities of people with mental illness in the workplace. 29 people selected “it depends on __,” with the most common answers being “it depends on the person” (7), “it depends on the treatment” (6) and “it depends on the illness” (4). These numbers revealed subjects’ understanding of the individuality and uniqueness of mental illness cases. However, the 3 people who affirmed that it was rarely or never possible for people suffering from mental illness to accomplish their work tasks successfully were prime examples of why many people refrain from revealing their mental health problems for fear of being fired.



Finally, the participants disclosed their perceptions about societal level of acceptance of individuals with mental illness in Chile. 72 people said they were “barely accepted”, 34 said they were “not accepted”, 15 people said they were “accepted,” and only 1 person said they were “very accepted.” This last person claimed the presence of a lot of acceptance because while the stigma of craziness existed before, he believed that in this day and age everyone goes to the psychologist. Contrarily, the one participant who asserted that mentally ill patients were not accepted declared, “*Es una sociedad de mierda que no entiende nada*” [This is a society of sh-t, where no one understands anything]. In general, the subjects perceived Chilean society as unwelcoming to people with mental illnesses. The fact that 106 subjects said that those with mental illnesses were minimally or not at all accepted revealed that stigma might very well exist in today’s Chilean society. Some people empathized with those with psychiatric disorders throughout the administration of the survey, but at the end, they stated believing their views were in the minority. The mental health system, as well as Chile as a whole, must take many steps before attaining widespread acceptance of those with mental illness.

II. Mental Health Professionals' Interviews

In the interviews with the mental health professionals, much information was discerned about how mental health functions within the Chilean health system. Each health professional defined the concept of mental health as “*sentirse más felices con las habilidades que tienen en el contexto que están*” [to feel happier with the capacities and handicaps that one has] (Pérez), “*lograr una estabilidad, un equilibrio con el medio ambiente, con todo lo que es el sistema*” [to achieve a stability, an equilibrium with the environment, with everything that is the system] (Varas), “*estar bien con uno mismo y con los demás*” [to be well with oneself and with others] (Osorio), “*es en un usuario y en una persona que no se atiende, [que] se involucre en diversas actividades y las puede desarrollar de buena forma*” [it is within both a patient and a person who does not need treatment; one who involves himself/herself in diverse activities and can perform them well] (Quiroz) and “*trabajar con las personas para pretender el bienestar físico, psicológico, social y cultural de las personas*” [to work with people to cultivate a physical, psychological, social and cultural well-being] (Acosta). These definitions demonstrated that mental health could best be described as how to feel the best that one can in as many areas of one’s life as possible. By not explaining health as the absence of sickness, the professionals expressed their belief in the simple need to develop and sustain oneself in one’s daily life, which matched the Chilean government’s definition of mental health, “*La salud mental es el equilibrio entre una persona y su entorno socio-cultural, lo que garantiza su participación laboral, intelectual y de relaciones para alcanzar bienestar y calidad de vida*” [mental health is a balance between a person and his or her sociocultural surroundings, which guarantees his or her work-related,

intellectual and relationship participation in order to achieve well-being and high quality of life] (Gobierno de Chile 2010).

In addition, all the professionals explained the role of mental health in one's comprehensive health. Natalia Pérez gave the following example, “*¿De qué te sirve poder caminar hacia la puerta, teniendo un estado físico, sin que sabes para qué es la puerta, si no sabes atravesar la puerta?*” [What good is it for you to be able to walk towards the door, being physically healthy, if you don't know what the door is for and if you don't know how to go through the door?] Moreover, with an intact mental health, one can work and effectively exercise his/her role in society, in the workplace, in the home and in all his or her surroundings (Varas). Maritza Acosta explained that mental health problems could develop into physical problems, and vice versa, because as Dr. Osorio noted, “*No creo en la división entre mente y cuerpo. Creo que son una sola cosa*” [I don't believe in the division between body and mind. I think that they are one sole entity]. This emphasis on the essential link between mental and physical health demonstrated the integral role of mental health in a person's health and happiness.

When the professionals were asked what illnesses were most frequent in their health centers, they named depression, schizophrenia, drug and alcohol addiction, anxiety disorder, personality disorders, mood disorders, psychotic disorders (including schizophrenia, personality disorders and mania), dementia, mental retardation, anorexia and bulimia. These disorders were similar to those enumerated by Minoletti & Zaccaria as the most frequent in Chile: agoraphobia (11.1%), major depression (9.0%), dysthymia (8.0%), and alcohol dependency (6.4%) (2005). Therefore, the most prevalent disorders mental illnesses in Arica, closely mirror those in the rest of the country.

With respect to the type of health insurance with which users could receive treatment in their health centers, all the professionals said that FONASA (public) was the primary one. However, they explained that one to three people with ISAPRE (private) could also be received at the ESSMAs, as could patients without any insurance (Pérez; Varas). Some service users from the armed forces could access treatment with CAPREDENA and DIPRECA (Dirección de Previsión de Carabineros) (Quiroz). In the ESSMAs, treatment was completely free for FONASA A and B because the SOME (*Servicio de Orientación Médica Estadística*), or payment processing center, had not yet been established (Osorio). Therefore, treatment was technically free for people with all types of insurance providers. However, Quiroz explained that once the cash box was set up, a consultation with the psychiatrist would cost 610 pesos for FONASA C and D. In the CESFAMs, mental health consultations were free for all four tracks of FONASA. This information showed that financially speaking, mental health services should theoretically be accessible to all people. Although the ESSMAs and CESFAMs exist within the public health system, people without insurance or with private insurance are not excluded from accessing them. Therefore, the perceived financial obstacle to seeking mental health care listed by the Arican subjects in this study suggested that many Aricans did not understand how to access the system.

On a grander scale, the professionals also explained how financing of their mental health centers functioned. The *Servicio de Salud*, or health department, administers money to the ESSMAs and the hospital, while the City of Arica administers money to the family health clinics (Osorio; Quiroz; Varas). The centers have to direct their own programs with the money that is distributed according to the number of people received

in each center (Quiroz) or by the population zoned to each public health center (Acosta). Varas explained that the Minister of Health implements a pool of money for health programs, and it is from this pool that mental health receives funds. If a professional wants more money to manage workshops or programs, he or she has to apply for a grant, and there are very few foundations that provide these resources (Pérez). Generally, the professionals believed that the money directed to mental health centers was rather little (Pérez), abysmal (Quiroz) and “*nunca va a ser suficiente como nosotros quisiéramos pero por lo menos ha aumentado*” [it will never be as much as we want, but at least it has increased] (Acosta). The professionals also cited bureaucracy (Pérez; Quiroz; Varas), lack of time (Pérez), lack of human resources (Quiroz) and lack of structural resources (Acosta; Osorio) as additional limitations to the efficient management of the mental health centers. These opinions revealed a belief in widespread deficiencies that obstructed the ability to manage all of the tasks and programs they would like to execute. These insufficiencies may have accounted for some of the general public’s perception of the inefficacy of mental health centers. Varas admitted that at the end of the day, professionals realized that not all patients received one hundred percent of the treatment that they should receive. Researchers noticed this same failure, explaining that the available resources for the National Plan of Mental Health and Psychiatry, assigned according to defined priorities within the entire nation’s budget, have been less than what was proposed in the original plan (Minoletti & Zaccaria 2005). So, mental health professionals often do not have enough money to work with to treat patients or to ensure a comprehensive hospitalization. Acuña & Bolis asserted that this discrimination towards mental health was easily observable both in terms of the budget allowances and the space

that the health sector dedicated to mental health programs (2005). These corroborating explanations from a variety of sources seemed to support Quiroz's sentiment that mental health was medicine's poor brother, "*La salud mental es el hermano pobre de la medicina.*"

In addition to the paucity of resources, the professionals also lamented the community's lack of information and understanding of mental health. When speaking about the dispersion of information about mental health, they all explained that they held programs, such as talent shows and Christmas parties to bring the service users and the community together. However, Natalia Pérez expressed, "*Yo creo que la promoción y la difusión de lo que es salud mental es muy muy poco [...] yo he hablado con ariqueños de años, y ellos me preguntan, '¿Qué es el ESSMA?' [...] no tienen idea [...] cómo atenderse si están con depresión, a quién recurrir*" [I think there is very little promotion and diffusion of information on mental health [...] I have spoken to Aricans who have lived here for years, and they ask me, 'What is the ESSMA?' [...] they have no idea [...] how to go about receiving help for depression, or where to go. The reality is that there is a lack of education in the community itself] (Varas). In addition, the media provides a lot of negative information, "*Cada vez que se suicida alguien, acá eso aparece en el diario. Lamentablemente*" [Every time that someone commits suicide, it appears in the newspaper. Regrettably.] (Osorio). Quiroz also chimed in on the theme, "*Yo he visto que [...] falta como invertir desde lo económico para más folletos, para más trípticos, información [...] para poder que estén, por ejemplo, en distintas instituciones públicas*" [I have seen that there is [...] a lack of economic investment for more bulletins, more pamphlets, more information [...] that could be placed in distinct public institutions].

Discrimination seemed to stem from multiple sources, including the national and local governments' stagnancy in funding awareness campaigns, the media in its churning out of biased information and community members in believing that information. At the same time, small steps had been taken towards positive change. Dr. Osorio divulged, "*Arica es una ciudad especial que tiene bastante tolerancia con las patologías psiquiátricas en general*" [Arica is a special city that is rather tolerant towards psychiatric pathologies], and Ps. Acosta opined, "*Yo creo que cada vez hay mayor conocimiento y desmitificación de lo que atiende salud mental*" [I think that there is greater knowledge and demystification about mental health with each passing day].

The professionals described how the overall lack of information affected their patients. Antonia Varas affirmed that the people who arrived at ESSMA Sur arrived with a lot of fear about what other people would say about them. Giving an example, she stated that some people said, "*Cuidado de esta persona, que le puede hacer daño al vecino, a los hijos*" [Watch out for that person, who can harm your neighbor or your children]. These types of statements only served to push people with mental illness away instead of integrating them into the community. The perception that exists was that "*la persona que viene, por ejemplo, al ESSMA Sur es una persona loca y no, fue una persona que a veces viene con depresión, con una fobia, no es un centro de esquizofrénicos*" [the person who comes to ESSMA is crazy, but no, a person often comes with depression, with a phobia; this is not a center of schizophrenics] (Quiroz). This prejudice extended beyond the general population to the families of mentally ill patients themselves, as some families maltreat their loved ones with psychiatric disorders, calling them crazy and threatening to lock them up in an institution (Osorio). Moreover, some doctors also held

this prejudice, as Natalia Pérez recounted, “*Una vez, me tocó internar a un paciente en urgencias y no lo quisieron atender. ‘O no no, con esquizofrenia, ya a psiquiatría’ [dijo el médico]*” [One time, I had to bring a patient to the emergency room, and they didn’t want to accept him. The surgeon said, ‘Oh, no no, if he has schizophrenia, send him to psychiatry’]. Furthermore, even within the mental health system, some psychologists did not like to work in the field of mental health [...] because they said that they would encounter a crazy or aggressive person, “*[Hay] algunos psicólogos a que no les gusta trabajar en el área de la salud mental [...] porque dice que se van a encontrar con un loco, algún agresivo*” (Varas). Mental illness stigma is a very real phenomenon.

Justifiably, in higher education, patients generally ask psychologists not to reveal their diagnosis for fear of being discriminated against or expelled from their track of study (Pérez). In the same manner, in the workforce, people who are fired from their jobs because they have a psychiatric pathology and have to leave work to go to check-ups, for example (Osorio). The reality of the situation is that the patients have to lie, “*Dicen, ‘Voy a ir a hacer un trámite al Centro,’ y no po’, vienen acá para el control con el médico para no perder el trabajo*” [They say, ‘I’m going to run an errand downtown,’ but no, they are coming here for a meeting with the psychologist, but they do not want to lose their job] (Quiroz). With discrimination stemming from the general public, employers, family members and even medical professionals, who theoretically should not harbor prejudices towards individuals requiring medical attention, those suffering from mental illness have a battle to fight on numerous fronts. Instead of integrating those with mental health problems, the rest of society backs away from them due to fear, which prevents the implementation of a solution for stigma (Varas). As this stigma often affects patients to

the point that they do not want to continue receiving treatment or that they try to kill themselves, it clearly has the power to evolve into a double-edged force (Osorio). Stigma then manifests itself as a direct product of personal and structural discrimination as well as stigma derived from one's own self-stigmatization (López et al. 2008).

In order to combat this stigma, the professionals believed that their own mental health services should take greater action, as maybe they were not fulfilling their full roles as community-based teams (Varas). Varas affirmed that she and her colleagues should work more with children and families within the community so that they could learn how to live with people with mental illness. This community work would create an avenue for their service users to join the community and be accepted just like any other person. Like Varas, Ps. Acosta cited community work as an important method through which to reduce stigma, but she noted that it brought a certain frustration with it because it could be extremely hard to see short-term results. In addition to working with families in their homes to encourage them to take positive action against stigma, Acosta believed that Chile should change its general policies, use propaganda and use the media, which could do a lot to change the course of stigma. Like these professionals, López et al. understood the importance of community work. They proposed an alternate community model for health care, in which mental health services did not organize themselves in a monographic way that isolated them from the rest of the medical and social services, but rather, they integrated themselves into the general network of medical attention (2008). A community model of health holds everyone accountable for the other and could do wonders for integrating currently marginalized groups. Even the professionals and the Chilean government agreed that establishing a mentality of shared responsibility could be

a possible starting point for change, as the official government's message was that mental health was a shared responsibility between a nation's government, the family, the neighborhood, the media, the workplace and educational institutions (Gobierno de Chile 2010).

Since society holds the power to either propagate or dissipate stigma, it needs the proper information in order to do the latter. The constant presence of stigma is often at the root of people's fear to seek professional treatment when they need it or to accept those with mental illnesses. To assuage that fear, both Osorio and Quiroz mentioned the importance of working with children. Osorio suggested working with children in schools to de-stigmatize mental illness and to eliminate the use of discriminatory terms when referring to the topic. For her part, Quiroz brought up that teachers already taught mental health awareness to students from the time they were very young in schools. However, she hoped that the government could take the stance to distribute educational books that included mental health information to standardize this education throughout all schools in Chile. Along a slightly different note, Pérez proposed educating society, but her focus was on adults rather than children. She felt this way due to an experience in which she had called the manager of Coca-Cola to meet with him and to explain that she had a dedicated group of individuals who were prepared to work, but they had some mental health disabilities. The manager declined, as did the human resources manager at the Líder chain store (Chilean Wal-Mart). Such discrimination without regard for an individual's qualifications counters the human right to realize "economic [...] rights indispensable for his dignity and the free development of his personality" (United Nations, Art. 22 1948). The stigma that leads to this type of discrimination is heightened

in Arica because the city is very small and everyone knows each other.

Uncovering the state of mental health care and the social ramifications associated with it revealed rather grave problems in Arica in terms of intolerance towards mental illness and those affected by it. Analyzing this situation also suggested possible avenues for change. The information gleaned intimated that comparing the state of mental health in a different society might reveal yet to be discovered truths about Arica. Thus, a comparative study was planned and executed in Rome, Italy to gauge how individuals in that society perceived mental illness and if citizens made use of the available services to treat their illnesses. The hope was to investigate mental health stigma in another country to draw wider and more profound conclusions about where mental health stigma exists, the capacity in which it exists, why it exists and how to combat it.

Methodology—Italy

This research was conducted during the month of July 2012 in the city of Rome, Italy. Since researcher did not participate in any formal study abroad program, but was conducting independent research, establishing contacts in Italy was difficult. After seeking contacts for a potential in-country advisor from the SIT academic advisor (a Chilean of Italian descent) and past Italian professors, neither option was fruitful. Undeterred, the researcher sent multiple e-mails to professors and doctors in Duke's Departments of Psychology, Public Policy, Global Health and even Duke Hospital, until finally receiving a response from a professor in the Center for Child & Family Policy. With his help, the researcher procured an advisor from the University of Rome's

Department of Medicine and Psychology. Although the researcher still had to apply for funding, having an in-country advisor allowed for progression in planning the research.

The same approach of a qualitative, realist epistemology was undertaken in this study. However, unlike the research conducted in Arica, only a two-week period, rather than a two-month period, of adaptation to the milieu prior to commencing the investigation was possible due to time constraints. Therefore, this research did not qualify as an ethnographic study, “Ethnographic studies that do not detail prolonged engagement [...] seem to be inappropriate to the rubric of ‘ethnography’” (Drisko 590). Also, the study was interview-based, but the concurrent observations could have been more in-depth if more time had been spent immersed in the culture. The value of observation cannot be underestimated in qualitative research, as it “allows researchers to collect data on events that are covert or that may not easily be captured and conveyed in words” (Drisko 590).

This design of this experiment was non-experimental because there was no deliberate manipulation of independent or dependent variables. The phenomena and subjects of study were observed in their natural environment. Within this classification, the study was transversal descriptive because the data was collected during one singular time period (July 5th-July 23rd), and the opinions of the Italian adults were procured in a descriptive manner.

The population of study was adults living in Rome, Italy, which included people with and without mental illnesses, in order to accomplish the general objective of determining the perceptions of Italians towards mental illness. The first of two samples was a non-probabilistic selection of 27 adults, who were chosen based on the need for

equal distribution between both genders and across the four age groups (18-29, 30-45, 46-64 and 65+). Thus, the sampling method was different from the Chilean study. This systematic, non-probabilistic sampling was useful in the short time frame that required a rapid collection of data, as it allowed the researcher “to identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied” (Mays & Pope 110). Instead of approaching subjects at random, it was possible to concentrate and direct efforts by selecting “key informants with access to important sources of knowledge” (Mays & Pope 110). The sample group was smaller due to the more qualitative nature of this study that required long narrative interviews. The sample group was not intended to be representative of the population at large, but rather, to be indicative of the specific opinions of the participants interviewed.

For this sample, a 5 to 10- minute survey of eighteen yes/no questions was administered as the first instrument of data collection, and the participants’ individual written completion of the survey was the technique of data collection. Additionally, a 10 to 20-minute oral interview consisting predominately of open questions, along with some closed and categorical questions, was the second instrument and technique of data collection. These interviews were much less strict in format than the Chilean interviews, allowing for more free-flowing dialogue depending on each particular participant. The two methods of data collection were selected in order to target different types of questions that lent themselves more to instinctive responses in the yes/no survey or to long, explicatory conversations in the interviews. The two methods served to present a more holistic representation of the participants’ attitudes towards mental illness.

Procuring participants proved to be rather difficult due to the lack of contacts held

in the country. Living in Rome alone and for the first time, the researcher struggled to find people who were willing to be interviewed. In general, Italian culture is not particularly warm or open towards foreigners, so dealing with rejection played a large role in the study. However, every person who refused to participate motivated the researcher to think more creatively to procure subjects, so she joined a gym to make friends, used a parent's company's contacts and capitalized on a lucky opportunity to interview physically handicapped individuals in an orthopedic clinic. These venues represented "open or public settings (e.g. vulnerable minorities, public records or settings) where access is freely available but not always without difficulty either practical (e.g. finding a role for the researcher in a public setting) or ethical (e.g. would we be intruding upon vulnerable minorities?)" (Silverman 2004). It was tiring and often discouraging work, but despite the frustration and disheartenment, the final sample provided the desired diversity of individuals to analyze a broad view of perceptions.

Additional stressors to be mentioned were the language barrier inherent in not being a native Italian speaker, potential subjects' negative perceptions of the researcher and the researcher's limited experience with conducting extensive qualitative interviews. In conducting research with human subjects harboring biases from the recent 1990s immigration explosion, the researcher had to be extremely cognizant of her appearance, attitude and tone as an African undergraduate female exploring the sensitive topic of mental health stigma in a strongly patriarchal and only recently immigrated country. This impression management involved "avoiding giving an impression that might pose an obstacle to access, while more positively conveying an impression appropriate to the situation" (Silverman 2004). Moreover, her underdeveloped observational skills naturally

lessened the possibility of thoroughly describing, documenting and interpreting “social processes, position, posture, tone of voice and expression [...] to convey the full scene in depth” (Drisko 590). However, the spoken views and major inflections in tone of voice were captured through the audio recording and transcriptions to provide additional interpretation to observed events and to enhance their meaningfulness.

To guarantee the rights of the participants, the researcher presented them with two separate informed consent forms to read and sign before participating in the survey or interview. These forms assured them of the voluntary nature of the study and of the confidentiality of their identity in the analysis of their responses. Each participant had the opportunity to sign the forms, thus agreeing to participate in either one or both segments of the study and/or agreeing that the interview could be audio recorded. The chronology of the administration of the surveys and interviews is as follows:

- July 5th: 1 male in his home at intersection of Via Tiburtina and Via Morello
- July 7th: 4 females and 1 male at Villa Mercede
- July 8th: 4 females and 2 males at the Parco dei Caduti
- July 10th: 1 female at l’Ospedale Sant’Andrea
- July 11th: 1 female at the Department of Anthropology—La Sapienza
- July 14th: 2 males and 1 female at La Sapienza; 3 males and 3 females at the Center of Orthopedics and Trauma at La Sapienza
- July 15th: 1 female at Piazza del Popolo
- July 17th: 1 male at his home in the Vatican district
- July 21st: 1 male at his home in the Magliana district
- July 23rd: 1 female at her home in the San Lorenzo neighborhood

The short time period available to complete the study presented limitations, as previously discussed. Although it is true that “prolonged engagement with participants, settings and the collected data typically strengthen qualitative research,” the audio recording of the interviews, in contrast to note-taking from memory or inference, added validity to the data collection (Drisko 591). Additionally, the fieldwork was described in detail so that other researchers could inspect the evidence independently.

As researchers can interpret meanings differently, qualitative research often faces the problem of establishment of the validity of the analysis and conclusions drawn. To safeguard the validity of the findings, the triangulation approach was taken in data collection, meaning that “evidence is deliberately sought from a wide range of different, independent sources and often by different means (for instance, comparing oral testimony with written records)” (Mays & Pope 110). Cross-referencing the surveys and the interviews was invaluable in the analysis process. The triangulation method illuminated key discrepancies in the participants’ oral and written responses, corroborated their written views on certain topics that were fleshed out more in the interview, or conversely, revealed opinions that they felt more comfortable writing down in the survey than voicing in the interview.

The design of analysis for the surveys and interviews was the creation of a database and graphs and tables on Microsoft Excel to analyze the trends of responses to all the data from the recordings, transcriptions and observational notes. The interview and survey responses were also analyzed side by side to compare the two instruments to each other. This database consisted of a compilation of participants’ answers to all the questions (open, closed and categorical), in order to effectively determine the frequency

of each response. In the data analysis, a software system was not used to analyze the content of interview transcripts, thus a computerized coding frame was not developed. Instead, care was taken to manually employ a consistent coding method. were inputted into a Microsoft Excel database with corresponding tables and graphs. A possible bias of the surveys was that explanations were only required if the subject responded in a particular fashion. For example, for one question, participants only had to explain their response further if they responded “no” against the right to vote for people with mental illness, which may have swayed their initial response.

Responses were grouped according to the broader context of the interview as a whole, including location, age and gender of the participant, education level and interaction with the researcher. Moreover, similar answers to open questions were grouped into themes, at the researcher’s discretion. For example, for the question about sections of the population most susceptible to mental illness, the grouping of “people without jobs” and “unemployed people” as one category while excluding “poor people” worked because the former two were similar, while the latter would have represented a presumptuous inference. Answers given in other parts of the interview that did not answer the particular question were still used in the analysis of the said question if they were relevant. This thematic coding was consistent with the fundamentals of qualitative research, “The construction of meaning is the task of qualitative research and reflects the specific methods used in the qualitative data analysis process” (Krauss 763).

The second sample of this study was a non-probabilistic sample of experts, and it consisted of twelve mental health professionals selected based on the type of health facility in which they practiced, in order to incorporate both public and private

practitioners. Initially, the plan was to interview 15-20 psychiatrists, psychologists, psychiatric nurses, social workers, psychotherapists and community educators from three public facilities and three private facilities to procure a wide breadth of viewpoints. The public facilities were to include two hospitals, three CSMs and a public residential community. The private facilities were to include two private residential communities, two private non-governmental organizations and two private clinics. However, the reality of time constraints, rapidly approaching vacation time for professionals and professionals' busy schedules dictated the final participants of the study. Case in point, the researcher arrived in Rome on June 19th, but the first interview was not conducted until July 9th. also, no social workers or community educators were interviewed, no NGOs were included and no private facilities were included, although private practitioners also working in public facilities participated in the study. These professional facilities represented "closed or private settings [...] where access is controlled by gatekeepers," with the in-country advisor and a psychotherapist contact serving as gatekeepers (Silverman 2004). Thanks to them, access was gained to one public residential community, two public hospitals—Ospedale Sant'Andrea and Ospedale Sant'Eugenio—, one ASL, one CSM, and three independent professionals, who worked in both the public and private spheres.

Oral qualitative interviews loosely based on a predetermined list of 21 questions were the instrument and technique of data collection, but the questions were tailored according to the professionals' time limitations, responses and areas of interest. Furthermore, some questions were deemed not to be useful in advancing the aims of the study after the first couple of interviews, so the subsequent interviews were modified to

make them as productive as possible. Each interview lasted 20-30 minutes, on average.

To guarantee the rights of the participants, the researcher provided them with an informed consent form, which they read and signed before beginning the interview. This form stated that they agreed to be interviewed and they agreed for the interview be audio recorded. Their names were not included in this study, so they were referred to as Professional # in the results section. The chronology of the interviews is as follows:

-July 9th: Psychiatrist and Psychiatric Nurse, Comunità Terapeutica “Sabrata”

ASL RM/A

-July 11th: Psychiatrist/Psychotherapist, Psychiatric Nurse and Psychologist (also private practitioner), Azienda Ospedaliera Sant’Andrea

-July 12th: Psychiatrist (also private practitioner), Ospedale Sant’Eugenio

-July 17th: Psychologist/Psychotherapist and Neurologist, ASL RM 25;

Psychiatrist and Psychiatric Nurse, CSM in ASL RM 25

-July 20th: Psychiatrist (also private practitioner), Ospedale Sant’Eugenio;

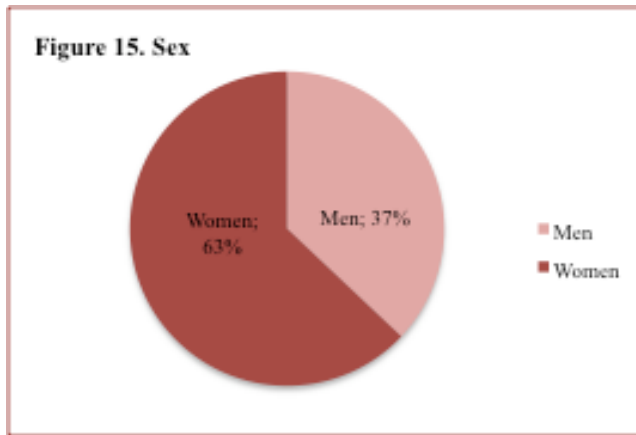
Psychologist/Psychotherapist (also private practitioner), Department of Psychology and Medicine—La Sapienza

The design of analysis for the expert interviews was the meticulous transcription of each audio-recorded interview—which was double-checked with native speakers—and the revision of the answers to understand their points of views on the functioning of the mental health system in Arica. In the data analysis, a software system was not used to analyze the content of interview transcripts, thus a computerized coding frame was not developed. Instead, the transcriptions and analysis were obtained manually to familiarize the researcher thoroughly with the details of each interview. This analysis of the

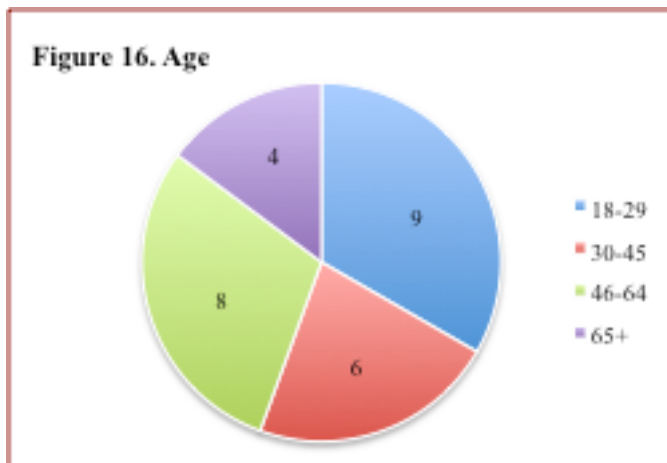
narratives allowed for the determination of similarities and differences between the professionals' answers with a reliable degree of conclusions drawn.

Results & Discussion—Italy

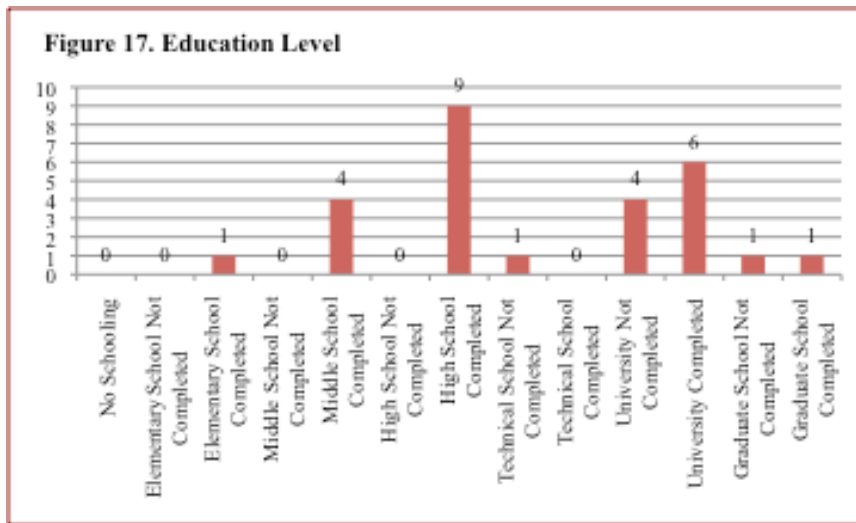
I. General Population Surveys and Interviews



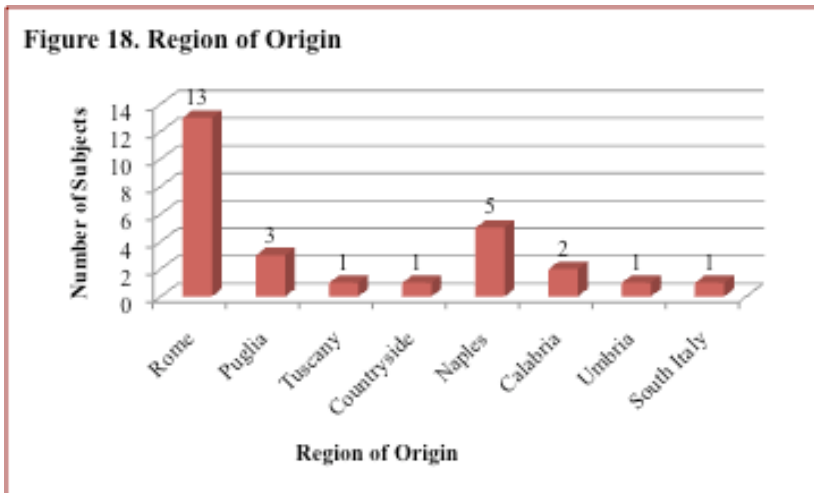
This sample group consisted of 17 women (63%) and 10 (37%) men, for a total of 27 subjects. Although a more equitable distribution was sought, more women than men were out at the public spaces ventured, presumably due to a higher percentage of men working during the day. So, the sample group was dictated by the natural conditions present.



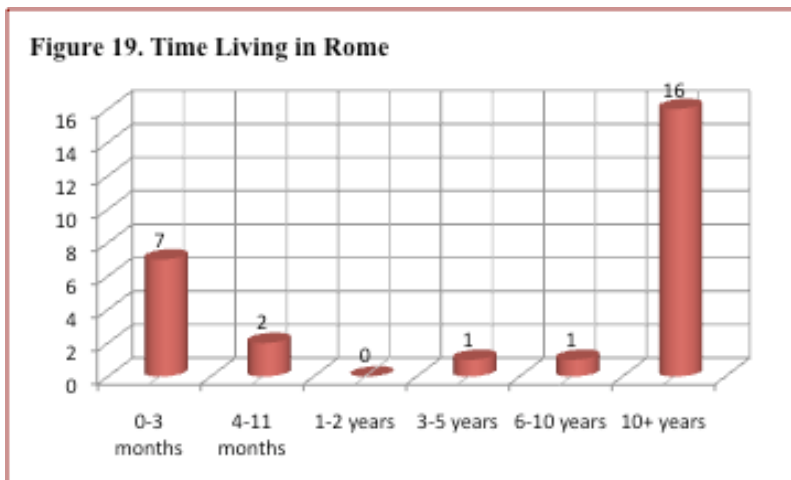
The aim was to achieve a sample as evenly distributed as possible across the above age groups. There were 9 subjects from 18-29 years of age, 6 from 30-45 years, 8 from 46-64 years and 4 from 65 years and older. Positive interactions were much easier with the youngest age group, to which the researcher belonged, possibly because of greater comfort for both the researcher and the subjects in interacting with their peers. It was much harder to convince subjects from the oldest age group to participate, and in fact, two of the four subjects were family members of the researcher's friends. This difficulty suggested preconceived notions held by the elderly when viewing the researcher or a cultural distrust or unwillingness by the elderly to engage with subjects in an unfamiliar project that they believed would be harmful to them.



The majority of participants had a high school level of education (9 participants), followed by a university degree (6). Due to the lower number of subjects in the sample, the subjects did not fill all of the categories. Across the board, level of education did not significantly impact subjects' views on mental illness, as there was just as much variety within the categories as between them.

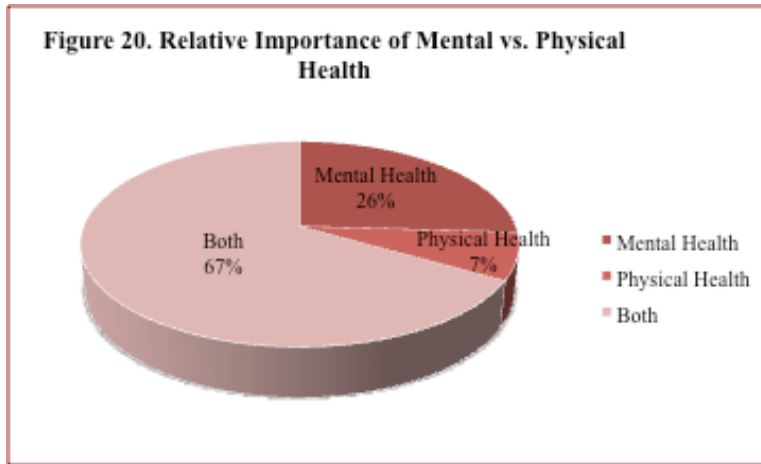


Because Italy was built more on regional affiliations than national unity, this demographic factor was included in the present study. However, these regional affiliations did not end up having a significant role in subjects' perceptions. The majority of subjects were from Rome (13), with Naples holding the second place (5 subjects).



More specifically, knowing how long the subjects had lived in Rome was important because the objective was to determine perceptions of mental health and illness in Rome. People with varying degrees of familiarity with Rome would theoretically have different degrees of understanding of mental health proceedings in Rome. The majority of subjects (16) had lived in Rome for over 10 years, which insinuated their being reliable

sources to the general atmosphere of the city. But, the second largest group (7) had only lived in Rome for three or less months. Therefore, there was a large difference in familiarity with Rome between the two most significant groups.



In this study, subjects were asked about their views on the relative importance of physical versus mental health. Since no participants said “neither”, that category was not included. 18 participants selected “both” (67%), 7 selected “mental health” (26%), and 2 selected “physical health” (7%). This distribution indicated an appreciation for the connected nature of health but also for the importance of mental health. Even some of those who chose “both” still recognized some predominance of the mind, “*Abbiamo un corpo, una mente, un’anima che se non sono di armonia tra di loro, si soffre. Cioè la mente prevale al corpo, all’anima...*” [We have a body, a mind, a soul so if they are not in harmony, the person suffers. That is to say, the mind prevails over the body, the soul...] (subject 2). Moreover, one subject noted with a dry laugh, “*Diciamo la malattia fisica si convive ma quella mentale ti porta anche del disagio*” [One can live with a physical illness, but a mental one brings you additional discomfort] (subject 22). Some reasons given for the greater importance of mental health were that since the brain notes

all physiological depressions, if it functions well, the body will also function well (subject 7); without the mind, one cannot know anything (subject 8); and the mind drives all actions, “*È la mente propria che mi porta a fare determinate cose, è vero?*” [It is the mind itself that brings me to do certain things, right?] (subject 21).

However, there was a sentiment that mental health should only be taken care of when something was wrong, “*Ma se non sento di esigenza perché non sono affetto di nessun problema di disturbo mentale, non curo nella salute mentale*” [But, if I don’t feel obliged because I don’t have a mental problem, I do not take care of my mental health] (subject 1). Of the 2 subjects who believed that physical health was more important, one was confined to a wheelchair due to a physical injury at the time, “*Quella fisica perché la mente non serve. Invece se non capisci è uguale. Se non ti muovi...Basta muoverti...Perché una persona che pensa di meno non è uguale a una persona che si muove?*” [The physical one because the mind does not serve you. If you do not understand something, it’s whatever. If you cannot move...It is enough to be able to move...Because isn’t a person with a lower mental capacity still equal to a person who can move?] (subject 17). The sullen pause he took after saying “*se non ti muovi*” suggested his personal struggle with his handicap. The second subject was an elderly woman, who was very traditional both in thought and speech (she spoke dialect better than standardized Italian). Added to the physical complications that come with getting older, her age could have influenced her answer, “*La salute fisica per prevedere che tu stai bene con il resto. È la salute lo importante, no? La salute ma anche il cervello che si apporta*” [Physical health to assure that the rest of you is fine. Physical health is the important part, right? Physical health, but the brain also contributes” (subject 27).

| Table 6. Do You Take Care of Your Mental Health? | |
|---|---|
| YES | NO |
| I consume berry flowers | But, I look to live serenely so as not to stress out my mind too much |
| I read a lot | I am too busy |
| I look to culture, philosophy, literature | I don't have mental health problems so I don't do anything |
| I read and speak to people, and I look to increase my knowledge so that my mind doesn't remain numb | I am fine mentally. Up to today, I believe I am fine. I look to keep my mind stimulated. I never see it obscured. |
| Sometimes I do yoga or I find half an hour to stretch out in the dark | More important than taking care of my mental health, I am taking care of my physical health right now. |
| If I have more serious problems, I go see a psychologist | I used to go to a psychiatrist but not anymore. |
| I have a rather creative spirit. I compose [music], play the piano, write poetry. I suppress my moments of depression and alterations in active creativity. | I don't see any specific studies or specific cures for mental disorders. So, I don't do anything. I think I have a rather strong character. |

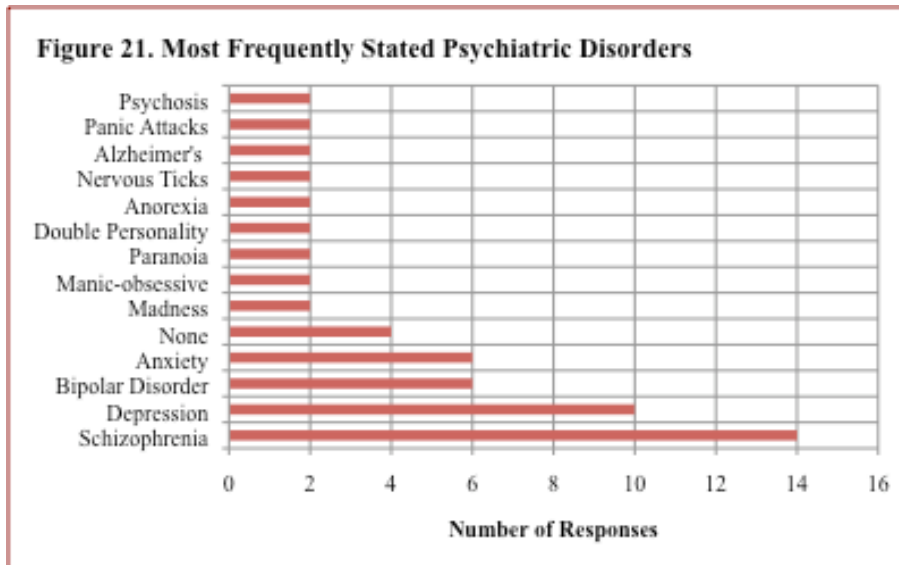
The table above describes how subjects explained taking care, or not, of their mental health. As important as the subjects deemed mental health to be, the question of how they took care of their mental health suggested otherwise. When asked if they did anything in their daily life to take care of their mental health, 11 said “yes” and 16 said “no”. Yet, in the survey question, “It is just as important to take care of my mental as my physical health,” all 27 subjects responded yes, demonstrating their reluctance to put a theoretical benefit into practice. All 27 people also responded “yes” that anyone could experience a mental health problem, suggesting their recognition that they were not immune to mental illness.

Interestingly, even while listing how he played the piano, composed music and wrote poetry, one subject felt the need to establish beforehand that he did not have any particular disorder that necessitated specific action, “*Beh, non vivo in disagio particolare per cui devo fare qualcosa di particolare*” (subject 22). Subject 26, a policeman, said his character was too strong to succumb to mental illness, “*Non ho avuto mai traumi particolari o delusioni particolari. Sono anche un tipo che affronto delusioni e situazioni difficili con molta forza, insomma. Cioè, difficilmente vengo sopraffatto dai eventi particolari, anche, credo, dovuto al lavoro che faccio. Riesco mantenere sempre una certa calma*” [I have not had any particular traumas or delusions. I am also the type of person who confronts delusions and hard situations very forcefully. Thus, it is difficult for me to be overcome by particular events, also due to the work that I do. I manage to always maintain a certain calmness]. Similarly, subject 27 said she did not take care of her mental health, but her answer suggested that she did not understand the question, “*Allora in questo momento sono in pensione e ho lavorato sempre a fare la fiorista che ancora ce l’ho. Però ce la mia famiglia adesso*” [So, right now I am retired and I always worked as a florist, and the store is still there. But, my family takes care of it now].

Of those who admitted to taking care of their mental health, subject 15 took a long pause before answering the question, and then he admitted that he went to see a psychologist when he had serious problems. His hesitancy suggested discomfort in displaying this personal aspect of his life. In a contradictory fashion, the same man who asserted that the ability to move was paramount over mental health listed many ways in which he took care of his mental health, such as reading, interacting with other people, feeling alive, listening to the radio and riding his bike (subject 17). For subject 23, her

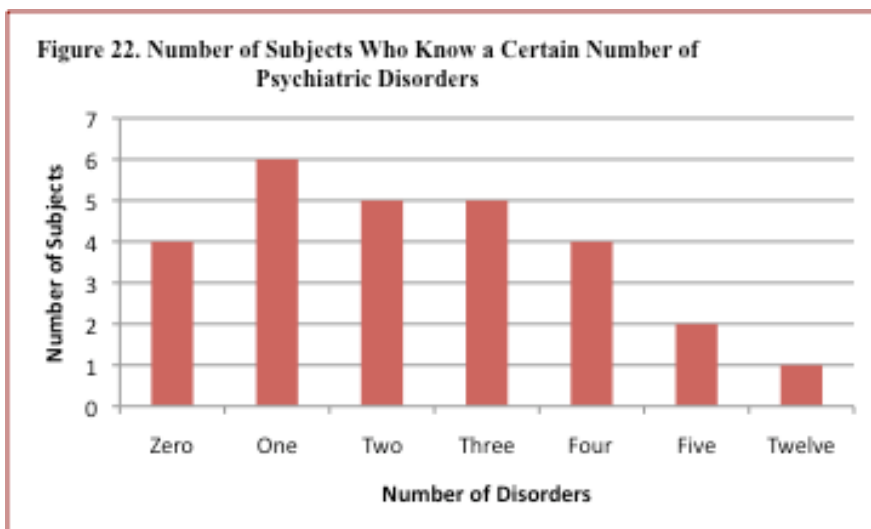
sister was the one who revealed that she used to see a psychiatrist, forcing subject 23 to then admit to it. However, she clarified that now she does not go anymore and no longer does anything in particular to take care of her mental health.

In the survey, some subjects reinforced the importance of taking care of their mental health by explaining that doing so was important for remaining young (subject 5), that the mind was a fundamental part of the individual (subject 4), *corpore sano in mente sana* [healthy body, healthy mind] (subject 9), *mens sana in corpore sano* [healthy mind leads to a healthy body] (subjects 15, 25), physical health depended on mental health (subjects 11, 14), a healthy mind generated less irrational limitations (subject 12), mental health was fundamental to leading a serene life (subject 20), and the psyche was an integral part of the individual and provoked physical illnesses (subject 23). Yet, others qualified their positive answers by saying they would not take care of their mental health if they did not need to (subject 1). In their interviews, subject 10 said he did not have any mental health problems, thus he did nothing to take care of his mental health, subject 9 said she did not manage to take care of her mental health, subject 6 said that he had not needed to take care of his mental health, subject 24 (an elderly woman) thanked God that her brain had been functioning well for the time being, and subject 22 said he did not have any particular problem that warranted a specific solution, but he read and had a creative spirit. Thus, these participants did not seem to have a culture of preventative care when it came to mental health.



When asked to list the psychiatric disorders they knew, subjects came up with a wide variety of responses. The most frequently stated disorder was schizophrenia (14 responses), followed by depression (10), bipolar disorder (6) and anxiety (4), in comparison with Chile's top four of schizophrenia, depression, none and stress. Generally speaking, schizophrenia and depression seemed to be the most well known disorders, for different reasons. As mentioned earlier, depression is widespread while schizophrenia affects a minority percentage of both populations, yet the severity of schizophrenia often overshadows the prevalence of depression when judging stigmatized perceptions. The disorders that were only mentioned once were neurosis, psychopathologies, stress, obsessive routine, bulimia, pedophilia, social apathy, epilepsy, autism, Parkinson's, dysphasia, phobias, mania and strangeness. Many of these disorders, such as epilepsy, autism, Parkinson's and strangeness and stress, are not psychiatric ones, revealing incorrect judgments of the classification of mental illness. Just one subject—subject 22—stated six of the singly stated disorders. Thus, a wide range of illnesses was mentioned, but most people repeated the same disorders.

Some subjects felt very uncomfortable with the above question, evidenced by nervous laughter, rapid assertion that they were not well versed in the topic or long pauses spent thinking. Subjects who did not feel confident in their knowledge were encouraged by the investigator to try anyway. Subject 1 did not know the definition of psychiatric disorders, “*Non so esattamente quali sono definiti disturbi psichiatrici. Penso, non sono ben ferrato sull’argomento quindi classifico tutti come disturbi psichiatrici, la pazzia in generale*” [I don’t know exactly what are defined as psychiatric disorders. I am not well versed in the subject so I classify everything as psychiatric disorders—madness, in general]. Others demonstrated their desire to learn, as one subject (9) even cut into her mother’s interview to ask what schizophrenia meant. Interestingly, one subject who had seen many situations of mental disorders, which should have bred familiarity with the topic, said she knew very little names, “*Per i nomi, conosco pochissimi però ho visto comunque molte situazioni di disturbi mentali*” (subject 10). Another subject’s response suggested a rather general knowledge of mental illness that glossed over the details, “*Non è che potrei specificare un disturbo psichiatrico. Ho avuto a che fare con persone che fino a un punto, io vedo una persona che è tranquilla, normale e poi hanno cominciato a dare i segni di squilibrio*” [It’s not like I could specify one psychiatric disorder. I have dealt with people who, up to a point, I see a person who is calm and normal and then they begin to show signs of disequilibrium] (subject 26). An important point to note is that this subject demonstrated his understanding of the importance of equilibrium for mental health in his response.



The graph above shows the number of subjects who could name a certain number of disorders. The majority of subjects could name one disorder (6 subjects), followed by two (5) and three (5). Subject 22 stood out from the rest in terms of his knowledge of mental illness, listing twelve disorders. Although he did not have a close personal relationship with mental illness, his work as a diplomat brought him into contact with various cases. He had completed university, and all the subjects in the same educational category knew at least one psychiatric disorder. However, of the four people who could not name even one disorder, various levels of education were present, including completed university (1 person), completed high school (2) and completed middle school (1), weakening indications of a significant correlation between education and knowledge about mental illness.

In order to ascertain what the subjects actually knew about specific mental illnesses, the researcher asked if people suffering from mental illness displayed any different characteristics than people not suffering from mental illness. A wide range of responses was given, with a low frequency of repetition. The most frequently stated

characteristic, with four individuals naming it, was “scared.” The various subcategories of this fear stemmed from the perceived need to defend themselves from others (subject 2), from eyes that denoted fear by being fixed open as if in fear: “*gli occhi un po’ spauriti. Timore*” (subject 3) and from apprehension during interactions with others (subject 15). Numerous other characteristics were stated by either one or two subjects, including defensive, insecure, violent/aggressive, fragile/sensitive, tendency to isolate/close themselves off, childlike openness to people, short attention span, tension around the mouth, disruptive, sometimes genius, harboring feelings of persecution, self-aggrandizement, nervous ticks, depends on the mental disorder and none. Clearly, the specific characteristic with which an individual associated people with mental illness would affect his or her perception of said people. The abundance of negative qualities listed suggested a baseline of perception from which to analyze the rest of the subjects’ answers.

Subjects also had the opportunity to respond to a variation of this question on the written survey. There were two yes/no questions asking whether those suffering from mental disorders were dangerous or unpredictable. Those options were chosen because according to research, the principal stigmatized characteristics attributed to people with mental illness are being dangerous and unpredictable (Stout, Villegas and Jennings 2004). 9 subjects responded that those with mental illness are dangerous, 15 responded no, and 3 did not respond either way. For unpredictability, the numbers were significantly more one-sided, as 24 subjects responded “yes” and only 3 responded “no”. One limitation to that question was that the Italian word for unpredictable, *imprevedibile*,

holds a slightly different connotation than in English, limiting the translatability of the results.

The three subjects who responded “no” to unpredictability also responded “no” to dangerousness. When taking their interviews into account, this opinion was consistent throughout. In her interview, subject 23 opined that particular characteristics of mental illness depended on the disorder, although some differences did exist. As for subject 22, when listing the sources of information he received about mental illness, he gave a lot of personal sources. In his work as a diplomat in the Italian consulate, he also acted as a social worker and worked directly with those with “*disagio sociale*,” or social difficulties. He also had friends with mental disorders, such as one with depression and bipolar disorder, which shaped the lens from which he framed his answer about dangerousness and unpredictability.

As for those who believed dangerousness was a valid characteristic, some responses were inconsistent between the survey and interview and even throughout the survey itself. For example, subject 1 stated that people with mental illness were unpredictable because they often did not use logic or reason, yet he believed that it would not be difficult to get along with or relate to a person with mental illness. He then qualified that his ability to get along with such a person would depend on the type of psychiatric disorder from which he or she suffered. Thus, he both recognized the uniqueness of different disorders and made a blanket generalization about unpredictability in the same survey. Additionally, he did not explain how it would be easy to relate with someone who did not use logic. Some subjects differed on the two characteristics, such as subject 4, who said that people with mental illness were not

dangerous yet were unpredictable. His first response against dangerousness matched his interview answer that people with mental illness were barely accepted due to ignorance and fear on the part of others. However, he deemed them to be unpredictable because depending on the disorder, they could have abnormal reactions that were unpredictable given a certain situation. Similarly, subject 5 responded that individuals with mental illness were not dangerous but were unpredictable, and his interview answer to whether acceptance into society depended on the disorder explained his rationale, "*Davanti ad una persona che è affetta da disturbi mentali, c'è un atteggiamento che può essere di paura che possano commettere queste persone degli atti così imprevedibili sicuramente e comunque anche pericolosi*" [There's a feeling of fear towards a person affected by a mental disorder that he or she will commit acts that are surely unpredictable and that can also be dangerous]. Subject 7 conflated the two characteristics, saying that people with mental illness were dangerous because they were unpredictable, and they were unpredictable because they were uncontrollable. Interestingly, subject 25 used the same explanation of uncontrollability, and specifically the inability to control themselves, to justify why people with mental illness were dangerous.

The rest of the subjects had a myriad of opinions. Subject 12 opined that people with mental illness were not dangerous because their actions depended on the place or the person with whom they were interacting. However, they were still unpredictable because one could not know how they would react. Subject 13 did not make generalizations, stating that people with mental were sometimes dangerous and were unpredictable, but it depended on the instability they had. In the interview, she admitted to not knowing all the psychiatric disorders well but also said that degree of acceptance depended on the gravity

of the disorder. If the disorder was very serious, it could certainly influence the surrounding people, especially if it was a disorder that generated violence. Subject 24, an elderly woman, used her experience with a mentally ill individual to guide her response, saying that people with mental illness were dangerous, as one such individual lived above her. In her interview, she explained that those with mental illness were unpredictable because their brains did not function like they should, and any little thing that went contrary to the expected plan would cause them to explode, "*Basta un nonnulla che li scatena...anche da una piccola contrarietà, loro esplodono.*" When her neighbor leaves his apartment and she sees him, she is too scared to even take the elevator with him. The general consensus, thus, was that unpredictability was a valid characteristic for those suffering from mental illness, while dangerousness was debatable.

In terms of familiarity with mental illness, 3 subjects admitted to having a family member with mental illness, 14 said they had a friend with mental illness and 6 said they had a colleague with mental illness in three separate survey questions. When asked if they knew anyone with a mental illness in the interview, 17 said "yes" and 9 said "no" (1 person was inadvertently not asked). However, there was some discrepancy between the two instruments, as subject 12 said he did not personally know anyone with a mental illness in the interview, but he listed having a friend with a mental illness in the survey. Subject 20 did the same, also listing a colleague in addition to a friend. Subject 24 chose not to respond to any of the survey questions, although he said he did not personally know anyone with a mental disorder in the interview. These discrepancies, apart from subject 24, most likely stemmed from a desire not to speak about mental illness out loud, while feeling more comfortable writing down the truth. For this reason, implementing the

two instruments in different ways—written versus oral—added to the breadth and profundity of the information gleaned.

Moreover, in the interview, subjects were asked if the individual with a mental illness whom they knew had personally influenced them in any way. Some individuals seemed to misunderstand the question and were quick to say no. The rapid negative responses gave the impression that they thought the question sought to determine whether the mentally ill person had affected their own mental health. In actuality, the aim of the question was to determine whether such a relationship would change an individual's perspective on mental illness, either positively or negatively. Those who said they had not been affected cited the following: seeing the person as a normal person with a problem, such as a broken leg (subject 2); the person wanted her to help him, but she had no way of doing so because she did not know how to help (subject 8); neither positively nor negatively affected (subject 10); she said no, but she still said that now she reflected more on things that she did not think about before (subject 11); she said no, but she still demonstrated increased sensitivity, saying that she spoke with her friend calmly in order to avoid setting her off into a panic (subject 14); he thought the same way now as he did before because people with mental illness were still people, and they could be helped by participation from others (subject 17); and he was adamant about absolutely not having been influenced because only weak people could be influenced (subject 25).

Of those who were influenced, they cited the following: she was more sensitive to mental health problems, in terms of informing herself more (subject 3); she was more willing to help in some way even when it was not easy because those with psychiatric disorders were slow to accept help from others (subject 4); dealing with people with

psychological disorders forced one to enter into their manner of reasoning, often succumbing to those disorders because to reason with such a person, one must think as he or she does (subject 15); now she knew how to approach people with mental illness better, namely by treating them like everyone else (subject 16); he was positively influenced, although he had always been attracted to cases of marginalized people since he was a child, so sometimes he stopped to talk to them and interact with them (subject 21); it was impossible not to be influenced because she had to help her friend who attempted suicide (subject 23); and in his job as a police officer he received calls from the same people, and he had changed his way of understanding people with mental illness instead of simply labeling them as crazy (subject 26). One elderly woman initially said she did not know anyone affected by a mental illness, but then her son, who participated in the interview due to his mother's old age and Roman dialect, reminded her of "*il matto che gira di sotto*" [the crazy man who wanders around downstairs]. The woman then asserted that she knew him and that sometimes he drank beer as he walked, when all of a sudden, he would scream in the street and grab people at random. Despite subject 26's emphatic description of a singular case, subjects still expressed having increased sensitivity towards those with mental illnesses and increased willingness to understand and help them.

In terms of people with mental illness being to blame for their condition, 4 subjects said "yes," 22 said "no," and 1 did not answer, explaining that it depended on the case (subject 11). It was important to pose this question because in the development of stigma and discrimination, "attribution theory holds that behavior is determined by a cognitive-emotional process: persons make attributions about the *cause* and

controllability of a person's illness that lead to inferences about *responsibility*" (Corrigan 2003). This determination of responsibility normally influences the way people think of and relate to those with mental disorders because they experience "*emotional reactions* such as anger or pity that affect the likelihood of *helping* or *punishing behaviors*" (Corrigan 2003). However, the use of the Italian word "*biasimare*" to indicate "blame" may have been confusing, as subject 1 stated "yes" people with mental illness were to blame because "*potrebbero avere reazioni e atteggiamenti apparentemente inspiegabili*" [they could have apparently inexplicable reactions and behaviors]. The explanation did not directly answer the question about if those with mental illness were to blame for their condition, thus suggesting a failure to understand the question posed. Similarly, subject 7 said they were to blame "*perché sono malate e non lo sanno*" [because they are sick and don't know it]. This explanation suggested an opposite answer.

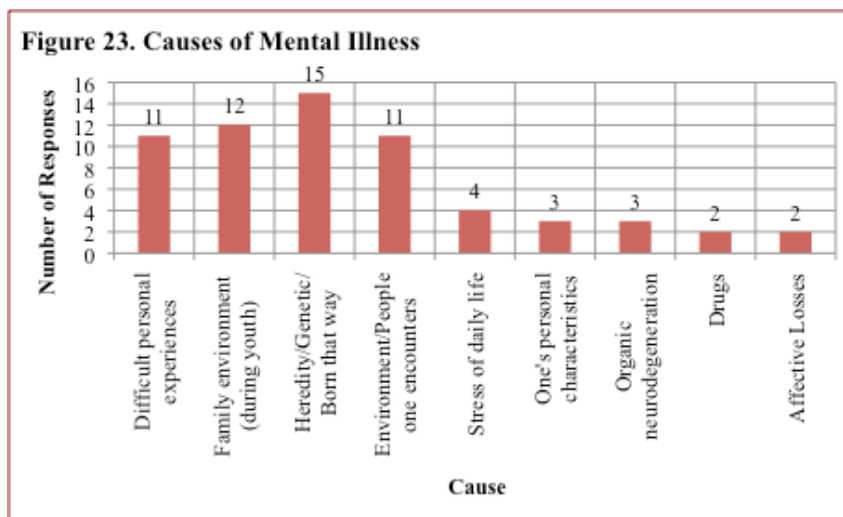
Subject 8 did not give a reason for answering "yes"; however, in her interview, she stated that schizophrenia was dangerous, that people with mental illnesses were dangerous because they behaved in a dangerous manner, that they were afraid that others would find out about their illness and that her only source of information on mental illness was from friends. She seemed to have a narrow exposure to mental illness in general, which may have led to her believing that those suffering from such diseases are to blame. Contrarily, also in her interview, she stated that people were born with mental illnesses, and life occurrences worsened their mental and psychological state, with no hope for a cure. This answer seemed to contradict the survey answer that an individual with mental illness was to blame. As for subject 12, he opined, "*non hanno i limiti delle convenzioni 'moralì' imposte dalla società*" [they do not abide by conventional moral

limitations dictated by society], which made people with mental illness to blame for their own disorders. In comparison to this research, Pittalis also gathered his own data on the topic of the blame of people with mental illness:

L'immagine generalmente rimandata del malato mentale nella popolazione generale [...] ricalca i canoni della persona pericolosa, imprevedibile, che va contro le regole del comportamento sociale, che si deve vergognare e biasimare per la sua malattia, che non ha scampo perché braccata da un decorso cronico e da una prognosi negativa. (2010)

[The general image of the mentally ill individual, as pushed forward by society, is that of a dangerous, unpredictable person who acts in opposition to the rules of social behavior, who should feel ashamed and take blame for his or her illness and who cannot escape the illness because of being hounded by its chronic nature and by a negative prognosis]. (2010)

He reflected all the negative responses given by the subjects in this research study.



By analyzing interview responses to questions about what caused mental disorders and whether they were curable or not, more in-depth insight was gained on perceived role of individuals in their sickness. The graph above shows the most frequently stated responses about causes of mental illness. As shown above, the most frequently stated cause of mental disorders was heredity or genetics, which suggested a

belief that individuals were born with mental conditions that were out of their control. The next most frequently stated response was family environment while being raised, followed by difficult personal experiences and current environment/people encountered. Other responses, such as stress and personal characteristics, were displayed on the graph. No response was given that indicated personal blame, except for abuse of drugs, which was more positive than correlating the survey question. Subject 2 explained family contribution, “...*Io ho sempre sostenuto che dipendeva dal rapporto con la madre. Se non sei sostenuto dall’ambiente, allora ti ammali*” [I have always maintained that it depended on one’s relationship with one’s mother. If you are not supported in your environment, you will get sick].

In their research work, Magliano et al. gave causes for the particular disorder of schizophrenia, as collected through their study. 34% of the general public, 20% of professionals and 68% of parents of children with mental illnesses said that schizophrenia was exclusively caused by psychosocial factors, while 61% of the general public, 63% of professionals and 25% of parents believed that there were psychological and biological factors for schizophrenia (2004b). 52% of the general public, 68% of professionals and 21% of parents believed that heredity was a factor in the development of schizophrenia. The overwhelmingly one-sided response of the parents suggested that they did not want to feel responsible for having passed along a mental illness to their children. Parents’ bias against their children was an important aspect of propagation of stigma against mental illness, as in many cases they were the primary caregivers for these individuals. Anyone involved in taking care of individuals with mental health problems, whether they be friends, doctors or family members, have the responsibility to control the way they

approach the topic of mental health, as they have the power to make or break individuals suffering from mental illness: *“Sono lo stigma e la discriminazione del malato di mente, dei suoi familiari e, addirittura, dei professionisti che se ne occupano, che producono conseguenze assai negative in termini di ritardato o mancato accesso alle cure, privazione di diritti di cittadinanza e causa principale di emarginazione sociale”* [Stigma and discrimination against the individual with a mental illness, by his or her family members and even by professionals who take care of him or her, produce very negative consequences in terms of delay or lack of access to treatments, deprivation of citizenship rights and is a principal cause of social marginalization] (Pittalis 2010).

After listing possible causes of mental illness, 11 subjects asserted that mental illness was curable, 7 stated that it was not, 2 subjects did not answer and 7 subjects stated that “it depends” on the hereditary or experiential nature of the disorder, the severity of the disorder, the person, the person’s support system and general environment, and the duration of the illness and of time suffered. Those who believed in the curability of mental illness explained: society’s mentality is changing because psychiatry is advancing (subject 2); one can change environment and manner of living, such as experimenting with meditation and isolation from everyday distractions (subject 7); there is no illness that cannot be cured (subject 10); he had personal experience with a boy who received an efficacious treatment, had positive abilities and sought treatment early (subject 15); love, affection and understanding can cure (subject 19); and it is curable if the person lives in a community where he or she is helped and according to his or her own capacities (subject 20).

Those who responded in the negative harkened personal experiences, including

that one could attenuate mental illness with medicine but one could not overcome it totally (subjects 3, 6, 9, 23); that no real cures had been discovered yet (subject 8); from personal experience, his sister had not yet been cured of her epilepsy (subject 21); and the complexities of the mental health field had yet to be uncovered:

No assolutamente no. Su questo ad oggi sono convinto che non sono curabili. Nel campo psichiatrico, secondo me, c'è ancora tutto molto un po' oscuro. Vedo che la maggior parte delle volte, le cure sono dei tranquillanti, delle medicine palliative. Ma non penso che ci sia proprio delle terapie specifiche oppure una spiegazione delle cause. (Subject 26)

[No, absolutely not. On this topic, I am convinced that they are not curable. In my opinion, everything is still quite obscure in the field of psychiatry. I see that most of the times, the cures are tranquilizers and palliative medication. But, I don't think that there are specific treatments or an explanation of the causes]. (Subject 26)

Speaking about stress, subject 7 opined, *“Io credo che tutto parta dallo stress. Dallo stress del sistema, di lavorare, lavorare per poi guadagnare i soldi per pagare questo, per comprare quell'altro. Sono tutte malformazioni mentali che vengono dallo sforzo di una vita imposta”* [I believe that it all stems from stress, stress from the system, from working and working just to make money to spend on something else. This stress causes mental malformations that come from the burden of life]. Whether the cause was deemed to stem from interpersonal relationships, daily stress or even from shocking, traumatic experiences (subject 12), results showed that the cause with which a subject associated a mental illness did not always directly correlate with his or her positive or negative view towards mental illness.

In addition to assigning blame for an individual's mental illness, the subjects also weighed in on the civil rights of these individuals. About the validity of their right to vote, 20 subjects chose “yes,” and 7 chose “no”. In general, they seemed to value the

right of people with mental illness to participate in the political processes of the country. Of those who said “no,” some explanations included: I don’t think that they are capable of having the correct lucidity to make such a decision (subject 1); they do not understand the topic (subject 7); they should become more informed, but they should still enjoy the right to vote (subject 11); and “*sicuramente non sono all’altezza*” [they are certainly not at the level to do so] (subject 18). Those who said “yes” were not required to qualify their answers, but subject 12 still wrote that those with mental illness had less prejudices, so they should be able to vote, and subject 13A (no interview) maintained that people with mental illness should be able to vote because we all think in the same manner. No one, however, founded his or her answer in the fundamental human rights of all people, “Everyone has the right to take part in the government of his country, directly or through chosen representatives” (United Nations, Art. 21 1948). If the question had been framed within this context of unalienable human rights, the responses might have been different.

About people with mental illness’s right to marry, 21 subjects chose “yes,” and 6 chose “no”. Although the majority was in favor of marriage, the small opposition was quite fervent. Three of the four subjects 65 years of age or older were against marriage for people with mental illness. No one aged 18-29 disagreed with the right to marriage. This inconsistency across ages indicated a clear generational gap when concerning the family unit. Once again, marriage is covered under the list of human rights, as “men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family” (United Nations, Art. 16 1948). Of the 6 individuals who did not agree, 5 were women, suggesting a different type of weight placed on marriage between the sexes.

Explanations given for the negative responses included because those with mental illness were sick (subject 7) and because they could not guarantee a serene relationship with the other spouse (subject 25). Subject 27, a woman over 65 years of age, did not explain why she answered in a negative fashion, but in her interview she explained her view towards people with mental illness, “*Soffro un po’ vedere le persone così. Mi danno un po’ fastidio nel cuore, a dire ‘poverino,’ capisci? Poverino che è diventato così*” [I suffer a little seeing people like that. They make me a little uncomfortable in my heart, so I say “poor thing,” you understand? Poor thing, who became this way]. This explanation illustrated her pitying attitude toward people with mental illness, judging them as less adult and more childlike than those without mental illness, which would explain her negative estimation of their right to marry. Similarly, subject 8’s negative stance on the issue could be explained from her interview. When asked if she knew anyone personally who had suffered from a mental illness, she said she did, but she did not know how to help that individual: “*Come lo aiuto? Loro non hanno affetti personali. Non hanno ragazzi. Non hanno moglie. E questa malattia che ti rovina il cervello, che fai?*” [How do I help him? They have no personal attachments. They do not have children. They do not have wives. And this sickness ruins your brain, so what can you do?] Aside from this gross generalization of all people with mental illness from her experience with that one man, she also asserted that mental illnesses were not curable, thus effectively ruling out family life for affected individuals. On the other hand, subject 12, a man between 18-29 years of age, was open-minded in his explanation that people with mental illness should be able to marry if they loved each other to a certain degree. His response was telling due to its focus on the love between individuals, irrespective of their medical condition.

Subject 17, a male between 30-45 years of age, believed that marriage was a right that should be afforded to people with mental illness but only depending upon what type of illness they had.

When asked if they would be okay with someone with a mental illness marrying into their family, the subjects' responses varied, with more people answering in the negative. 18 people said "yes," and 9 said "no". Everyone who said "no" to the previous question responded in the same fashion to this one. Most people who chose "yes" for the general marriage question also said "yes" to this one, except for subjects 5, 19 and 22. Subject 5 explained that she would be worried, while subject 19 did not directly explain his opinion. However, a response during his interview shone more light onto his thought process. When asked whether Italian society accepted people with mental disorders, subject 19 said they were fairly accepted because "*oramai sono tra noi e quindi li dobbiamo accettare. Certo, poi la convivenza non è sempre uguale*" [Now they are amongst us so we need to accept them. Of course, living with them is not the same story]. Thus, a certain amount of physical distance seemed to be the key to relative comfort in dealing with people with mental illness, which confirmed why this subject 19 would not be comfortable if such a person married into her family. In an extremely honest response, subject 22 explained that although he believed that people with mental illness should have the right to marry, he would not be okay with such an individual marrying into his family due to his own prejudice, though in the end he would accept the person. This self-awareness was refreshing.

When asked if people with mental illness should have children, 18 said "yes," 7 said "no", 1 said "I don't know," and 1 did not respond. In comparison, when asked

whether people with mental illness should be able to adopt children, the positive responses were lower. Only 11 subjects said “yes,” 10 subjects said “no,” and 6 subjects either did not respond or did not know. Those who said “no” to the first question answered in the same manner about adoption.

The thought processes behind negative responses for the right to adopt were detailed in the explanations of participants from both sexes and all age groups. Subject 1, a male between 18-29 years of age, answered negatively to both questions and explained that if individuals were affected by a serious disorder, they would not be able to raise their children correctly. On the other hand, subject 4 made a distinction, saying that people with mental illness should be able to have their own children but should not adopt, depending on the disorder they had. Subject 7 remained certain throughout, saying that people with mental illness should not have children because such illnesses were hereditary, and they should not adopt because “*sono pericolose!*” [They are dangerous!] The exclamation mark represented the strength of her assertion, judged via the exclamatory tone in which she spoke. On the other hand, subject 22, a male between 46 and 64 years of age, explained his differing opinions based on a legal and moralistic standpoint. He said that in the case of adoption, it was the minor who should have the right to a parent, thus it was necessary to safeguard that right rather than that of an adult to have a child. Subject 25 agreed, although less eloquently, stating that adoption could be executed only to “normal” people without psychiatric problems. This male over 65 years of age also believed, however, that people with mental illness should not have the right to bear children because they could transmit their illness to the children. In his

interview, he explained that many psychiatric disorders were hereditary, and that in many cases, the parents suffered from the same problems as their children.

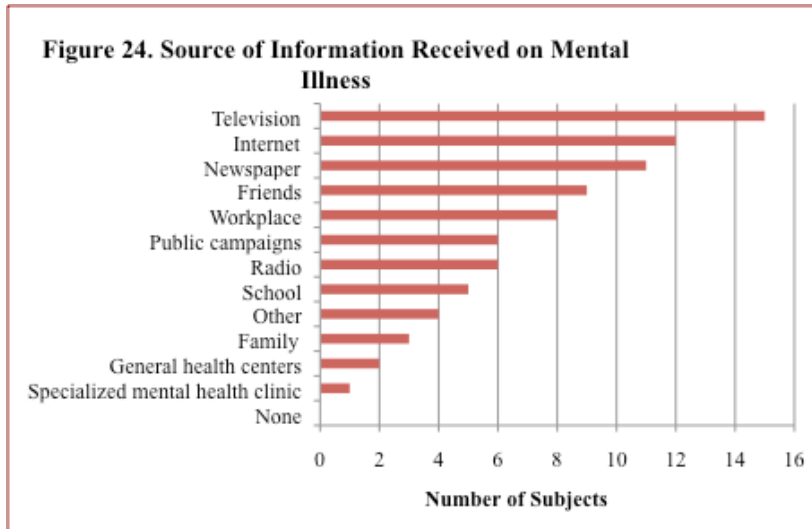
Some subjects remained torn on the issue of adoption. Subjects 3, 5 and 13B (with an interview) responded in a similar manner, saying the right to adopt depended on the severity of the disorder, but they did not explicitly choose a “yes” or “no”. Subject 5 qualified her “yes” answer to the right to bear one’s own children, saying that she did not think psychiatric disorders were genetic. However, in her interview she listed genetics as a possible cause for mental illness, revealing contradictory beliefs. In the adoption question, she claimed she did not know because it depended on the gravity of the illness. Therefore, genetics were not even the issue in the first place; it was the actual capability to raise a child while suffering from a serious mental illness. Subject 9 could not answer either question, simply stating that she did not know. This answer suggested an internal struggle to make a moral decision on the topic. Subject 11 said that a person with a mental illness could have children as long as he had an attentive wife. It was unclear why she assumed that the affected individual would be a male, as later in the interview she stated that men and women were equally at risk for mental illness. She could not make a decision about adoption, circling both “yes” and “no”. Subject 16 differed on her responses but did not give a clear reason as to why. She believed that people with mental illness should have the right to bear children, but she could not answer about the right to adopt, stating that it depended on the psychiatric disorder they had.

In a more positive vein, subject 12 responded “yes” to both answers, explaining that people with mental illness should be able to have children because in any case, they would be their children and the love of a child would only be beneficial to them. This 18-

29-year old male also said that adoption was fine if the couple so chose it. Subject 14 showed a little more apprehension, stating that while people with mental illness should be able to bear children and adopt, it depended on the disorder and on whether the sick individual decided to seek treatment. Subject 17 responded “yes” to all of the five preceding civil liberties questions, but he qualified that each positive answer still depended upon the disorder. The family is defined as “the natural and fundamental group unit of society and is entitled to protection by society and the State” (United Nations, Art. 16 1948). Thus, the subjects’ perceptions did not overwhelmingly align with the established doctrine of human rights, at least not concerning individuals with mental illness.

When asked whether people with mental illness could be successful at all the same jobs as people not suffering from mental illness, 16 subjects said “yes,” 8 said “no,” 3 said “I don’t know,” and 1 subject did not respond. Reasons given for placing limitations on their work capabilities included: often such disorders can compromise a course of action though not always (subject 1); they are limited by their sickness (subject 7); it depends on the situation (subject 10); and in the work environment, one is in contact with too many people and personalities outside of the family nucleus (subject 12). Subject 8 explained in her interview that for her, people with mental illness always remained like that. There was no physical or mental improvement. However, subject 11 stated that a person with mental illness might sometimes have more success in the workforce than a person without the illness, but she did not provide a reason as to why she felt that way. Subject 17 was more analytical, saying that although an individual with

a mental illness could succeed in the workforce, the potential for success depended on the disorder. Other subjects did not explain their reasons for saying “no” or “I don’t know”.



Keeping these responses in mind, investigating the sources of information and general perceived availability of information about mental illness was necessary. In the interview, the subjects had a chance to answer a multiple-choice question about the sources from which they received information about mental illness. The graph above depicts their responses. The most frequently stated major source of information was the television, with 15 subjects selecting it, followed by the Internet (12), newspaper (11), friends (9), workplace (8), public campaigns (6), radio (6), school experience (5), other (4), family (3), general health centers (2) and specialized mental health clinics (1). A positive was that no one stated having no source of information on mental illness.

Despite this positive, only three subjects listed receiving information from an actual qualified source, which would be a medical practitioner. One of the subjects who received information from a general doctor also received information from the Internet, family and school, but none from other media sources. He responded to the question immediately without waiting to read the given options, “*Sempre sono i medici che hanno*

questa informazione...mi spiegano i sintomi e mi spiegano determinate malattie in seguito. La televisione, no. Escono solo i farmaci, quelli più commercializzati. Niente. Né giornale né radio” [It is always doctors who have this information. They explain the symptoms and particular illnesses to me. Television, no. It only shows pharmaceutical drugs, which are more commercialized. I do not receive mental health information from newspapers or the radio] (subject 10). Interestingly, this subject was the only one to note the commercialization of mental illness by the television and the only one to explain the intellectual value of doctors.

A joint analysis of two questions was used to explore the prevalence of the medical field as a source of information. In the survey, when asked whether they had ever visited a mental health center to receive treatment, 6 subjects said “yes”, 20 said “no” and 1 did not respond. This question was made more specific, after the confusion in the Chilean study that did not specifically state the condition of accessing such a center for personal treatment, rather than to visit a patient. Although the low numbers indicated either a lack of use of mental health centers, or more likely, the discomfort in revealing such information, the use of the words “*centro di salute mentale*” could have been misleading because a CSM is a particular type of primary care service for mental health in Italy. Case in point, subject 15 stated not having visited a mental health center, but he said in his interview that he takes care of his mental health by seeing a psychologist. There are other avenues through which to receive care, such as seeing a psychologist or psychiatrist in a private practice, being directly admitted to the emergency room of the hospital or being admitted into a residential community for prolonged mental health care.

As the CSM receives patients with even the mildest mental disorders, however, the use of a broader term probably would not have elicited more “yes” responses.

Although public campaigns should be a positive source of information, their effect clearly had its limitations. Subject 1 explained that he had heard of mental illness from public sensitization campaigns, he but did not gain enough information from them. He vaguely remembered the campaigns but did not remember the content of the campaigns. Similarly, subject 13 listed public campaigns, along with radio, television, newspaper and the workplace as his sources of information, but she ranked radio, television and the newspaper as the primary sources. Subject 14 said surely the radio and television, which she watched often, maybe the newspaper, and surely her scholastic experience. She added public campaigns as an afterthought, also saying that her family had not talked much about the topic. Thus, public campaigns did not seem to hold as central a hold on the divulgence of information on mental health as other sources like the media.

The overwhelming amount of information gained from the Internet, newspaper, friends and the workplace was troubling because of the questionable quality of information divulged by these sources. Many studies have been conducted on entertainment media and on news media’s tendency to link mental illness with violent behavior “to a degree greater than the real world association” (Wahl 1992, as cited in Stout, Villegas & Jennings 2004). Subject 27 explained that in the newspapers she bought, she saw that people with mental illness attacked other people because they were not quite right in the head. She stated that by watching television, everything was explained to her. As for the Internet, it was not clear how this second-highest response

could have affected the subjects in this study because although the negative impact of newspapers and television was well known, relatively little was known about the impact of newer sources such as the Internet and video games on people's perceptions of mental illness (Stout et al. 2004). The sources named in "other" included the following: reading books such as Paolo Coelho's *Veronica decide di morire* (although subject 17 misnamed it *Veronica che ha deciso di uccidersi*), which subject 17 explained was about psychiatric institutions' use of cruel treatments, such as insulin, that sent patients into comas (subject 17); having a disabled son encouraged him to deepen his understanding of cerebral dysfunctions on his own (subject 22); daily life and traveling, where she had encountered people behaving in a strange manner (subject 24); and personal observation through direct contact and life experiences (subject 7). Subject 7 was staunchly adamant that the only reliable source of information was her personal experience. When asked if there were other specific sources of information, such as the television, that she relied on, she gave a passionate response that encapsulated her distaste for the media:

La tele è come una informazione sbagliata dove tutti fanno il loro spettacolo in base al cervello che possono fare ogni individuo. Però diciamo che sono macchine di schiavitù mentale. Sono macchine di schiavitù mentale. Per questo io non vedo la televisione, sono stanca. Vogliono condurre l'individuo dove loro vogliono. Lavare del cervello. La televisione è un mezzo para lavare il cervello. I giornali sono mezzi para lavare il cervello perché in realtà non fanno niente utile. Fanno tutto meno utile. Non servono per niente.

[The television is a wrong source of information, where everyone performs his or her spectacle about the brain, which any average person could do. Let's say that televisions are machines of mental slavery. For this reason, I don't watch television. I'm tired. Those on TV want to steer the viewer where they wish, brainwashing him or her. Television is a means of brainwashing. Newspapers are a means of brainwashing because in reality, they don't do anything useful. They do everything useless. They do not serve any purpose].

Many researchers would agree with her assessment, as the media has been known to misrepresent mental illness throughout the years. In fact, Granello and Pauley found in 2000 that the “amount of time spent watching television was significantly and positively related to intolerance toward mental illness, was associated with authoritarian views toward people with mental illness, and was associated with less positive attitudes of benevolence” (as cited in Stout et al. 2004). In the same vein, Pittalis found that the media held a lot of the blame for the development of stigma. Through media-based information, symptoms of psychiatric patients were not moderated or mediated but embellished and emphasized. He also believed that media sources were not instruments adapted to divulging delicate scientific material, such as psychiatry; the television created its own language code to incorrectly describe psychiatric pathologies, using expressions such as “delirious, hallucinating, maniacal” in daily coverage (2010). Although most subjects still relied on the television as their main source of information, they tended to agree with Pittalis’s viewpoint, with only 2 subjects who stated that it was adequate, 2 subjects who did not directly answer the question and 23 subjects who revealed that the quality and quantity of information they received were scarce, insufficient or inadequate. Their specific responses included: “*le informazioni non vengono date un giusto peso a quello che si dice*” [information is not given due weight in terms of what is said] (subject 3); there is little information, and even the quality is rather lacking (subject 4); there is little information because a person with a mental illness is not a topic of interest to everyone, and it should be the family members who take interest in this topic (subject 8); we need more public campaigns, more information, more conventions, more conferences and more overall information (subject 9); there is little information on particular illnesses

that actually arrive in enough time to help you get better, as many doctors say it is nothing when you actually have a serious illness (subject 10); the media undervalues this topic because its goal is to make everyone seem happy and smiley (subject 12); the quality of the information is not clear or easy to understand for the general public (subject 13); there is scarce information as we still do not know how to interact with these people (subject 19); there is not enough information for the community or for the individuals who may be suffering from a mental disorder (subject 20); there is no information from the media, and also, the study of psychiatry is poor because psychiatric disorders tend to be seen as a scapegoat when the doctor cannot find a physical cause for illness (subject 23); and the information is very selective (subject 26).

Of the two subjects who gave roundabout answers, subject 18 stated that although there were not specific programs on mental illness, she received information from the news. Subject 25 explained that he did not follow this topic, but sometimes he heard about news stories from the television or the newspaper, like the story about the guy who blew up a bomb in a school and killed a girl, "*E questo è una persona normale che a un certo punto poi è diventato un folle*" [And this is a normal person who at a certain point, became crazy]. The use of the word "*folle*" is an additionally stigmatizing term, due to its insensitive description of those suffering from a broad range of mental illnesses as crazy. Both of these examples showed what influence the media had on those who did not receive much information from other reliable sources, namely that it provided one-sided, sensationalized examples of mental illness. This negative penchant in the news makes sense because the writers are in the business of selling stories, not providing factual, unbiased information that no one will take the time to read.

Of the people who said the information they received was enough, subject 21 claimed that the quantity and quality of information was good and that people received information, at least he did. Although he did not understand it one hundred percent, as he was not a doctor, the average person could understand the general gist of the problem (subject 21). Subject 14 was less straightforward in her answer. She believed that there were certainly truisms that existed, although they were obviously not always true and were influenced by the media. Her thought was that maybe the media contributed to the creation and propagation of these truisms, through fiction and the television, but sometimes, useful information could still be divulged, such as in public campaigns.

The type of information gained by the general public was not overwhelmingly positive or reliable, leading to the question of whether people with a mental illness would even go seek treatment. When asked whether they believed that the majority of people suffering from a mental illness sought treatment or not, 8 subjects believed they did, 17 subjects believed they did not, 1 subject did not know and 1 subject did not answer the question appropriately. Some cited an increased openness with regards to talking about mental illness that made people less afraid to go to the psychologist and ask for help (subject 2), while others maintained that people were still too ashamed to confront and accept their problems (subjects 3, 14). Subject 19 believed that people did not seek treatment for fear of being “*ghettizzati*”, referencing ghettos, which are areas of racial, ethnic and religious persecution via marginalization. The use of this term revealed the severity of the fear induced by mental health stigma. Uncovering another layer of the problem, subject 4 explained that a lot of people did not admit to having a problem because their close friends and family would not encourage them to go to specialized

centers, or they might not even know where these centers were. Thus, she detected the three-fold problem of a lack of personal acknowledgement, lack of support and lack of knowledge about how to seek treatment. Subjects 5, 17 and 26 agreed that without external support, people with a mental health problem would not go seek treatment on their own. On the other hand, if they lived in a suitable social or familial context, they were more apt to consistently go to treatment. Adherence to treatment was brought up as another problem, with subject 15 saying that even when people started treatment, they would abandon it if they did not have a social context that motivated them to continue. Moreover, subject 15 added that other times, people did not even complete any portion of treatment because they did not have support from the medical institutions or from society. This young man drew from his personal experience, as he had had mental health problems in the past and had also been influenced by his interaction with a friend with a psychological disorder.

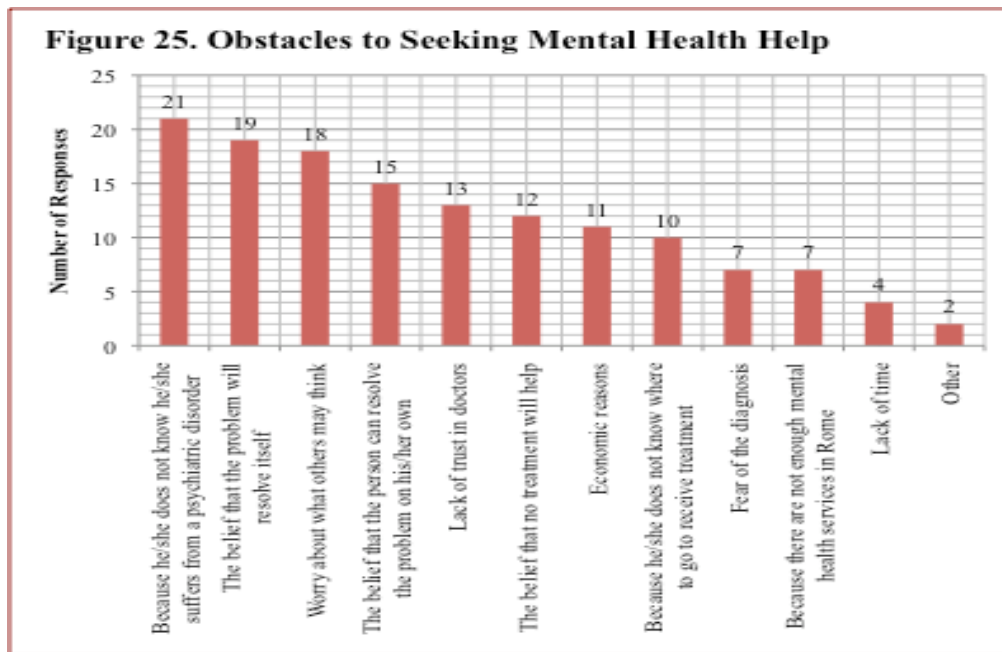
Some subjects answered the question of seeking treatment based on personal experience. Subject 16 asserted that the people she knew who had mental illnesses sought help (subject 16), while subject 8 claimed that seeking help was pointless because mental illness were not curable. Similarly, subject 18 asserted that people sought help but still got worse. Subject 21 summarized all of these ideas in his response. He stated that people sought treatment, but he was speaking from his personal experience with his epileptic sister. An important point to make is that epilepsy is actually a neurological, not a psychiatric, disorder. From her birth, his family had been taking her to the doctor for treatment, so that was normal for him. In his words, one would always seek to have results, even if at the end, the results were little to none. Another subject lamented the

gap between private and public care, saying that in general, people with psychiatric problems sought help, but at the public level, there was limited treatment, while at the private level, there were a lot of treatment options (subject 23). She spoke from her personal experience of seeking treatment and of having friends with psychiatric disorders.

Another big obstacle to seeking help that was found was the ability to recognize that one had a problem. Subject 7 expressed her opinion, “*Quando arrivano a un punto che loro stessi non sanno che non siano normali, questo è il problema. Che conduce un pazzo a curarsi?*” [When they arrive at a point where they themselves do not know that they are not normal, this is a problem. What incites a crazy person to seek treatment?] This woman between 46 and 64 years of age showed no hint of reservation or embarrassment when referring to people with mental illness as crazy, using the stigmatizing word *pazzo* so freely, as though it were a part of her daily lexicon. The ideas she expressed about the mental illness overwhelming one’s rational thought process were logical, but her delivery indicated how the loose use of hurtful words can propagate stigma. On the other hand, another subject, a male between 18 and 29 years of age, accidentally said the word *pazzo* when discussing Italian dramatist, novelist and poet Luigi Pirandello’s theory of different masks we wear in society, and he was immediately embarrassed, as evidenced by his flushed face, his apologies and his verbal backtracking. He explained, “*Una persona quando è pazzo semplicemente—cioè “pazzo” tra virgolette, scusami—che soffre di qualche... “pazzo”, sempre tra virgolette, per come lo intendeva Pirandello...*” [When a person is simply crazy—I mean, quote-on-quote crazy, excuse me—and suffers from a certain... “crazy,” still within quotations, to use the term Pirandello intended...] (subject 12). He was trying to explain that someone with a mental

illness was simply a person who had removed a certain mask in front of society.

Normally, every time we interact with another person we change our mask because we have different personalities, or masks, that we create for different situations. Instead, a quote-on-quote “crazy” person has removed all of these masks, “*Quindi per lui semplicemente vede la realtà in modo differente sempre uguale, coerente con se stesso probabilmente non andrebbe mai a farsi curare perché non lo sarebbe*” [Thus, for him, he simply sees reality in a different way, which is still equal, and coherent with himself, he probably would not ever go seek treatment because he would not know he needed to].

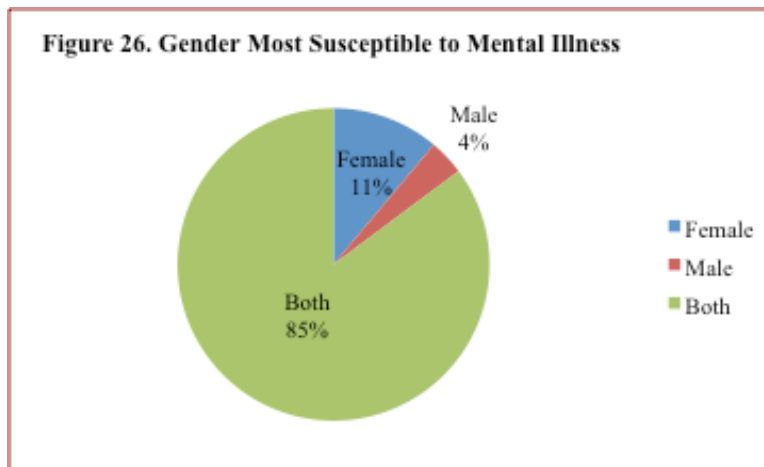


Although the subjects were given the opportunity to discuss their views on treatment access in an unstructured narrative, they also had the chance to answer a multiple-choice question about the obstacles that influenced people not to seek treatment when they needed it. The graph above shows their responses and suggests key areas to be addressed in order to reduce stigma around mental health care. The top three reasons, as listed above, were not knowing one suffered from a psychiatric disorder (21 responses),

the belief that the problem would resolve itself (19 responses) and worry about what others might think (18), indicating an unwillingness to acknowledge one's disease, a lack of knowledge of one's disease and fear of others' judgment, respectively. The fifth and sixth most selected obstacles were quite problematic, as they dealt with what happened in treatment. The distrust of doctors (13) and the belief that treatment did not work (12) were institutional issues that must be resolved from within the medical sector.

Thankfully, money did not seem to be a major factor, with only 11 responses, and neither did the perceived lack of mental health services in Rome, with only 7 responses.

Therefore, subjects knew that treatment centers existed, and that in general, people had the financial means to access them, but other factors presented barriers. The graph above could be employed as a starting point to target areas that must be improved upon in order to decrease mental health stigma and to provide people with the treatment they need.



In order to ascertain subjects' perceptions of those affected by mental illness, they were asked about different groups' susceptibilities to mental illness. In the survey, all 27 subjects stated that anyone could have a mental illness. In order to break that answer down further, subjects were asked in the interview whether they believed men, women or

both genders were more susceptible to psychiatric disorders. The pie chart above displays their responses, with 3 people choosing “females,” 1 person choosing “males” and 23 people choosing “both”. The majority response suggested a general understanding that mental illness as a whole did not discriminate between sexes. However, in his research on the socio-demographic factors associated with mental illness in Italy, de Girolamo et al. found that of those subjects who had had a mental disorder for twelve months, males represented 3.9% of Italy’s male population and females represented 10.4% of Italy’s female population. In the course of one’s lifetime, 11.6% of males and 24.4% of females suffered from mental illness. Thus, a greater proportion of females were affected. The exceptions to this overwhelming female presence were psychotic disorders (schizophrenia, mania, bipolar disorder), which affected both sexes equally and personality disorders, which affected males disproportionately more (Girolamo et al. 2006). The subjects’ responses did not closely match these researchers’ because the former required less specificity in terms of categorizing the mental illnesses and because the average person formed opinions based off of personal experience, rather than off of actual research data.

Most responses that asserted that both genders were equally susceptible to mental illness included a variation of the belief that there was not a particular difference between brain function between men and women and that mental illness was hereditary. However, more specific answers included the belief that mental illness affected people who were more sensitive, regardless of gender, which made them more susceptible to depression or anxiety (subject 3); that both men and women worked, so both experienced equal stress that could cause anxiety (subject 9); that it depended on how one was raised during

childhood years (subject 12); and “*Penso in realtà che tutti siamo partendo da una persona che in teoria sta bene. Siamo tutti esposti ad avere un problema futuro*” [I think that we all spring from a person who is theoretically healthy. We are all exposed to having a problem in the future] (subject 20). As for subject 23, she immediately said “women” when asked this question, but once the researcher inquired more, she exclaimed, “*Ma in realtà, no! Entrambi, non donne,*” [But, in reality, no! Both, not women], and both started laughing together at her passionate change of heart. She said that she knew a lot of men and women who had mental health problems, and each sex had certain characteristics that drove them to have certain types of disorders.

As for the three subjects who chose “women,” two were women and one was a man. Subject 2, a woman, expressed that maybe women were more vulnerable, due to an emotional factor and the fact that they expressed themselves more. Subject 7 was more harsh, speaking about men’s obsessive control of women, “*L’uomo fa parte di causa di che le donne abbiano questi disturbi. Penso così perché l’uomo non ha ‘evoluzionato’ nel tema della donna. L’uomo vuol essere ancora il padrone della donna. Ci sono ossessioni di possessioni che danno confusione allo stato mentale anche per l’uno come gli altri*” [Man plays a role in why women have these disorders. I think this way because man has not evolved on the topic of the woman. Man still wants to be the master over the woman. There are obsessions of possession that cause confusion in the mental state for both individuals]. In her opinion, the patriarchal nature of many men played into perpetuating gender inequalities, which affected women’s mental state. Finally, the one man who said women were more susceptible was over 65 years of age, and he was referring to menopause. He stated that menopause made women more nervous, but at the same time,

some women became more tranquil and serene. This explanation actually referenced hormonal changes, not mental illness.

Interestingly, the one person who expressed that men were more susceptible to mental illness was an elderly woman who also spoke about menopause, “*Anche quando l'uomo fa menopausa parte pure a loro un po' la testa, non solo la donna. C'è chi la prende bene e chi invece è nervoso. Ma anche le donne soffrono*” [Even when men undergo menopause, they lose their minds a little, not just women. There are some men who take it well, while others become nervous. But, women also suffer]. The answer elicited laughter from all, but the subject maintained that what she was saying was true and that men also experienced menopause. She might have been referring to men’s midlife crises rather than the actual process of menopause.

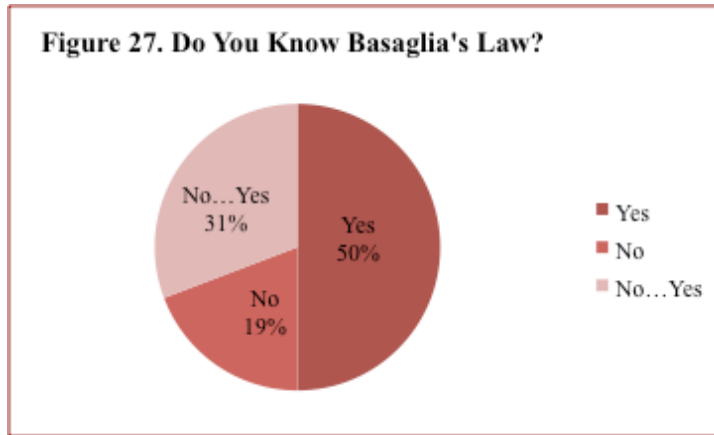
Table 7. Sections of the Population Most Susceptible to Mental Illness

| | |
|--|---|
| None | 4 |
| Victims of childhood trauma | 2 |
| General trauma victims (including torture victims) | 2 |
| Immigrants (including refugees) | 1 |
| Adolescents | 1 |
| People with unstable/difficult family situations | 4 |
| Stress of poverty | 1 |
| Genetically predisposed individuals | 1 |
| Job insecurity/people who work excessively | 2 |
| Weak/sensitive/fragile people | 6 |
| Adults | 1 |
| Unemployed people (nothing to occupy their time) | 1 |
| | 1 |
| People with extreme thoughts | 1 |
| Children | 2 |
| I don't know | 1 |
| Yes (vague) | 2 |
| Retired men | 1 |
| Rich people | 1 |
| People who have undergone serious disappointments/losses | 1 |

In addition to analyzing gender differences in mental illness, the researcher sought to uncover which particular subsections of society subjects believed to be most

susceptible to mental illness. The groups above were listed, and as the table shows, few groups were named more than twice. Thus, this table demonstrates the breadth of thinking of the subjects about who could be affected by mental illness, rather than pinpointing a particular group in Italian society that was most affected. Answers were widespread, ranging from no particular group to children because they were vulnerable to adults because they actually understood that they were sick to unemployed people who were subject to depression to people who worked too hard to poor, stressed people to rich people with more opportunities for vices. According to a study performed on 4,444 participants in 2006 on socio-demographic determinants of mental illness, the experience of psychiatric disorders in general was evenly spread across age groups. 7.6% of participants between 18 and 24 years of age, 6.5% of participants between 25 and 34, 6.4% of participants between 35 and 49, 8.0% of people between 50 and 64 years of age and 8.1% of elderly over 64 years of age had suffered from a mental illness within the past twelve months (De Girolamo et al. 2006). Specifically, the elderly had the highest rate of mental illness, but no one in the present comparative study listed this group. De Girolamo et al.'s did not include children in their study, so the accuracy of children or adolescents as being most susceptible could not be evaluated. In terms of occupation, 6.2% of those with paid employment, 7.3% of the unemployed, 6.9% of the retired, 10.9% of housewives, 2.9% of students and 34.3% of disabled individuals had suffered from a mental illness in the past twelve months (De Girolamo et al. 2006). The subjects in the present study listed some of these groups (unemployed, employed and retired) so they showed some knowledge of key groups. If anything, the table above reflects

contradictions and shows that the subjects had varying perspectives of what mental illness was and who could be affected by it.



To explore the societal awareness and ramifications of legal action taken by Basaglia's Law, or Law 180, in 1978, the researcher inquired as to whether the subjects knew what this law was. As shown by the pie chart above, 50% of the subjects, or 13 individuals, responded that they knew the law, 19%, or 5 subjects, responded that they did not, and 31%, or 8 subjects, responded that they did not know the law, but after a little bit of prompting, they realized that they knew what it was after all. For the one subject who did not respond, her interview was not audio recorded, and the answer was inadvertently not written down. These responses showed that 21 of 26 people had at least some recollection, or recognition, of Basaglia's Law, which was reassuring, given the gravity of its importance. Some subjects were confident in their positive response even adding some explanation like Franco Basaglia's full name or saying it was the law to close down mental institutions, while others were more unsure, "*Eh, sì. Non...ma sì. La chiusura dei manicomì*" [Uh, yes. No...but, yes. The shutting down of mental institutions] (subject 4).

Table 8. Educational Level and Age of Those Who Did Not Know Basaglia’s Law

| Age | Educational Level |
|-------|-----------------------------|
| 18-29 | University Completed |
| 18-29 | High School Completed |
| 30-45 | High School Completed |
| 46-64 | High School Completed |
| 65+ | Elementary School Completed |

The subjects who said they did not know the law still had no recognition of it after it was explained to them. As seen in the table above, they came from the above levels of education, suggesting that knowledge of this law was not necessarily directly correlated with level of formal education. It was not clear if age played a role in not being familiar with the law, as all age groups were covered in the table above. Three of the four subjects over 65 years of age had heard of the law, with the one woman not knowing it having answered previous interview questions in an often incongruous fashion. She was rather advanced in age, which could have played a role in her memory and communication skills.

For those who initially said they did not know the law and then changed their minds, some key words sparked their memory. For example, subject 1, an 18-29 year old college-educated male, realized he knew the law once the researcher began to explain, “*OK, questa legge era una legge per chiudere...*” [OK, this law was one to close...], and he finished the sentence with, “*...i manicomi. Non sapevo che si chiamava così*” [...asylums. I did not know it was called that]. Another subject finished off the sentence, “*...manicomi. Ah sì. Allora questa legge la conosco*” [...asylums. Ah, yes. I know this law] (subject 6). The source of confusion may have stemmed from the fact that in Italian, the law is more frequently referred to as *Legge 180* rather than *Legge Basaglia*. Not all respondents in this group were able to finish off the sentence, as subjects 7, 16 and 25 all

simply said, “*Ah, sì*” [Ah, yes] after the explanation was given. Subject 20 also let out an exclamation of recognition, “Ah!”, as though he had temporarily forgotten. Finally, an over-excited subject even exclaimed, “*Ah, sì sì sì sì! Lo so! Lo so!*” [Ah, yes yes yes yes! I know it! I know it!], after realizing she had heard of the law, even though she had not been able to recall it on her own (subject 23).

Subjects were then asked whether they felt that the law had provoked some sort of change in Italian society’s behavior towards people affected by psychiatric disorders. Although this question aimed to address the law’s implications on society’s perceptions, many subjects solely spoke about their personal feelings about the closure of asylums. Moreover, many subjects were not old enough to describe societal differences from before to after the era of asylums in order to note any kind of change over time. However, when this question was compared in conjunction with the survey question asking whether community health centers were more effective than asylums for treating mental illness, subjects’ thoughts on treatment methods, not just perceptions, could also be gleaned. For this question, 19 subjects thought community health centers were more effective, 6 thought asylums were more effective and 2 could not decide.

Many subjects believed that community health centers were more useful than asylums. In terms of treatment options, subject 1 believed that treatments were given in a much more useful and constructive fashion in community health centers, making them more effective. He honed in on this fact in his interview, saying that although Basaglia’s Law helped those with mental illness receive better treatment, it had not really changed society’s views on them. Subject 2 agreed, viewing Basaglia’s Law as revolutionary because mental asylums had often enclosed those who did not even have psychological

problems but who were simply burdens upon their families (subject 2). For example, subject 12 noted that even people with Down syndrome had been locked up in institutions as prisoners, so the new treatment style post-Basaglia was an improvement. Even without knowing the difference between the types of centers, subject 13A stated that by virtue of being within the community, present-day treatment options must be better than institutions of the past. Similarly, subject 15 did not know about community-based mental health services, but watching news reports on the mental asylums did not give him a good impression of them.

Furthermore, by drawing people with mental illness into the community, the law shed light on problems and questions that were ignored before because people did not want to know (subject 3). Subject 7 noted the increased humanity and understanding in current centers that contrast the cruelty that existed in psychiatric institutions. Many of the prior injustices occurred for so long because they were hidden from society. Following suit, subject 10 affirmed that as a society, Italians were learning to respect even those different from them by wishing them well and treating them like the normal people that they are. Subject 5 did not even know Basaglia's Law, so she was not able to speak to any changes, but she still believed that community centers of today were more effective than asylums.

In terms of relationships, subject 3 noted in her survey that community centers were a space where people with similar problems could come into contact with one another to foster group support that was not present before. Similarly, subject 22 asserted that Basaglia's Law allowed people who were interned in asylums to develop relationships with others and to be accepted and seen because before they were invisible.

Subject 19 was on the same page, saying that in asylums, individuals were grouped with others who were in a worse state than themselves, while what they needed was love and affection to perform the same activities as people without an illness. She believed that today, people were treated as normal people by mental health centers and family members, rather than being treated like animals.

As for the rights of people with suffering from mental illness, subject 4 opined that the law was positive because she was staunchly against asylums, as they limited the freedoms of individuals enclosed within them. Subject 14 added that Basaglia's Law granted more rights to people with mental illness, which aligned with her "yes" answers on each survey question about civil liberties. In a more drastic vein, subject 17 likened past mental asylums to jails, and he believed that people who exited the asylums had been well taken care of by having the possibility to integrate themselves into society, whereas they would have died in the asylums.

On the other hand, some individuals took the time in their responses to criticize the shortcomings of Basaglia's Law. Although subject 6 believed in the superiority of community treatment for mental illness, he still believed that the practical applications of the law had not been adequate because alternative structures to replace asylums were not created. He cited "*le case famiglia*", or residential homes, as centers that did not have enough qualified personnel who were willing or available to meet the users' rather particular needs. Subject 15 recognized these problems, but he asserted that it was not up to the law but up to society to change its perceptions in interactions with people affected by psychiatric pathologies. Although subject 20 believed that current community-based treatment provided space for people with mental illnesses to lead their lives as close to

normally as possible and allowed even people with minor disorders to be helped, he stated that there was still a lack of information on the topic amongst the average populace. Due to ignorance, people sometimes thought that the new centers were ex-asylums that had simply taken on a new name, so they did not want to use them (subject 20).

Of the subjects who did not know how to respond to the survey question, their interviews still shone light on the issue. Subject 13B stated in her interview that before Basaglia's Law, people with mental illness were locked up like prisoners in a cell. Due to being locked away from society, society did not confront the problem, as they did not see it. But now that mental illness was treated within the community, society saw it and had to acknowledge that it existed. This viewpoint matched that gathered by the Italian Federation for Mental Health's explanation of Basaglia's Law, "*...Si faceva prima a nascondere il malato mentale tenendolo recluso in una struttura, nascondendolo agli occhi di tutti*" [Before, the individual with mental illness was isolated in a structure and hidden from the eyes of everyone] (Federazione Italiana per la Salute Mentale 2011). On the other hand, the inability to answer the survey question was also telling of a low level of information on mental health. Subject 16 stated that she was not informed enough to answer the survey question, and after her friend interjected with his opinions during her interview, she simply repeated his response that post-Basaglia, people with mental illness were a lot more integrated in society.

Of the subjects who believed that present-day community health centers were not more effective than mental institutions, subject 11 admitted in her interview that she did not know the difference between the two. However, she explained that she lived in a

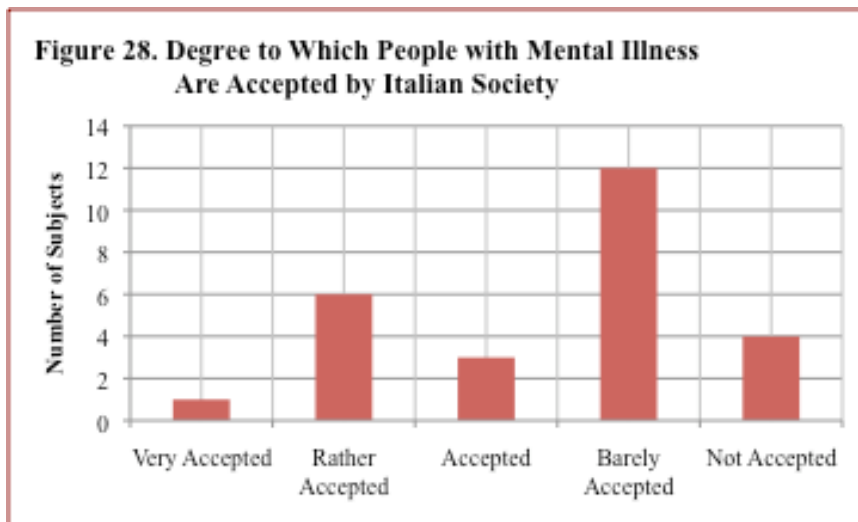
small town where there were not many people with mental illnesses walking around in the street talking to themselves or exhibiting other strange behaviors. Thus, in her town, fear and prejudice were heightened because people were not exposed to such individuals. Subject 23 said that community centers were not more effective than institutions because although asylums no longer existed, now it was only the rich who could access adequate treatment centers. She added that although community centers could treat people with bipolar disorder, if someone had curious desires that led him to murder people, he should not live within the larger community. Subject 24 was an elderly woman who took a firmer stance, asserting that it was a mistake to close down asylums because patients were under control there. Her answer was counterintuitive because she explained that in asylums, patients were given medicine that intoxicated them, and she had seen on television how they would relieve themselves and the caretakers would leave them in their waste. She almost justified the inhumane conditions, saying, “*Chi non si rende conto di quello che fa, naturalmente...*” [He who does not realize what he does, naturally...] Her female peer was of the same opinion, stating that closing down asylums was a mistake that should not have been made, “*Stavano bene lì. Che sono tutti sparsi, poverini. Abbandonati nelle stazioni*” [They were good there. Now, they are scattered everywhere, poor them, and they are abandoned in stations]. With the last comment, she was referring to the homeless people who spend the night in front of the Termini bus and train station, thus conflating mental illness and homelessness.

Agreeing with the previous judgments, subject 25 said that pre-Basaglia, many crazy people were calmly in institutions, and they did not bother anyone. Now, these same people were walking around on the streets. It was highly probable that he was

referencing homeless people with grave illnesses who had no other option but to wander the streets since they had no fixed place of residence. Moreover, he stated that today's centers were not more effective because they lacked specialized personnel. Subject 26 was of the same opinion, but for a different reason. He claimed that science and medicine had not yet found real organic causes for mental illness so most treatments were tranquilizers or other types of palliative treatments that could not reach the root of the problem. He also noted the confusion between mental illness and homelessness that arose after Basaglia's Law, having heard people exclaim, "*Ah! Hanno chiuso i manicomi e questi devono stare nei manicomi!*" [Ah! They shut down mental asylums, and these people should be in those institutions]. However, such a correlation between mental illness and homelessness should not be generalized, as it has been shown to vary depending on specific areas (Maone & Rossi 2002). However, upon further reflection of the wording of the question, saying that community health centers were not more effective than institutions did not mean that institutions were better than these centers. Subjects could have regarded them to be on an equal level. For instance, despite not thinking community centers were more effective than institutions, subject 18 still believed that individuals with mental health problems needed to receive treatment but not in asylums because those asylums were like a prison.

Conflicting responses between surveys and interviews were also noted. Although subject 8 wrote that current centers were better than institutions in the survey, in the interview, she revealed a pro-asylum mindset. In a slightly hesitant tone, she stated that asylums were centers where people were cured by being held under control, which did not happen today when they were in the streets doing as they please. She believed that it

was worse now because people with mental illness murdered people, and when living with family, they often escaped. She had a very negative view of mental illness, previously stating that it was not a topic of interest to her because it was a problem to be taken care of within the family. In fact, after subject 8 asserted that asylums were sources of cure, her daughter interjected angrily, refusing to agree with her mother's statement. Her daughter (subject 9) countered that asylums were brutal because they used treatments like electroshock, and they took in many people who did not even need treatment but rather just needed a little bit of affection to resolve their problems. However, she agreed with her mother on the point that most people did not want to live near people with a mental illness because they were dangerous, and people were scared that neighbors with mental illness would kill them. Interestingly enough, in her survey, subject 9 said that people with mental illness were not dangerous, showing an inconsistency in her opinions.



To pull all of these ideas together, two extremely important questions were asked. Firstly, subjects were asked on the survey if they would avoid telling anyone if they had a mental health problem. Then, in the interview subjects were asked to which extent they

believed society accepted people with mental illness. Some sort of correlation between the two questions was expected. Surprisingly, 6 subjects said they would avoid telling anyone, and 21 subjects said they would not avoid telling someone. These responses suggested that the majority of the subjects would be open about their mental illness, should they have one. As for the level of acceptance, the question was posed as a categorical one, but the order of the options may have been confusing. The answer choices were listed as “very accepted,” “rather accepted,” “accepted,” “barely accepted” and “not accepted” due to the researcher’s confusion about the connotation of “rather”. In actuality, “rather accepted” was more negative than “accepted,” so the order should have been switched in order not to suggest that “rather accepted” was a more positive choice than “accepted”. It is unclear whether the subjects stuck with the actual meaning of the terms or if they rearranged their thinking based on the way the options were listed. In any case, the graph above shows the distribution of answers. Most of the subjects chose “barely accepted,” following by “rather accepted,” which showed that there was a long way to go before attaining acceptance for people with mental illness.

Two of the six subjects who would avoid telling someone if they suffered from a mental illness were over 65 years of age, 1 was 18-29, 1 was 30-45 and 1 was 46-64, which covered all age groups. Thus, age did not seem to be an indicator of how open someone would be about divulging a psychological disorder. These 6 subjects cited prejudice for their anticipated reticence. Subject 9 said she would avoid telling anyone due to racism (presumably, she meant prejudice). She also believed that people with mental illness were barely accepted by society because people only wanted to hear beautiful things, not complaints, whining or crying. Subject 12 also said he would avoid

telling anyone because reactions of “normal” people worried him. Although subject 19 did not give an explicit explanation in the survey, she stated in her interview that the majority of people with a mental illness did not seek professional help for fear of being marginalized. This fear may have played a part in her survey response. Likewise, subject 24 said that people with psychiatric disorders were barely accepted because others always had certain reservations. In his opinion, it would only take an insignificant occurrence to set them off. He would not tell anyone if he had such an illness. Subject 27 also said she would avoid telling anyone, but she did not provide an additional explanation. In her interview, she struggled to select a response, and she was rambling around without making a clear decision. Her son, who was present during her interview, said her choice was “barely accepted,” and she agreed. She acknowledged that mental illness could strike anyone, saying “*Può succedere a me, può succedere a te, può succedere a qualunque persona. Nessuno si contra mai il male, no?*” [It can happen to me, it can happen to you, it can happen to any person. No one is immune from misfortune, right?]

On the opposite end of the spectrum were the subjects who would not avoid revealing a mental illness. Subject 10 said he would not avoid telling someone but would be proud of himself even though Italian society did not accept people with mental illness. Likewise, subject 13B said she would not avoid telling someone, although in her interview she acknowledged that people with mental illness were barely accepted by society due to its ignorance, fear and difficulty in managing the interaction process. In contrast, subject 2 said in her interview that despite some prejudice, there was a greater openness about mental illness in Italy. In her survey, she also selected that she would not avoid telling someone if she had a mental illness. For some subjects, the wording of the

question may have been confusing due to the double negatives. Subject 11 said that he would not avoid telling someone, but he could still do it, “*Non eviterei raccontarlo. Ma potrei comunque farlo.*” It was unclear whether “*Ma potrei comunque farlo*” was positive or negative. Finally, subject 20 explained that he would not avoid telling someone because such a revelation could help one overcome one’s difficulties. He also said that people with mental illness were rather accepted because perceptions varied from place to place. In large cities, people understood more, whereas in small towns, the community still saw mental illness very poorly (subject 20). This logic did not necessarily seem to hold true when studying Rome in isolation, given answers gleaned throughout the study, but it maybe it would if compared to smaller Italian towns.

Like subject 20, subject 15, said he would not avoid telling friends and colleagues, but he did not mention telling family members. He believed that people with mental illness were rather accepted because according to him, mental illness was normal, especially amongst the younger populations (which would explain why he would tell his peers). Subject 22 had no problem telling someone, but he did mention that people with mental illness were barely accepted because Italy promotes the fundamental cultural ideal of the beautiful family that the media constantly pushes forward. For example, in the show *Molino Blanco*, the cast is a model family that is happy and healthy and there is no place for a person with a mental illness. Subject 5 corroborated this thought, saying that Italians were very moralistic people, who did not like to witness illness.

Solely in terms of perceived acceptance, subject 11 could not give an answer because she believed the level of acceptance depended on whether the person was aggressive or dangerous. Causing slight confusion, subject 3 said that people with mental

illness were accepted, but her explanation suggested otherwise. She said that there was always a bit of prejudice against those who were different from the norm, and people with mental illness were always a little marginalized and excluded from the social context. Subject 6, who believed that people with mental illnesses were barely accepted by society, explained that a distinction had to be made between theory and reality. He explained that people at first would say that they were willing to accept those with mental illness, but in fact, many times they still rejected them. Subject 26, who said that people with mental illness were not accepted by Italian society, brought up this same dichotomy. He explained that many people were brave in their words, but when they actually had to approach people with mental illness, they would say that they were scared or that they did not know how to manage the situation. Subject 14 explained that people suffering from mental illness were still barely accepted by society because often people approach them with little respect, calling them imbeciles, in the same way that they called people with physical disabilities handicapped.

In his interview, subject 21 stated that due to having an epileptic sister, he accepted people with mental illness (to clarify it again, epilepsy is not a mental illness). He said he could only speak for himself because unlike the researcher, he did not go around asking people on the street what they think. Touching upon a larger societal perspective, subject 25 said that people with mental illness were rather accepted because in his opinion, at the depths of their hearts, these people could get better and recover. However, he did add that he was not scared of people with mental illness because only weak people should be scared. In his opinion, associating with a person with mental illness could be dangerous for weak, fragile people, from a psychiatric point view.

Inadvertently, he still stigmatized people with mental illness by implying that if they had been stronger mentally, they could have avoided succumbing to illness. Even more positively, subject 17 believed that people with mental illness were very accepted from what he saw. He stated that they were people, and treatments existed today that allowed them to integrate with other people, although perhaps this level of integration depended on the disorder. He was the only subject to say that those with mental illness were very accepted.

In one particularly critical response, subject 7 asserted, “*Non possono essere accettate perché persone così non possono essere accettate. Dovrebbero vivere in comunità fra di loro perché loro si possono capire. Però un sano con un malato non si può mettere perché anche il sano diventa malato. Chi va con lo zoppo impara a zoppicare*” [They cannot be accepted because people like that cannot be accepted. They should live in a community amongst themselves because they understand each other. But, a healthy person cannot be placed together with a sick person because then the healthy person will become sick. He who hangs with a lame person will soon begin to limp]. She also added a story of the assassination of John Lennon to explain that people with mental illness should not live within the community:

Sono i pazzi che stanno insieme a tutti gli altri. Però adesso risulta che un giorno può succedere, com'è successo a John Lennon, possono uccidere a uno qualsiasi di noi. Si svegliano con una rotta ancora peggiore di quella che hanno e i mazzi mettono un coltello nella pancia. Questa è quello che si rischia. Si rischia anche la vita stando con questa persone.

[Crazy people are all amongst us. But, now one day something can happen like what happened to John Lennon. They can murder anyone of us. They wake up feeling worse than before, and they stab you in the belly with a knife. This is what is at risk. We are risking our lives being with them].

This sensationalized belief in the need for physical segregation on the basis of mental illness was troubling and showed the heightened level of fear that some people in Italian society still held. Further invalidating the above view, research showed no significant correlation between mental illness and criminalization (Maone & Rossi 2002). In light of the highly divergent responses, there was a wide spectrum of opinions on whether Italian society was accepting or not of mental illness.

II. Mental Health Professionals' Interviews

Seeking mental health professionals' expertise was crucial to this investigation because they provided information about institutional practices within Italy's mental health system, as well as information about their direct contact with service users. The twelve psychiatrists, psychologists, nurses and psychotherapists interviewed were told their names would not be disclosed, so they were referred to as "professional #" in this section according to the order in which they were interviewed.

All professionals began by explaining their role in their specific mental health team, in order to give context for their following answers. Because they worked in different types of specialized centers, the professionals honed in on the problems faced in their particular facility. When asked why mental health was important in terms of a person's global health, most everyone explained the inherent interconnection of mental and physical health. Professional 1, a psychiatrist from the residential community, was the only subject to conduct the interview in English, although Italian was his first language. He provided a succinct but insightful statement, "There is no health without mental health." Likewise, his colleague, a psychiatric nurse, recited a version of the Latin

emblem, “*Corpo sano, in mente sana,*” [a healthy body within a healthy mind]. Although the original saying is, “*Mens sana in corpore sano*” [a healthy mind in a healthy body], the meaning still came across that for either mind or body to be healthy, its counterpart must also be healthy. Professional 5 also cited this emblem, adding that one could not separate the body from the mind or vice versa.

Professional 3, a psychiatrist and psychotherapist in a large, public hospital, promoted this idea by explaining that in order to speak of health, one had to speak of the whole person. However, he noted that people still thought of the Cartesian subdivision between *res extensa* and *res cogitans*. These Latin terms refer to Descartes’ extensible corporeal substance and the inextensible psychic reality, respectively. Along these same lines, professional 6 asserted that the organic, or biological, and the psychic, or psychological, were profoundly intertwined. Similarly, the one neurologist interviewed agreed that mental health was an expression of organic health and would be better named as biological psychiatry (professional 8). Focusing on childhood, professional 12, a psychologist/psychotherapist working in the private sector, spoke of the healthy development of a subject and how attention should be paid to mental health in the first moments of the life of a child rather than only when a serious pathology arose. The only professional to hone in on the daily social ramifications of this question was professional 10, a nurse from a primary care CSM. She first noted that the question was a little bit bizarre because without mental health, a person could not do common things by himself or herself. The way she answered indicated that she believed the answer was obvious, and she further reasoned that without a healthy mind, people could not live in a socially satisfactory way for themselves and those around them.

By virtue of the diversity of these professionals' specialties and places of practice, they treated very different types of patients. They were asked about the most common mental illnesses they had encountered in Rome, in general, not just in their specific centers, in order to ascertain if their experiences matched up with research data. But, most of them ended up detailing the disorders they treated within their centers.

Professional 1, who was thinking more objectively than subjectively, gave the national statistics that during the course of their lifetime, 1% of the population suffered from schizophrenia, 1% suffered from bipolar disorder, 20% suffered from psychological or emotional disorders and 30-40% of the population suffered from some symptoms of mental illness. Specific to his residential facility, he mentioned earlier on that it hosted young adult patients with severe mental illnesses, which mainly included schizophrenia, personality disorders and bipolar disorder. However, professional 3 (psychiatrist/psychotherapist) and professional 4 (psychiatric nurse) from Sant'Andrea Hospital worked more closely with patients with anxiety and depressive disorders, giving them a broader range of disorders to treat. The psychiatrist said that in terms of illnesses he had encountered, anxiety disorders ranked highest on the list. However, it was mostly the patients who entered the hospital through ambulatory care who exhibited these disorders. As a whole, the hospital also received patients with more severe disorders, such as mood disorders, bipolar disorder and a variety of psychoses. The nurse was more succinct, listing bipolar disorder as the main disorder seen in the day hospital, which contradicted the psychiatrists claim that anxiety was most frequent in ambulatory care. This discrepancy may have arisen from the fact that no hard numbers were given, and both professionals were speaking from their personal view of the abundance of a certain

type of disorder. In a more particular situation, professional 5, a psychologist from the same hospital, worked specifically with patients who had attempted or planned to attempt suicide, so she spoke about the helpline she operated to counsel those considering suicide. Her patients' range of disorders encompassed mood disorders, bipolar disorder, schizophrenia and other psychotic disorders.

Professional 7, a psychologist at the ASL, expressed having observed many people with depression, encompassing its endogenous (hereditary) and reactive (experiential) forms. She also named bipolar disorder as the highest-ranking disorder seen, with obsessive disorders, panic attacks, neurotic disorders and personality disorders also being in abundance. This long list reflected professional 9's statement that in a public service, people with all types of disorders arrived to be treated. Professional 10, a nurse in a CSM, said that in the ambulatory center, they received many patients with neurotic disorders (including anxiety, depression, phobias and obsessive compulsive disorder), while the majority of younger patients arrived with psychoses (including schizophrenia, mania and personality disorder). In the CSM, patients between the ages of 18 and 65 were the primary users because after 65 years of age, problems, such as Alzheimer's and dementia, were often neurological, requiring a neurologist, not a psychologist or psychiatrist. Professional 10 made a point of mentioning that the CSM often received patients in advanced stages of their mental disorders because they initially undervalued the problem, "*All'inizio uno pensa, 'Oddio! Beh, passerà. Non sarà niente, passerà'*" [At the beginning, one thinks, 'Oh dear! Well, it shall pass. It will not amount to anything; it shall pass.'] Unlike the professionals in the CSM, professional 12 dealt with a more specific group of patients depending upon whether she was practicing in the

public or private sector. Through group therapy in the public sector, she had seen and worked with many schizophrenic patients. However, in her private office, she worked more with patients with depression and post-traumatic stress disorder. These responses indicated the breadth of psychiatric disorders that were present in Rome and which professionals tend to encounter them most frequently.

An extremely important question whose answer could only be ascertained inferentially by the general public was the opinion on the amount of national funding and local funding that existed for research and treatment of mental health. Professionals' factually based answers to this question revealed a lot of deficiencies in the Italian mental health system, and they indicated certain areas that could be targeted in order to begin to address the problem of mental health stigma. All of the professionals agreed upon the point that insufficient funds were being dedicated to the mental health sector; however, they differed on which specific areas required the most immediate attention.

Continuing with his factual approach to the interview, professional 1 explained the financial situation with percentage values. He explained, "There have been cuts in funding year after year. For example, when a professional retires, it is impossible to substitute him or her with a new professional, so the teams during the last years [have] diminished every year." Struggling to understand why funding was decreasing when the knowledge of the importance of mental health was increasing, the researcher focused on this seemingly paradoxical point. To clear things up, professional 1 explained the current economic status of Italy, "Because the welfare state is in crisis in all of Europe, because there is not enough money to sustain the demand for treatments and medication for all of health...the costs increase year after year, so the system can't tolerate this request for

money.” Similarly, professional 4 also mentioned the crisis, stating that healthcare was hit the hardest, “*Tutta la medicina è penalizzata. La salute mentale è più stigmatizzata per un problema culturale in Italia*” [All of medicine is penalized. Mental health is more stigmatized, due to a cultural problem in Italy]. Professional 1 broke down the fact that although the law required the national budget to set aside 5% of the total healthcare budget for mental health, in reality, only 2-3% of the healthcare allotment actually reached mental health. The inability to sustain large enough medical teams translated into a subsequent lack in comprehensive care for all patients who required it. Professional 3 added to this account, stating that national funds came from the *Servizio Sanitario Nazionale (SSN)*, or the National Health Service. The funding it could provide were decreasing across the board, so the problem was not only local or regional. Because Italy has a national health system with universal healthcare for all citizens, everyone has the right to access all public treatment, with the state paying for the services. Thus, patients do not generate income for these facilities. Professional 3 explained that as a result of the deficiency in personnel, mental health centers had to close down, which then affected potential users negatively. In her opinion, although Law 180 was optimal, it was difficult to apply it without the economic resources to fund all the ambulatory centers, day hospitals and residential communities that the law established.

Professional 5, a psychologist in Sant’Andrea Hospital, opined that the funding was never sufficient because even when it did arrive, it was allocated to too few people, who assumed roles that were too varied and dispersive in nature. The resources were so thinly spread out because Italy is a country in which professionals train in too many micro-specializations. Even more assertively, professional 6 claimed that the funding for

mental health was absolutely insufficient, and the field was neglected. Specifically, there was a difference between the private and public sectors, as professional 7 pointed out. She explained that almost all the clinics that supported patients fully were private clinics affiliated with the state, yet being private facilities, they did not even belong to the state.

Thinking internationally, professional 8 was of the opinion that the decade of the brain had passed because in the 1990s and 2000s, nations were investing in mental health. Now, in Italy and in the region of Lazio, specifically, these investments were close to nothing. Funding was insufficient with respect to what an adequate approach and treatment for mental health requires. Also, funds were not used efficiently because what should cost 10 Euros to treat a patient with a neurological disorder ended up costing 1,000 Euros the way treatment with current treatment plans. Additionally, he bemoaned the enormous wastage of time, energy and money in Italian society, in Lazio, and in his specific district (RMA – 25). Of the same accord, professional 10 asserted that mental health professionals had basically no funds to work with. She explained that very little money had arrived in order to permit the ASL to conduct different programs. The last type of project they executed was fifteen or twenty years ago when they took children on two-week summer vacation, where they went swimming and underwent hippotherapy on horses with nurses and psychologists. Since then, the ASL had to rely on its own limited resources. To make up the difference, the staff went to plead for a soccer field for their service user to play soccer once a week, and luckily, a businessman donated the balls, teachers and shoes. However, there was no bus to the center, so if a patient could not transport himself, the nurse would drive personally to pick him or her up. With such a program, it was a lot more difficult to motivate the female children because often, they

wanted to do another activity. One girl was forced to play soccer because there were no other options, so she played for a year, but she was the only one (professional 10).

Interestingly, professional 11, a psychiatrist working in both the public and private spheres, said that the amount of funding was enough, "*Basta.*" However, when asked to explain further, she explained the opposite view, saying that obviously there was a lack, especially of personnel, so by consequence, there was a less services were provided to users. Since the state cannot fulfill the demands of the citizens, many end up seeking help in the private sector. In terms of accessing the public mental health centers, the researcher asked for clarification about the emergency room as the point of entry to the immediate mental health attention. Professional 11 responded that it often was, but this reality should not occur. She was of the opinion that there should be a mental health network that bypassed the emergency room because so many people entered from there, which limited the available resources in an attempt to accommodate everyone's needs. Professional 12 was the only one to distinguish between funding for research and treatment. She asserted that finances were very low, if not nonexistent, for mental health research. It occurred either in a clinic or in a university, but with much passion and little funds. If funds did exist, they came from donations. She explained that all the national funding for mental health went towards patient care in order to guarantee clinical treatment for the patient and to guarantee the development and testing of new pharmaceutical drugs.

Although money is crucial for a functioning healthcare system, other aspects also contribute to the effective management of the mental healthcare system. Professionals were asked to identify any factors that limited the ideal administration of their specific

mental health service. Professional 5, the psychologist working in the suicide help center at Sant'Andrea Hospital, cited the lack of space as the main problem, with other obstacles being personal dynamics and fulfilling too many roles at the same time. She explained that psychologists had to make photocopies, be on the phone and receive patients all at once, serving as both psychologists and organizers. Everyone wanted to hold his or her own weight and fulfill each duty, but the required multitasking was too much.

On the other hand, at Sant'Eugenio, a psychiatrist in the department of mental health could not think of any hospital-specific limitations. Instead, she spoke of generalized problems, such as the innate difficulty in dealing with mental health, as well as the flawed organization of mental health services in Italy. Like subject 6, she believed that the theoretical goals of Basaglia's Law had not been brought to fruition because after asylums were closed down, they were not replaced with adequate secondary structures. After a general doctor referred a patient to a CSM, that patient was then supposed to continue on to a residential community or a day center for additional care, depending on the psychologists' expert opinion (professional 2). However, after receiving primary care attention, those requiring more extended care often do not have enough secondary care options from which to choose. Similarly, professional 8, the neurologist, asserted that the limited number of local services prevented accommodation of the needs of the vast spectrum of mental illness, especially considering the quantity of patient hours a service user needed but could not receive due to the center's lack of economic means.

Yet another professional cited this same problem. Professional 6 explained that there were problems inherent in the organization of the mental health system that resulted in a lack of rehabilitation centers, which are secondary levels of care. Professional 10 also

explained that facilities did not exist to receive patients after they spent the maximum ten days in the hospital for an acute condition. If their families could not take them in, they began to circle through various clinics. But, professional 10 did not know how beneficial these clinics were because sometimes patients left with nothing resolved. After completing treatment in a clinic, the users still needed a place to live, and there was only one male and one female group apartment (presumably, in the particular region) that were both about to close down. Given that so many professionals from different fields and services cited the same problem, it was necessary to pay attention to the structural organization of the mental health services available in the public sphere.

Another problem that was brought up was personnel's insufficient attention to patients' needs. Professional 7, a psychologist, explained that medical personnel at the ASL often minimized the degree of fear and discomfort felt by users who did not exhibit overt symptoms. In her opinion, personnel often overlooked these problems because of the rigidly structured centers, which promoted focusing on the collective good, rather than individual attention. At this point, the psychologist chuckled nervously and said that she hoped the interview would remain between us because of the way she had portrayed Italians and communicated her views. After receiving assurance of her anonymity, she said that was perfect, although she still assumed responsibility for her words. She expressed that she was afraid about how she had conveyed her views, "*Ma era per come te l'ho detto, probabilmente, forse nemmeno molto bene, questo per temevo. Di non avertelo tradotto bene il mio pensiero*" [I was scared because the way I told you my views was probably not very good. I was afraid of not having conveyed my thoughts well.] Her fear was surprising, and it suggested that criticism of the functioning of a

mental health service was not encouraged. This fear of speaking out to challenge the status quo was problematic, as it promoted stagnancy and complacency over progress.

As for additional limitations to the ideal administration of her mental health center, it took professional 10 a while to think of any, so she repeated that she did not know. However, she then began to speak of programming, recounting that since the soccer team was shut down, a movie group was started, through which the CSM showed films once a week, followed by commentary from the children in attendance. She then listed the first actual limitation that many children did not have families who could help them effectively, so they were rather lonely. Moreover, she described the terrible location of ASL RM 25 as removed from any direct bus or train line and so displaced from the center of town that users without cars or money for a taxi had to walk by foot to arrive. Offering a perspective from a freelance professional working in both the private and public spheres, professional 12 cited a limitation to her practice as its disconnect from the public sector because she had to do twice the work—work with the patient and then constant work to communicate with the public sector, which was exhausting. Moreover, there were fewer benefits for those in the private sector, as they did not receive the same amount of legal protection and structural support as workers in the public sector. Also, patients in a private practice had fewer opportunities to access social services or to be included in social work programs and rehabilitation programs. Therefore, if she did not share the responsibility for a patient with a professional in the public sphere, she preferred to treat patients with less severe neurotic disorders or anxiety disorders that did not require the engagement of a psychiatrist, a social worker or a wider network of

professionals. Her opinion was the first one that disclosed some negative aspects of private health care.

After dissecting these negative aspects of Italy's mental health system, the study shifted to explore professionals' opinions on the advantages and disadvantages of the different types of centers available to individuals with mental health problems, such as spatial location, number of personnel and type of treatments offered. Professional 1 observed that the advantages and disadvantages of each type of facility depended on the quality of that particular facility, which also depended on the training of the staff, their motivation and "many practical local conditions." Giving a similarly general answer, professional 2 noted that there was a need for more physical buildings, as with so many sick users, the public sector was so overwhelmed that users were forced to use private services. More specifically, professional 3 explained that in some CSMs, there was no staff turnover after certain professionals retired, so many of these services had to shut down. Speaking directly about her service in Sant'Eugenio Hospital, professional 6 cited direct access as an advantage because the hospital was a point of intervention. However, a disadvantage of the hospital structure was that being a general hospital, the psychiatry department within the hospital was often discriminated against, "*Viene vista male, viene accettata male*" [It is not viewed positively; it is poorly accepted]. She told a story of a garden that was constructed for patients with mental illnesses, and other doctors complained about why that space had not been not used for cardiology or for another department that brought greater prestige to the hospital, "*Continua a essere la mentalità quella di nascondere*" [The mentality continues to be one of hiding the psychiatry department].

A psychologist working both at Sant'Eugenio and in her own private practice explained that the differences between the two were a little bit complex. In her opinion, public services were at a disadvantage due to their inability to offer continued treatment, and this inability limited users from following a stable recovery plan within the disorganization of the system. Moreover, she explained how public hospitals and the SPDC wards within them had a cap on the money they could spend, while the demand for treatment of psychiatric pathologies was high. Thus, treatment and hospitalization was managed mostly by private facilities. Making this categorization clearer, professional 12 explained that there were two big groups of public services: emergency services (emergency room, SPDC, hospitals) and ambulatory care services (ASL, CSM, day hospitals). In her opinion, there were more advantages to ambulatory care, when thinking of global treatment of the patient in a therapeutic project, as there were more overall possibilities for treatment in a CSM or in a day center. Her reasoning was that with more professionals, such as social workers, available in ambulatory care, they could focus on long-term treatment plans, rather than simply managing the immediate symptoms with which the patient presented. In this system, the psychiatrist, psychologist and social worker come together to decide upon the medication the patient will take, the types of psychological therapy he or she will undergo and the type of employment he or she can seek. However, emergency services were necessary in moments of acute severity because they allowed the patient to have a chance of recovery after a period of crisis.

After comparing the different types of services, the professionals were asked to explain the general rapport between their particular center and other services in order for the researcher to gauge the level of interconnectedness and support between the mental

health services. Professional 3 explained that Sant'Andrea Hospital was connected to other services because it was appointed to a specific residential territory by the city. Every residential zone in Italy is divided into sectors, and each citizen in the zone is directed to a CSM depending upon the sector in which he or she lives (professional 6). Thus, when patients arrive in a hospital, either via referral from a CSM or via the emergency room, the their doctor contacts a doctor in a CSM, who comes to see the patient and begins a course of treatment in the CSM or in other ambulatory care center. Professional 4 from the same hospital explained that the local region knew to refer patients to the hospital. So, for every patient who arrived, the doctors called the psychiatrist from the CSM to assume care of the patient. Both the hospital and the CSM are primary care centers, so when patients exhaust their resources, they advance to secondary care facilities, which include residential communities or group apartments, where they are gradually reinserted and rehabilitated into society (professional 6). Thinking towards the future, professional 5 explained that there was someone in the hospital who was trying to promote a broad networking project between the hospital and all of the local services of Lazio. She also noted that as for the level of conducting mental health research, more could be done to remain in contact with the universities.

For her part, the psychiatrist at Sant'Eugenio believed that relations between services were very good and that the doctors were very connected, especially with the two CSMs associated with the hospital. Thus, patients who left the hospital knew which two CSMs to access. In contrast, professional 8, as he worked in neurology, not in a mental health center. Working independently, he did not often consult with other doctors when taking care of patients with psychiatric disorders, such as bipolar disorder,

schizophrenia, Autism, and eating disorders. Professional 11, a private practitioner, opposed this view, affirming that there absolutely was collaboration between doctors. Similarly, professional 12 a private practitioner, who also worked in a CSM, believed that relationships could be very good, but everything depended on the quality of the doctor and the capacity of the private practitioner to maintain strong relations with those in other health centers. The bottom line according to professional 12, though, was that mental health professionals should work within a network of support in order to draw on each other's experience and expertise to best treat a patient.

As for the relationship between the mental health centers and the community, for example the presence or absence of educational programs for community members, professionals provided varied responses. Professional 1 did not understand what was meant by "relationships," and he asserted, "We do not have relationships. We have relationships with users, who come to our service and ask for intervention and care." However, he later spoke about the community's attitudes, saying that the neighborhood in which the residential community was located was very tolerant. On the contrary, the nurse working in the same center stated that the surrounding community did not collaborate much with the users, and in fact, they tended to marginalize them rather than integrate them. The two opposing views made it difficult to correctly assess neighborhood attitudes towards the residential community. Instead, they indicated that the perception of those attitudes could be rather subjective.

For professional 9 in the CSM, she believed relations to be good because many people from all social strata of the community frequented the center for treatment. Therefore, she focused on the willingness of community members to access the CSM for

treatment without touching upon the understanding and acceptance of the CSM by community members who did not need mental health attention. Citing the importance of informing the users and their families, she mentioned some rehabilitative activities, such as the soccer team, whose games were publicized in newspaper. However, from what professional 10's discourse, the teams were not mixed with users and non-users, which would possibly have been a more effective way of bringing the two into direct contact with each other. She had a different view of the relationship between the CSM and the community. She explained that it was already difficult for people to access the center and recognize that they had a problem, and the additional barrier of a lack of regular public transportation to the CSM did not help the situation. In her opinion if there were a bus to shuttle service users back and forth, it would be simpler for people to seek treatment. She also mentioned that people were still wary that mental health centers did not represent a clean break from asylums of the past, so it has taken many years for them to become comfortable with them.

In any case, the CSM also published articles to highlight the positive vision of the service, how to access it, what illnesses were treated and what results were reached. In a highly detailed manner, professional 10 described how most people came to the center with a recommendation from someone they knew, such as the family doctor or a neighbor, but no direct information was handed out to the community. She supposed that people could find information on the Internet because the website explained how to schedule an appointment. Because her response veered towards a user accessing the center for treatment, the researcher asked if any cultural programs or parties to bring the entire community together existed, and the nurse responded negatively. However, she

said that maybe that would be a great idea. When asked why the CSM did not initiate such programs, she responded that they had so many patients and with the economic crisis and subsequent unease, less of those patients exhibited characteristics of “*lo psicotico puro*” [the pure psychotic] or “*la psichiatria proprio classica*” [classic psychiatry]. Because the professionals saw more patients with neurotic disorders or desperation due to the economy, rather than those with severe psychiatric disorders, professional 10 did not believe in the necessity of a party to educate people on accepting mental illness. Furthermore, she mused that maybe the center did not hold these types of events because it already had so many patients to treat, and it really did not need more publicity. With this answer, it seemed that she missed the concept of the cultural programs. They would serve to reduce stigma, not to draw additional patients to the mental health service.

Concentrating further on the information provided to community members who did not use the mental health services, the researcher asked the professionals to list which structures and programs they had in place to provide mental health information to the community. Professional 4 admitted that there were very few programs of that nature in Sant’ Andrea Hospital. When asked whether her impression was that people with depression or anxiety went to psychologists or therapists, she responded in the negative, citing shame as the obstacle to seeking health. Professional 5 was more optimistic, saying that there was an immense effort to attempt to inform the community. For her in particular, she spent a great portion of her days sending emails to different mailing lists and searching on the Internet for email contacts of doctors throughout Italy to advocate for different causes. For example, Sant’ Andrea Hospital hosted a race called “Race for

Life,” which was a race to spare the lives of those suffering from mental illness by engaging the community about suicide prevention without packaging it as something of which to be ashamed. Professional 6 of Sant’Eugenio spoke of the distribution of pamphlets on mental illness, affirming that there was information on the website of the ASL associated with the hospital about both the ASL and the hospital. These centers’ mental health professionals also partook in meetings and conferences open to the general public to clarify their stances on different health initiatives. She did not expressly state the level of attendance at these meetings, but their existence, nonetheless, showed efforts to engage the community in a mental health discussion.

In contrast, an area of deep concern arose when professional 11 responded that she did not know of any type of program to disperse information to the community and did not even know that such programs existed, “*Questo non lo so. Non ho la conoscenza su questi tipi di servizi.*” With this answer, it was clear that the priority did not lie with societal integration, but rather with purely medical treatment. However, professional 12 lent some hope to the situation, describing her mental health prevention and promotion programs that she conducted with children between 6 and 17 years of age. In these programs, she lectured the classes in school and also held yearlong workshops to push them to create a multimedia product to think, study and reflect upon the topic. This program was remarkable because by targeting school-aged children, she already set them up to be informed about mental health and to potentially be more accepting of those suffering from psychiatric disorders of different kinds.

Given the different interest level in programs to educate the community, the professionals were asked to give their personal opinions on how informed Italians were

about mental health. Professional 1 stuck by his initial stance that his health center should focus on its users and not on the community at large. He explained that people should become informed naturally, not through any planned educational program. He did note, however, that some schools held programs and the media also provided information about health. When asked how accurate that information was, he said, “Well it’s quite accurate,” which was surprising considering how the general population thought the media often misconstrued facts. Professional 2 disclosed that people sometimes knew about mental illness but simply ignored it, “*Si sa che ci sono malati mentali però si tende a nascondere, a fare finta che non ce li siano*” [People know that there are mentally ill people, but they tend to pretend that they do not exist]. Interestingly enough, professional 3 opined that people were rather informed in this day and age, and they received their information from their general doctors, the ASL and the CIM (*Centro Igiene Mentale*) [Mental Health Center]. This opinion was directly contradictory to the results garnered from interviews with the general population, in which only one person spoke about receiving mental health information from a medical practitioner. In direct opposition to professional 3, professional 11 expressed that people did not receive any information and were barely informed, “*Penso che non ricevano per niente informazione...penso prevalentemente quelli che dovrebbero dare informazione a questo tipo sono la rete sul territorio, quindi i medici di medicina generale*” [I think that they do not receive any information...I think that prevailingly, those who should give this type of information are the local health network, thus doctors from general medicine]. Interestingly, both professionals 3 and 11 were psychiatrists at large public hospitals, although professional 11 also worked in the private sector.

Professional 4's views were more aligned with the information gathered from the interviews with the general population. She stated that the people were barely informed and preferred to keep it that way, "*È molto stigmatizzata come malattia quindi meno si sa, il meglio è*" [Mental illness is very stigmatized as an illness, so the less one knows, the better off one is]. In her opinion, things had definitely changed since 1978, but more time was required before society would accept mental illness like any other illness.

Professional 5's response confirmed the negative effects of the absence of community programs for mental health, as she explained that little was done for the population aside from the patient-doctor conversation that occurred within the service. She made an extremely insightful comment about the lack of consciousness-raising initiatives for the populace, "*In genere, il paziente fa esistere questo servizio. Non so se è il contrario*" [In general, the patient makes this center exist. I don't know if the opposite is true]. The doctor cannot exist without the patient, so doctors should work harder to make people open to using their services. More harshly, professional 8 recounted that patients arrived to him terrorized because in their minds, having to visit a neurologist meant that they were dangerously altered versions of their previous selves. This fear often caused patients to give up and stop taking their medication. In his opinion, ignorance about the brain and mental illness was abysmal. By virtue of being a relatively unexplored field, mental health always fostered annual debates and conferences, but even some of the professionals in attendance held strange beliefs, according to professional 8. He stressed that the development of the field surrounding the brain was unpredictable, painting the image that uncovering definitive information in neurology and neuroscience is akin to having to climb a skyscraper and then ring the bell in order to enter, "*[È] come se*

dobbiamo entrare in un grattacielo e dobbiamo suonare i campanelli per entrare.” Since there is so much to be learned and so much contention on the topic, if professionals are not of one accord, one cannot expect the general public to know the truth.

Dissimilarly, some professionals were still optimistic. Professional 6 spoke of how Italians were certainly more informed than they once were, *“Perché prima credo che venissimo visti, sia psicologici che psichiatri, proprio come delle bestie nere...i mostri che uno si sogna durante la notte e da cancellare dalla propria mente”* [Because before, I believe that we psychologists and psychiatrists were considered to be black beasts...the monsters you dream about at night and have to block from your mind]. Professional 7 also referenced the improvement in society’s mentality, asserting that although there was a still taboo, people were a little bit more cultured and more willing to bring someone in need of treatment to a center with enough time in advance. Likewise, professional 12 acknowledged the difficulty of answering this question but ended up affirming that Italians were informed since there were many types of information from the Internet, the television, general medicine doctors and family doctors. But, for the same reason, they were not well informed, *“Le persone in Italia tendono a raccogliere informazioni da soli, sull’Internet, sui libri, sui giornali e a farsi una propria idea. Questo potrebbe essere pericoloso”* [People in Italy tend to gather information on their own, from the Internet, from books, from newspapers and they tend to formulate their own ideas. This could be dangerous].

When considering these sources of information, public campaigns were not cited as a significant source of information, just like in the general population interviews. In describing the amount and quality of public campaigns to protect people with mental

illness, the professionals found similar limitations. Professional 1 had a strong stance on the issue, calling public campaigns controversial because they were useless in their efforts to change perceptions or attitudes of the general public. In his opinion, “The effective factor to change attitudes in people is to personally experience a relationship with this kind of person,” which harkened back to the idea of familiarity. Professional 2 also responded negatively but with some reservations. She expressed that not all public campaigns were effective because people undervalued the problem and did not recognize just how many people in the population were affected by mental illness. However, increasingly, people have come to understand the pervasiveness of mental illnesses, due in part to publicity from groups like *Auto Mutuo Aiuto* [Mutual Self Help], which consists of parents of children suffering from mental illness, who want their voices to be heard. Another similar group called *L’associazione lotta contro lo stigma* [Association Fight Against Stigma], was instituted by Sant’Andrea Hospital. Professional 5 explained that this group had done a lot to speak against stigma, “*C’insegna sempre che c’è il malato, non la malattia. C’è la persona e non il disturbo. C’è il depresso non la depressione. Cioè mette di pensare alla persona prima di tutto*” [The group always teaches us that there is the sick person, not the sickness. There is the person and not the disorder. There is the depressed person, not the depression. Thus, the group puts an emphasis on the person above all]. In contrast, professional 4 believed that public campaigns could do much more because in Italy people were still barely sensitized to psychiatric ailments. Professional 8 also said that public campaigns existed but were hardly effective because incomprehension and prejudice followed patients when they left the ambulatory care center. For her part, professional 11 denied the existence of any such campaigns.

With the questionable quantity and quality of public campaigns, the issue of discrimination was then addressed. As the closest point of contact to mental health service users, the professionals gave insight into any acts of discrimination their patients had revealed from their daily lives. Their responses exposed various sources of prejudice within Italian society, as well as how those struggling with mental illness dealt with the discrimination. Professional 1 confirmed that his patients did experience discrimination, which was why the residential community was important in providing an environment of low exclusion, high acceptance and high tolerance. He did mention, however, that they had positive relationships with the community, which generally included stores, bars, the local McDonalds and other such establishments. Outside of this microcosm of society, things changed, “The big problem is when they have to go out and to return to the community life. The system is not organized in a way, which allows them to participate effectively in community life.” Since the economic collapse and the widespread crisis that ensued in Europe, these individuals have had even fewer job opportunities. This dilemma of individuals recovering from mental illness without any prospect of making a steady income posited the risk of regression, “Because it’s difficult for the system to find an independent solution for each patient, the risk is to recreate a new phenomenon of institutionalization—a sort of erased institutionalization. Because at the end, they are either in the streets or in [private] institutions very similar to the old psychiatric hospitals.” Discrimination from the workforce greatly impacts these individuals’ chance for complete reintegration into society.

Similarly, professional 3 answered that patients had told her about instances of discrimination, especially in the employment sector. Giving more specifics, professional

4 explained that users had difficulty finding jobs or even just going to pay a fine for a ticket because they were figuratively held at an arm's length. The form of discrimination varied according to the patient's diagnosis, as someone with schizophrenia might be seen as crazy, while someone with post-partum depression or depression would not. She opined, "*C'è proprio uno stigma. La cultura italiana è molto discriminante*" [There is a stigma. Italian culture is very discriminatory]. Correspondingly, professional 6 also mentioned employment disadvantages. She stated that employment was the first and foremost source of discrimination, as many times employers did not hire individuals with mental illnesses. It is of note that ideally, "Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment," but this human right is clearly violated daily due in great part to negative perceptions about the worth and capabilities of people suffering from mental illnesses (United Nations, Art. 23 1948). Professional 6 also mentioned other instances of discrimination, such as a woman who tried to adopt but who was refused on the basis of a past mental health problem that was recorded in her file many years ago. Finally, she mentioned discrimination within the medical field of some doctors not holding psychiatrists in high esteem.

Casting the net out more broadly, professional 2 listed examples of discrimination directly from community members. As the nurse at the residential community, she explained that service users had dealt with people who marginalized them by not giving them the time of day and refusing to speak to them. But, according to her, these acts of marginalization did not exist at the university level, "*Ah, chiaramente, no, nel livello universitario, no*" [Ah, clearly no, not at the university level]. Her certainty in this

response, with the word “clearly” suggested that younger, educated Italians had a more positive perspective towards mental illness. In the general public surveys, the 18-29 year olds with incomplete or complete university education were subjects 1, 11, 15, 16, 20 and 23. Except for subject 1, they gave overall more positive responses on questions on civil rights, and they all said that it would not be difficult to relate to a person with a mental illness. Four of the six believed that those with mental illness were not to blame for their condition. Only subject 20 said they were dangerous, while subjects 1 and 11 said that it depended. Thus, as a whole, their perspectives corroborated professional 2’s opinion on the higher level of tolerance among college-educated youth.

In contrast, professional 12 said that discrimination existed especially with her younger patients between 18 and 25 years of age who had severe diagnoses, such as personality disorder or schizophrenia. She explained how much pain they felt at being rebuffed by their friends at school, which made them tend to close up in shame and for fear of being judged, *“Anche con molto dolore e molta passione si sentono rifiutati all’università dagli amici e tendono a chiudersi per vergogna e per paura d’essere giudicati.”* In her experience, young adults struggled more because they could not partake in activities with their peers, such as going out for a beer, driving or taking notes in class because their medication might cause muscular tremors that made these activities inadvisable.

Not only friends, but family members also spew out negativity. Professional 7 went to great lengths to describe instances of injustice her patients had confronted from their family members. Ideally, if doctors could not place the users in a residential community, they would remain in the care of their families, which came with its own set

of pros and cons. Some families really pushed for the recovery of their children and for them to thrive by working, getting married and building their own families. However, other families were pathologies in themselves, and they aggravated the individual's ailment (professional 7). In her opinion, families often added to the emergence of a mental illness because the illness developed within the family nucleus due to abuse, aggressiveness, neglect or lack of love within the home. She stressed that doctors should prepare families to handle mental illness because many times the latter feared the unknown or even trivialized it. She gave examples of a parent blaming herself for a mental illness she did not understand, "*Li devo accontentare di più, li devo dare più cose,*" [I have to love them more, I have to buy them more things], as well as parents who were so afraid that their children would stab them at night that they locked their doors before going to sleep.

When asked if users revealed their diagnoses to their friends, family or colleagues or if they tended to keep them hidden, professional 2 was of the opinion that users revealed their conditions because many of them knew that they were sick and needed help. She believed that patients tended to be proactive about seeking treatment, which went against what the majority of the general population believed. However, she did say that parents required an adjustment period that was often very painful and difficult because they had to come to terms with accepting that they had a child with a psychiatric disorder. Lending a different perspective to familial relationships, professional 5 recounted a story of a couple who came to a suicide group therapy and while the wife spoke about wanting to die, her husband was in the dark and had no idea of her struggles. Thus, mental illness was sometimes kept a secret even in the most intimate relationships.

However, time fostered some progress, as users' tendency to hide their conditions is now less than before (professional 6). The decision to reveal one's condition was linked to various factors. Professional 3 asserted that users' willingness to reveal their diagnosis depended upon what type of diagnosis they received. Professionals 10 and 11 were also of the same opinion, with the former stating that those who had a problem for more time could speak about it more calmly, while those who were at the beginning of their journey either did not recognize the extent of the disease or did not talk about it due to shame.

Professional 11 explained that the answer was subjective, much like revealing a diagnosis depended on both the type of patient and the type of diagnosis. She made sure to note that the reason for keeping the diagnosis a secret was not always shame or fear, as some people were just private individuals who would not even reveal physical problems.

Professional 12 believed that people disclosed their illness for one of two reasons—trust that their friend, significant other or employer would understand and accept them or as a defense mechanism, especially for young people to attack and provoke those who rejected them. In her opinion, those who kept their mental health condition private were usually older individuals or those whose disorders were mild and under control. Thus, if someone's problem did not significantly interfere with his or her day-to-day activities, that person was more likely to keep it private.

As opposed to the other opinions, professional 10 asserted that she had not heard of instances of discrimination, but maybe it was because those with extremely severe disorders did not even recognize others' prejudice. She stated, "*Non ho sentito di persone che si lamentano per grosse ingiustizie o perché comunque sono state discriminate... insomma, la gente non è così feroce, così cattiva*" [I have not heard people lamenting any

gross injustices or lamenting having been discriminated against...overall, people are not that ferocious or that mean-spirited]. This answer was in line with the rest of her interview, in which she focused on institutional issues such as finances, poor location of the CSM and lack of public transportation, rather than focusing on patient qualms. However, she did list discriminatory attitudes on the part of the non-medical staff at the ASL (which also held the CSM), such as those who worked in the legal medicine department, explaining that they did not understand what mental health professionals did nor did they wish to inform themselves on the topic. They tolerated them but did not actually like them, so the CSM has had to fight to remain in the facility when others tried to force them elsewhere. For example, whenever there was a clamor or disorderly noise, ASL workers immediately thought that a patient in psychiatry was the cause because of their belief that “*sta nella sua natura questo problema*” [this problem is in his or her nature]. She also witnessed nurses in general medicine lose their patience and treat mental health service users badly when they ask for directions in the center.

Like her, professional 11 did not know of any discrimination faced by her patients, either in the public hospital or in her private practice. However, when asked how she would describe the general behavior of Italian society towards people with psychiatric disorders, she admitted to the presence of stigma, albeit hesitantly, “*Ma, diciamo che forse ancora è presente lo stigma della malattia mentale ma sicuramente è meno rispetto che in passato. Forse da volta c’è anche una sottovalutazione di quella che è la sofferenza mentale rispetto per esempio alla sofferenza fisica*” [Well, let’s say that maybe there is still a stigma present against mental illness, but it is surely less than in the

past. Perhaps sometimes there is also an undervaluing of mental health suffering with respect to physical suffering, for example].

To give the professionals the opportunity to clearly state their opinions on the effects of Italian attitudes on mental health, the researcher asked them to what degree they perceived society to accept individuals with psychiatric disorders. Interestingly enough, some professionals failed to answer the question and instead spoke about the mental health facilities and not society at large. Professional 5 responded by saying that social workers were available to patients and that public healthcare services were free for citizens, so if they were willing to seek treatment, they could do so. Similarly, professional 6 spoke about how her ASL had so many initiatives for integration. In her opinion, Rome is a privileged city because as opposed to small towns, it has mental healthcare options available for those who need them.

Actually focusing on the question at hand, professional 9 believed that those with mental illness were not really accepted by the community because it was still very difficult for them to find employment. Without a job, their role within society remained ill defined, and they did not know where they fit in. Flipping the blame a little, she said, *“In questo senso, certo che sono discriminati, ma è la loro stessa malattia che non li permette di avere quella capacità di trovarsi un lavoro, di fare delle cose”* [In this sense, they are discriminated against, but it is their illness itself that prevents them from having the capacity to find themselves a job and to do things]. Although mental illness can certainly reduce individuals’ employability in some fields, her answer suggested that she was absolving society of its role in failing to provide jobs to individuals struggling with mental illness, while blaming the illness for incapacitating the individual from

functioning within society. This placement of blame was problematic because this very thinking caused people to believe that individuals struggling with mental health problems were lesser than other individuals.

Professional 10 clearly stated that people with mental illness were not integrated into society but perhaps because the facilities in place did not allow them to be. Always one to focus on the institutional errors, she recounted how in all of her life, she had only seen three or four people with disability support for their psychiatric problems receive a protected job. Aside from them, no others were called off of the special job placement list with job offers. She then said that she did not know if the problem lay in the way the lists were organized or in the lack of motivation of the individuals because their disability checks automatically guaranteed them a minimum income. Another point she brought up was the possible lack of support networks outside of the mental health centers, which would make it difficult to look for a job. When asked as a follow-up question whether she believed that discrimination existed or not in society, she responded that she sincerely did not believe it existed because she had never heard anyone speak about it. This rationale was shocking, but if a mental health professional could think this way, a citizen uninformed on mental health issues could easily think the same. Just because one does not personally come into contact with injustice does not mean that injustice does not exist. Professional 11 gave a more realistic portrayal of the situation, saying that those suffering from chronic pathologies that render them disabled were not very integrated in society because even the day centers designated to taking them in were not favorable facilities for fostering integration within the rest of society, in terms of employment. She mentioned that without working, prior service users were not integrated and were left to

themselves. Other patients, however, with mood disorders or milder conditions managed to integrate themselves.

Expanding upon the issue of type of illness, when asked if the opportunity for recovery and integration depended upon the type of diagnosis received, professional 2 made it a point to note—twice—that recovery was never total, “*La malattia mentale non si guarisce. Ne cerchiamo un percorso riabilitativo curativo non totale. La malattia mentale non si guarisce*” [Mental illness is not curable. We look for a rehabilitative treatment plan that is not total. Mental illness is not curable]. This belief matched up with just 7 of the members in the general population who also said mental illness was not curable. Interviewing a professional with this opinion revealed that in the mental health field, intentions are not always to fix a problem, but rather to help someone live with it, “*Risuciamo a dargli al meno una possibilità di una vita decente*” (professional 2). However, the use of the word “*decente*” rather than even a basic positive word like “good”, suggested possible limitations placed upon patients’ chances of thriving post-treatment, whether due to the illness or to the realities of the society in which they live.

An important aspect of investigating mental health stigma in Italy was to understand how Basaglia’s Law, or Law 180, had influenced the mental health system. Thus, the researcher sought to determine whether this law positively altered Italians’ mentality towards mental illness and to determine what the limitations, if any, of the law may be. In an emotional, passionate account, professional 2 spoke highly of Basaglia’s accomplishments:

Basaglia è stato per me un grande perché ha ridato questa dignità alla persona chi nessun'altra persona si sia confrontata con un problema così grande—quello della malattia mentale. È come se ognuno di noi dicesse, “Ma che ci fa questo sulla terra?” Invece, Basaglia, no. Ha voluto credere...il pubblico, ci ha messo

molti anni [...] Siamo in 2012 e la gente li tiene un po' messi da parte. La Legge 180—i manicomi chiusi. Si è arrivata una dignità all'uomo.

[Basaglia was one of the greats for me because he gave back dignity to the person when no other person confronted this large problem—that of mental illness. It is as though every one of us said, “But, what are they doing on this earth?” Instead, Basaglia did not. He wanted to believe...[for] the general public, it took many years [...] We are in 2012, and people still keep [those with mental illness] at arm's length. Law 180—psychiatric institutions closed down. Dignity arrived to man.]

As for professional 1, he did not directly respond to the question of Basaglia's power to shift society's thinking, but he did touch upon the practical changes to the system once mental asylums were closed down. Even thirty-five years after this law, he believed that only a few patients received good quality care because “structure and care are linked,” and the existent facilities did not permit effective long-term treatment for patients. When they completed their treatment, users often had no place to live and no further options for treatment. Therefore, although Basaglia took a moral stance that others were unwilling to take, the full effects of his law are yet to be seen. This fact gives credence to the thought that laws do not change society—society changes society.

Professional 3 had a more positive view on the matter, insisting that Basaglia changed the culture with his law, although it took years to do so. The new therapeutic treatments and drugs that emerged helped Basaglia's Law because they allowed for a new level of compliance to treatment, which was fundamental. Nonetheless, professional 3 also believed that the law could be improved upon to fit to today's climate. As professional 5 explained, it takes time for any revolutionary law to take effect. She expressed doubt about if Basaglia's vision would come to complete fruition, but she still acknowledged some improvement, “*Stare nella complessità una cosa vuol dire anche*

non raggiungerla mai nella perfezione” [Being complex also means not ever reaching perfection]. Likewise, professional 4 said that the law certainly changed the public’s perception, as Italians were more sensitive to mental illness with respect to the past. Although more should be done, it had not been possible due to the lack of enough facilities to receive patients. This lack of facilities mentioned most likely referred to the lack of adequate secondary level facilities for users to access in the case of needing prolonged treatment for more severe disorders.

With a more negative opinion than professional 4, professional 8 asserted that a change in society’s attitude had not yet occurred. The law created a figurative hole because it was not implemented all the way through to create the facilities intended to receive patients who were removed from institutions. Professional 10 expressed the same complaint, explaining that people with mental illness who lived with their families often needed professional help in order to get better, and necessary facilities did not exist to assist them. So, even though the law was wonderful in and of itself, those who could not stay with their families for one reason or another ended up in a clinic that was a mini asylum because “*oltre all’ambulatorio e il centro diurno, il territorio che è grande, il controllo non c’è*” [other than the ambulatory center and the day center I this large region, there are not home visits]. Without these home visits, there was no concrete way of knowing how patients were progressing during their recovery period, what they were doing on a daily basis and what further support they needed in the context of how they actually lived. In a nutshell, there were no real limits in the idea of Basaglia’s Law; rather, the limitations existed in its application (professional 12). In professional 12’s opinion, Basaglia’s idea was to cure mental illness through the community, not only

within the community, which was a moment of great civility. Thus, the community was supposed to help those with mental illness just as those with mental illness were supposed to help the community. Being from Friuli Venezia Giulia, where community networks were extremely tight and parents often began to work in mental health centers, he believed this model could be replicated elsewhere but it was difficult to do so everywhere in Italy.

Professional 6 was able to recount how things were before 1978 versus now. A child when the Santa Maria della Pietà mental health institution closed down, she described that the impact was extremely harsh because most people, other than those in the region of Lazio, lived far away from the institution. So once people with mental illness were reintroduced into the community, it was very difficult for them and for the community to even understand what their relationship should be. Now, however, she believed that society had matured to treat those with mental illness better, though not as well as they should. Professional 7 also spoke of a similar improvement, judging that the law worked because it closed down effective prisons, where people were left to themselves after undergoing electroshock sessions. The law raised awareness among Italians and made the idea of mental illness less terrible. People began to understand that people with mental illness could be cured, could improve and were only crazy or violent when abandoned and isolated. Moreover, she explained that many of the homeless people outside the train station Termini were ex-patients of mental institutions, who never had the support to make something of their lives. Many of their families were still looking for these elderly individuals, so the mental health system did not properly account for them. In her opinion, asylums were the worst of the worst, even institutionalizing people with

Down syndrome and mental retardation along with those with psychiatric disorders, so Basaglia's Law undoubtedly humanized these people, "*Cioè un idiota può riconoscere il valore di quello che è stato fatto e di quello che c'era. Perché la memoria storica, uno deve averla*" [Even an idiot can recognize the value of what was done and what used to exist because one must have historical memory].

This issue of historical memory was integral in determining whether people appreciated the changes made by Basaglia. In professional 9's opinion, the perception of Italians had changed because now people have to care to some degree about those with psychiatric disorders because they are their family members, friends and neighbors. All around they have more close, daily contact with people with mental illness, which forces them to acknowledge it. Professional 11 agreed that with the reform, people could no longer ghettoize mental illness. Like many other professionals, she believed that Basaglia's intentions to introduce the acceptance of mental illness within the society were only partially executed. Moreover, activities and situations to integrate mental illness awareness throughout the general population were not enacted. So, in the end, once asylums shut down, psychiatric patients simply returned home or in more serious cases, they never returned. When asked whether the level of societal fear had increased or decreased since the closure of institutions, she responded that she could not know how it was before, but now people were not stigmatized against simply by virtue of having a psychiatric disorder because the population's knowledge on the topic had increased.

The whole aim of this research was first to identify a problem and then to propose a solution. Therefore, in order to ascertain what steps were needed to reduce mental health stigma, the researcher asked the professionals what current measures were being

taken in Rome and Italy to reduce discrimination against mental illness. The follow up question inquired into what personal suggestions they had to reduce stigma. Professional 2, who had described *Auto Mutuo Aiuto*, maintained that there were so many publicity and awareness programs, as well as roundtable meetings on the topic. However, society itself was sick, in the sense that it refused to do what was needed to reduce stigma. She asserted that just as homosexual people exist and have to be accepted, accepting those with mental health problems is not the job of a single person, but it needs to be shared by the rest of humanity. Her suggestion to fix the problem was the distribution of more information, as people were too poorly informed on mental illness. Moreover, more public campaigns were needed. In contrast, professional 1 did not believe that more campaigns were needed because acceptance should be an organic process, “If you impose people to diminish the attitudes against mental illness, it could risk increasing the stigma.” Thus, only through personal contact and interaction could the problem be solved, in his opinion. As for professional 9, she stuck to her belief in financing mental health facilities to empower them and to allow them to spend more funds on the small group of people with severe disorders who did not respond well to short-term treatment in ambulatory care. Moreover, she noted that poverty and mental illness were often linked, so communal social services, such as daily assistance and housing assistance, required strengthening in order to facilitate social integration. In her opinion, targeting this minority group was paramount because when its members were forced to be roam the streets while also dealing with severe mental illness because they were not supported in their efforts to find jobs or housing, they provoked stigmatizing views from others.

As for professional 3, his wording made it difficult to determine if he believed Italian society had some projects in the works to reduce stigma. He claimed that culture and media were undoubtedly working to minimize stigma against the mental health patient. He asserted that through media, one could reduce stigma because nothing was more efficient than talking about the problem. His belief was that by broaching the topic through the media and protests, society could combat the feeling of isolation that those with mental illness face. However, he made no mention of the frequently erroneous information provided by the media. Professional 4 agreed with the assessment that information was key, saying that although patients still felt shame about admitting their problems, there was much more information available compared to the past. For example, the professors associated with the Sant'Andrea Hospital have an anti-stigma association, through which they work diligently to reduce shame and stigma towards psychiatric disorders. Professional 4 suggested reducing stigma by publicizing mental illness more, in the same way that alcohol prevention and the movement opposing violence against women are publicized to society. Thinking more along the lines of the individual, professional 5 mused over her answer for a long time, and then hesitantly suggested the need to be curious and not afraid. If people recognized that they could learn something from everyone, especially those with psychiatric disorders, they would be more inclined to talk to them and break down barriers. Additionally, by involving the family to prepare a home to welcome their loved ones struggling with mental illness, society could arrive at a point where the fundamental problem of stigma would not exist.

Like at Sant'Andrea, the psychiatry department at Sant'Eugenio also holds anti-stigma meetings, posters and advertising to decrease stigma (professional 6). Moreover,

popular national talk shows on television interview people who suffered and recovered from very serious psychiatric disorders in order to allow them to tell their stories and show viewers they are not the monsters that people assume they are (professional 6). Although she had not seen the shows herself, professional 6 affirmed that they have had a positive impact on the people she has spoken to who watch them. In terms of her own personal suggestions, she asserted that her friends, collaborators, colleagues and all the workers in the department engaged others in dialogue at every occasion. For example, when she is riding the bus and she hears someone refer to a mentally ill individual as a crazy person who would be better off locked up, she speaks up at the moment to dispel this negative type of thinking. Moreover, she mentioned the importance of teaching children not to point at people with mental health problems and to teach them in elementary school that having a mental health problem does not make one ugly or bad. Thus, the best way to reduce stigma for her was through taking up the daily responsibility to promote a different culture, not just through ephemeral television programs or singular initiatives. Also focusing on childhood education, professional 8 listed pre-scholastic and scholastic education as the key to reducing stigma. As a neurologist, he spoke of psychiatric neurology as the key frontier upon which to link the environment with the mind, the psyche and the brain. Investigating how the environment modifies neurotransmission and the development of the nervous system could lead to great steps towards progress. In terms of measures currently taken, professional 8 stated that the Italian Society of Neurology and international organizations like the American Society of Neurology have held global awareness campaigns for the past three years. Also, in March

of 2012, the ASL opened up a neurophysiology laboratory for scholars to begin to give a different message about what the brain is.

In contrast to professional 8, professional 11 declared that there were no anti-stigma campaigns in Italy. She asserted that the campaigns that did exist were campaigns for the prevention of certain types of disorders, such as campaigns directed towards youth against substance abuse or eating disorders. Her suggestion for reducing stigma was increasing the possibility of social integration within both the employment and leisure contexts. Due to her previous assessment of campaigns, she expressed her distrust in the potential of success of stigma reduction based on campaigns in and of themselves. As for professional 12, she mentioned the existence of many anti-stigma programs for youth, as well as anti-stigma program for the general public conducted via pamphlets, brochures, televised information and interviews about mental health stigma conducted by the *Istituto Superiore di Sanità* [Higher Health Institute]. Given that she listed so many sources dedicated to reducing stigma while other professionals could imply that the sources were not widespread enough to come to everyone's attention. Reflecting on her work with youth, she asserted that providing information early to children was without a doubt the best avenue to reduce stigma.

Therefore, from leading by example to relying on personal curiosity to promoting publicity campaigns to reconfiguring the structure of the mental health system to targeting childhood education, professionals provided divergent suggestions as to how to attack the problem of stigma. These suggestions should be taken seriously in order to move forward towards guaranteeing the rights of those with mental illness to enjoy equal access to opportunities within their communities.

Comparative Discussion of Both Studies

Conducting two separate studies with two slightly different methodologies in two different countries and two different languages was definitely challenging. While Chile and Italy share commonalities, namely religion and similar gender norms, Arica and Rome are extremely different in terms of physical size, population size, demographics, economic resources, language spoken, global influence and history with mental health advocacy. Therefore, it is necessary to note the limitations of transferability across cities and contexts. Moreover, it is important to note that different questions were included in both studies to cater to the population at hand, such as including questions about Franco Basaglia in the Italian population and adding a civil rights bent to the Italian study to improve upon the Chilean study. Also, Aricans were asked to list mental health centers they knew because of the limited number of them available in the small city, but due to the large size of Rome, the subjects were not asked to list individual centers. Looking back, a valuable question would have been to ask subjects to list types of facilities one could access to receive mental health treatment. Comparing the two studies, however, held immense value, as it permitted insight to a broad range of difficulties that surround mental health systems and to how different types of societies can broach these problems effectively.

Comprehending the history and current culture of a society before entering it is crucial because it provides the researcher with the necessary background information to analyze the research participants' answers thoroughly. Unfortunately, the Chilean study did not investigate the role of Pinochet in contributing to the current state of mental

illness of Chileans, which could have provided an additional layer of complexity to the collected results. Thus, after that study, changes were made to the methodology in order to gain increased qualitative information from the Italian study. In Arica, including a larger sample of 131 individuals allowed the researcher to get a more comprehensive view of what numerous citizens opined about mental illness. In the interest of time, the methodology was constructed as a survey with significantly more closed and categorical questions than open questions. A drawback to this method was that subjects did not have the opportunity to elaborate and provide more information in narrative-type responses. Their concise answers did furnish an important, general scope of people's perceptions, which was the original intention, but when approaching the second study, the researcher decided to focus more on the individual rather than solely on the collective.

Therefore, a smaller sample size was obtained and participants received both a survey and an interview in order to express their opinions in different forms. By having free reign to respond to open-ended questions, the subjects revealed more profound information than what would have otherwise have been collected from closed questions. Additionally, the researcher was able to engage in a dialogue with them, depending upon how they steered the conversation. No one method was necessarily better than the other, but both served to reveal different types of information about mental health stigma. Importantly, the more qualitative nature of the study in Rome allowed the researcher to analyze the delivery of the language and not just the words themselves. Therefore, unusually long pauses before responding, laughter during a response or stumbling over one's words all exposed underlying emotions of hesitancy, amusement or discomfort, respectively, about answering the specific question. These reactions added to judgment of

apparent stigma.

Continuing along the lines of language, conducting foreign language studies inevitably introduces definitional and conceptual limitations in how the researcher frames certain questions. Some of these limitations have already been addressed throughout the paper, but restating them here serves to clarify them in one concise location. To tackle definitional limitations first, in the Chilean study, the use of “*conocer*” when asking subjects which mental health centers they knew might have misled subjects. In many situations, “*conocer*” implies knowledge of something through personal experience. Thus, some of the subjects who did not list any mental health centers may have refrained from doing so because they had not personally used any of the centers. Similarly, the use of “*visitar*” when inquiring whether anyone had sought treatment at a mental health center, was not specific enough to rule out visiting a mental health center to visit a patient, rather than accessing one for treatment. Furthermore, asking the subjects whether other segments of the population, in addition to gender, tended to have proportionally higher rates of mental illness was troubling for many subjects, as the use of the word “*segmentos*” was not one they felt fit with the context of the question. Thus, those questions were changed to be more precise in the Italian study. Italian subjects were asked whether certain groups of people in society suffered more from mental illness and if they had ever visited a mental health center for treatment. However, the use of “*centro di salute mentale*” posed an additional problem because in Italy, that term represents a very specific type of mental health center, while the researcher sought to know whether the subjects had seen any mental health professional in general. Also, the use of “*imprevedibili*” in the Italian survey to ascertain subjects’ opinions on whether people

with psychiatric disorders were unpredictable or not was not a completely accurate translation because in Italian, “*imprevedibile*” connotes something slightly different from the English “unpredictable”.

In terms of conceptual limitations in the research, the categorization of the level of education in both studies posed a slight problem. In the United States, a clear distinction exists between undergraduate studies and graduate studies. However, in Europe and South America (as well as in much of the rest of the world), students attend university and graduate with professional degrees. Therefore, the study included “*universidad/università*” and “*postgrado/post-laurea*” to replicate that distinction. Conceptually, however, it is confusing to separate the two in terms of ascertaining the equivalent degree level in the United States. If one attends university and can become a doctor or lawyer at its conclusion, he or she has technically attained a level of education considered to be graduate-level in the U.S. Yet, graduate studies in the U.S. are referred to as post-graduate studies in Europe and South America, not university level. Finally, in both studies, the use of “*bastante aceptadas*” and “*abbastanza accettate*” in the categorical question to determine the perceived societal level of acceptance of mental illness was misleading because the researcher believed that those terms were more positivity than “*aceptadas*” and “*accettate*”. The researcher knew that “*bastante/abbastanza*” meant “rather/fairly”, but the glitch occurred in understanding the English denotation of “rather.” “Rather/fairly accepted” indicate a lower level of acceptance than baseline “accepted,” thus the order in which they were placed in the scale of acceptance was incorrect. “Rather accepted” should have been presented following “very accepted” and “accepted”, rather than in between the two.

Aside from the above limitations, the research study divulged much significant information on mental health stigma. Both studies found that subjects acknowledged the importance of mental health in theory, but they did not necessarily take care of their mental health. When discussing barriers to accessing mental health centers, both general population samples cited ignorance of having a mental health condition as the foremost reason. This choice is telling as it signifies that people do not have enough information to know when they are sick and when they are healthy. Knowledge is power, so its transmission is paramount. In both samples, the most frequently listed sources of information were television, Internet and newspaper, with the Arican sample listing “radio” fourth and the Italian sample listing “friends” fourth. This heavy reliance on the media for information already suggests the first area to target in order to improve the quality of information divulged to the population and to reduce mental health stigma.

In order to promote mental health in the community, the media must be modified. Mass media promotes the image of mentally ill individuals as incomprehensible, dangerous and incurable, and in sensationalized newspaper articles, psychiatric patients are presented as protagonists of crimes, which is ethically wrong (Piccione 2012). As Piccione asserts, to modify societal attitudes, effective knowledge must be provided about how to maintain one's own mental health (2012). In their 2004 review of studies published in the previous decade on how mental illness was portrayed in the media, how those images influenced individuals' knowledge, attitudes and behaviors towards mental illness and how the media could use its power to reduce mental illness stigma, Stout, Villegas and Jennings explored an extremely important factor in the propagation of stigma. One group of featured researchers was Gerbner et al., who explained the

fundamental reason why this study was important, “Cultivation theory suggests that heavy exposure to consistent and recurrent messages on television will ‘reiterate, confirm and nourish’ values and shape perceptions of social reality to conform to those presented on television (as cited in Stout et al., 2004, p.49). Unfortunately, televised messages reach children while they are young and impressionable, such as fictional films that portray characters with mental illness as frightening and television programs for children 10 years old and younger that were found to use the terms “crazy”, “mad” and “losing your mind” 46% of the time (Stout et al. 2004). Since media representations warp people’s perspective of real life when they “consistently link portrayal of people with mental illness and violent behavior to a degree greater than the real world association,” the media as the main source of information for the Chilean and Italian subjects underlines the urgency of taking measures against stigma (Wahl 1992, as cited in Stout et al. 2004).

Apart from sources of information, when listing the psychiatric disorders they knew, both general population samples listed schizophrenia and depression most frequently, demonstrating the similar perception of the illnesses as most representative of mental illness. Both samples generally agreed that both genders were equally susceptible to mental illnesses, but when describing other groups in the population that tended to experience these illnesses more, the Chilean sample overwhelmingly believed that there was no particular group, but of the groups that were listed, the most frequent one was “poor people”. In contrast, the Italian sample listed “weak people” first followed by “none”. This difference in responses suggested a greater understanding amongst Chileans than amongst Italians of mental illness’s ability to attack people indeterminately.

However, in the Italian surveys, subjects expressed their belief in the ability of mental illness to strike any person. Finally, the key question in both studies targeted the perceived level of acceptance of those with mental illness by society. In Arica, the greatest responses were “barely accepted” and “not accepted,” while the most frequently chosen responses in Rome were “barely accepted” and “rather accepted”. Although subjects’ understanding of “*bastante aceptadas/abbastanza accettate*” could not be determined, given their erroneous placement in the list of categories, the overwhelming selection of “barely accepted” speaks volumes to the negativity that surrounds mental illness in both societies.

Given the multiple similarities between perceived public perceptions in both sample groups, discerning tangible differences between the two mental health systems were left to the mental health professionals. By virtue of only five professionals being interviewed in Arica versus twelve in Rome, more information was gleaned from the professionals in the second study. Different types of information were procured due to the job descriptions of the professionals. In Arica, the professionals included one occupational therapist (Pérez), one social worker (Varas), one psychiatrist (Osorio) and two psychologists (Quiroz & Acosta). In Rome, the professionals included psychologists, psychiatrists, psychiatric nurses and psychotherapists, but no occupational therapist or social worker. The inclusion of the occupational therapist and social worker in the first study added important insight into the relationship between service users and professionals who were highly involved in their daily lives. Because Pérez’s job description included assuring that service users know how to budget their money, how to use transportation, how to take their medication, how to complete daily activities like

bathing and dressing themselves, and how to succeed in school or look for a job, she offered much insight into the day-to-day activities that caused people with mental illness to struggle. Likewise, Varas's work within the community provided similar information, as she conducted house visits, assured patients' stability in various aspects of their lives and gave them social and socioeconomic advice.

As a whole, the professionals in Arica provided specific examples of discrimination against mental health on all levels. They all explained how the lack of adequate funding prevented them from conducting all of the programs they would like to conduct for their service users. Also, they mentioned lack of human and structural resources, just as the professionals in Italy did. However, there was an overwhelming emphasis on the lack of funds by the mental health professionals in Italy, which also contributed to inadequate secondary-level facilities for patients with more severe disorders. Moreover, professionals from both studies mentioned bureaucracy and lack of time to complete all tasks as additional limitations to the ideal management of their facilities. In both countries, accessing public healthcare is free, and many mental health services are also free of charge. An important difference between both studies, however, is that the professionals interviewed from Chile all worked in secondary care facilities, except for Ps. Acosta, and all of the professionals in Italy worked in primary care facilities, except for professionals 1 and 2. Additionally, no professionals from the private sector were included in the first study, which curtailed commentary about programming opportunities in private facilities. Another unfortunate difference between the two studies is that no social worker was interviewed from Italy. Having the point of view of a social worker adds to the information obtained because social workers spend a significant

portion of their time with users outside of the service, whereas psychologists and psychiatrists are usually confined to seeing patients within the facility.

A gaping deficit in the Italian mental health care facilities was the lack of emphasis on community outreach. Most of the professionals recognized a lack of information on the community's part, yet they did not push for the incorporation of community-oriented programs about mental health in their facilities. While the professionals in Chile emphasized the lack of community knowledge and acceptance of mental illness as key problems, the Italian professionals, as a whole, placed greater emphasis on the lack of employment opportunities for individuals with mental illness. Thus, they held up employment as the key to social integration. Also, they focused much more on structural deficiencies, such as the lack of secondary-level care facilities in the aftermath of Basaglia's Law, than did Chilean professionals, probably because the Arican population is smaller and the available services have not yet been overwhelmed by patient demand. Importantly, although all the Italian professionals praised the theoretical merits of Basaglia's Law, they also all pointed out the flaws in its practical applications.

Finally, in terms of suggestions to decrease mental health stigma, all of the Chilean professionals focused on community outreach and education of some kind. They truly believed in the impact that informing the community could have on the fight against stigma. However, not many professionals in Italy mentioned purposeful education programs. Many claimed that either unforced personal interactions with people with mental illness or daily efforts to correct occurrences of stigma would be most effective. Others relied on the media or public campaigns to make a change. And, in the same bent as the rest of their interviews, they repeatedly highlighted the need for increased financial

contributions to mental health facilities and social services, such as housing assistance, to combat stigma. Only two professionals recommended educating the youth as an effective manner to reduce mental health stigma. Thus, in general, professionals in Chile seemed more prepared and willing to take ownership over venturing out into the community and advocating for change, whereas professionals in Italy wanted change to occur from the top-down or without deliberate, collective action. Their views clarified the types of initiatives from which each society could potentially benefit.

Conclusion

This research study was successful in terms of accomplishing the two sets of general and specific objectives listed for each country. Overall, the research aimed to compare the perceptions of two adult populations towards mental health and illness in Arica, Chile and Rome, Italy. Each study was conducted with slightly different aims, however, so each had a separate set of objectives. As a result, each subject pool's range of perceptions had to be analyzed through the lens of its society's particular cultural and social relativism.

In Chile, the general objective of the study was to determine the principal factors that influenced the perceptions of adults towards mental illness in Arica. The study brought to light that the subjects depended more upon what they had personally experienced and lived through instead of on official information to learn about mental illness. Throughout the interviews, subjects corroborated their responses with declarations like, "It is what I have seen," "I see as many men as women wandering the

streets” and “I think this due to my personal experience.” The generalizations they made about mental illness was dangerous because they increased the likelihood that someone would project the aggressiveness of one schizophrenic individual he or she encountered onto all people who suffer from psychiatric disorders. Again, subjects were not asked if their personal experiences were influenced by events of Pinochet’s dictatorship, thus the degree to which that dark period in Chilean history still directs people’s opinions today was not determined.

The first specific objective of the same study was to understand how the perceptions of Aricans influenced their valorization of mentally ill individuals. The majority of the sample opined that it was only sometimes easy to distinguish between people who had a mental illness and those who did not, which demonstrated their understanding of the varying degrees of mental illnesses. However, not all of them valued the professional capabilities of people with mental illness because more than a fourth of the participants stated that it was rarely or never possible for people with mental illness to be successful in the workforce. After gathering all the data, the researcher concluded that the Chilean subjects perceived a general failure to accept people with mental illness, as equals with the same potential for leading a prosperous and accomplished life as anyone else.

The second objective of investigating how Aricans’ perceptions affected the way they took care of their mental health was also accomplished. Since the majority of participants affirmed that physical and mental health were equally important, yet they did not take care of their mental health in the same medical terms as they took care of their physical health, they revealed a wariness about admitting one has a mental health

problem. Moreover, many subjects automatically associated mental illness to untreated schizophrenia, and it thus followed that they would be hesitant to access a mental health center that they believed catered solely to people with schizophrenia.

The interviews with the mental health professionals permitted the achievement of the third objective of uncovering mental health professionals' opinions of the ramifications of mental health perceptions and mental healthcare structure on those suffering from mental illness. They also added more specific facts to the general public's broader revelations of sources of mental health stigma, which allowed for the achievement of the fourth objective to identify possible sources of stigma that surrounded mental illness. The professionals explained that mental health service users experienced discrimination from multiple sides, including educational institutions, places of employment, the medical sector, the community and even their own families. Due to the lack of resources to educate the community effectively, this discrimination persists, and it forces many people with mental illness to lead double lives. That is to say, they have to hide their health condition, they feel marginalized from the community and in extreme conditions, they may attempt suicide. Furthermore, professionals consented that scarce funding arrives to the mental health system from national avenues, which also indicates a state-level low regard for the importance of mental health for the country's citizens.

In comparison, the general objective of the study in Italy had different historical nuances, as it was to investigate the perceptions of Italian citizens about mental health and illness, especially in light of Basaglia's revolutionary Law 180. Like in the previous study, subjects claimed that both mental physical health were important, yet they did not take steps to inform themselves about mental health and illness from reliable sources.

They did, however, understand that multiple factors could contribute to mental illness, and the individuals suffering were often not to blame for their condition. Although they mostly believed that mental institutions prior to Basaglia's Law were inhumane prisons, they still acknowledged the prejudices against people with mental illness that exist today.

The first specific objective of the study was to detect differences in perceptions of adults who lived during and after the era of asylums, including how their perceptions influenced their valorization of those with mental illnesses as productive members of society. This study revealed that of the elderly subjects who had witnessed the mental asylums, half thought they were effective structures for treating people with mental illness while the other half rejected this notion. The younger generation was overall more open to accepting those with mental illness and trusting in their capabilities in terms of being able to vote, hold a job, get married and raise children. In fact, the majority of all subjects, irrespective of age, promoted these civil rights as rights that should be upheld for people with mental illness (except adoption). Therefore, hailing from the first country to close down asylums in 1978 did not make these elderly Italian subjects significantly more accepting of people with mental illness. Mental illness remains a topic on which many people are uninformed and have no desire to become informed. However, there is a hope for the future, due to the younger generation's more open-minded attitude.

Secondly, the next specific objective of investigating how Italians' perceptions of mental illness affected the way they took care of their mental health was also achieved. Although subjects claimed to regard mental and physical health equally, less than half of them confirmed doing anything to take care of their mental health. Furthermore, they did not seek information from mental health professionals and believed that most people did

not access mental health care centers when needed. Although their negations of having accessed a mental health care center for treatment could very well be from a lack of necessity, stigma against revealing such information might have played a role. Although they claimed that they would have no problem revealing their mental health condition to somebody should it deteriorate, they still mentioned multiple times that there was a stigma against using those centers.

The interviews with the professionals helped the researcher achieve the third specific objective of uncovering mental health professionals' opinions of the ramifications of mental health perceptions and mental healthcare structure on those suffering from mental illness. Their interviews also allowed for the achievement of the fourth specific objective to identify possible sources of stigma against mental illness in Italy. Although the professionals focused largely on the lack of funding for mental health care facilities, they also explained that Italians were not as informed as they should be about mental illness. The large emphasis on employment discrimination displayed how societal prejudice keeps people with mental illnesses from participating in the workforce and from making traditionally productive contributions to the communities in which they live. This sort of discrimination is the root of much of the marginalization they face, according to professionals. However, marginalization of mental health occurs at all levels, from the family to the allocation of funds for government spending, and the journey to normalizing mental health has been slow and rather inefficient. The professionals all had widely divergent opinions about the correct measures, if any, that should be taken to reduce stigma. These dispersive beliefs suggested a difficult path toward unified action to eliminating stigma at its roots.

The final conclusions were sobering because they revealed that there is still a long way to go before the universal acceptance that “all human beings are born free and equal in dignity and rights” (United Nations, Art. 1 1948). Although many subjects certainly stated that they believed in the equality of all human beings irrespective of their health condition, they still perceived that the majority of others did not think as they did. The results gleaned from both studies revealed some misunderstandings, stereotypes and stigmas about mental illness that exist in Chilean and Italian societies. The general public and professionals alike proposed several avenues from which to tackle these issues, and added to the entire body of results from this investigation, hopefully some positive changes can be made to decrease the stigma against mental illness.

Recommendations

Due to the different levels of attention paid to certain aspects of mental health care in Arica and Rome, each society requires a slightly different set of recommendations. These recommendations to decrease stigma include implications for theory, practice, policy and future research.

The results gleaned from both studies revealed some misunderstandings, stereotypes and stigmas about mental illness that exist in Chilean and Italian societies. In terms of theory and practice, a common recommendation for both countries is to launch an aggressive awareness and education campaign to bring people’s full attention to the often-illegitimate nature of their prejudiced views. Not everyone who holds a stigma is aware just how much his or her view unjustly marginalizes another. Explaining what

mental health is, what mental illness is and how these two sides of the same coin can be broached to ensure the highest quality of wellness for the individual is essential before people can recognize the far-reaching consequences of the stigma they propagate. Moreover, national and local governments, not just anti-stigma organizations, should hold a stake in these campaigns, so that they can reach the greatest number of people possible. Whether they do so through policy changes, increased funding or official written and televised support from prominent leaders, the government must take the step forward so that its people follow suit. It is important not to present these campaigns as jarring backlashes to stigma, but rather, they should serve to both inform and destigmatize in a manner that is as natural as possible. For example, in Chile, well-known celebrities participated in a series of print advertisements and television commercials to speak out against the use of an offensive term to refer to homosexual individuals. People had included the derogatory term as a normal part of their lexicon, so a campaign to halt its use required a constant reminder about why that term was unacceptable without attacking people for using it.

In terms of policy, both countries' governments must take an active stance in shifting the example they set for their people. The neglect of mental health in the healthcare budget already sets the system up for failure. If the government sets aside 5% of the healthcare budget towards mental health, it must follow through with this percentage, especially considering the large percentage of both societies that have experienced mental health problems. With increased national funding, mental health facilities would be better equipped with material, human and structural resources to execute comprehensive programming to treat users within facilities and to track their

progress within the community.

Additionally, many professionals mentioned the role of employment in facilitating social integration. Revising the system of obligatory divulgence of an individual's mental health history before obtaining employment would allow individuals to be judged based on their qualifications for the particular job, rather than on their mental health condition. If users do not have to state their mental health condition in job applications or interviews, but rather, only have to procure approval from their social worker before applying for a certain job, they will be able to work in a capacity that best fits their capabilities. With a job, people with mental illness could derive pride from contributing to the economy like their peers and could build positive relationships with people who would not otherwise interact with them. These relationships could sow the seed for the normalization of contact between people with and without mental illnesses.

Another policy proposal has to do with the government control over public education. Numerous Chilean professionals advocated for formal education of children from primary school throughout their adolescence on the topic of mental health. Therefore, in public schools, the standardization of the curricula to include mental healthcare lessons, along with the distribution of science textbooks that cover this topic would allow for the practical application of a theoretical goal. Children must learn about mental health and illness early enough not to become contaminated later on by biased societal attitudes. Evidently, children are the future, so if an entire generation receives the proper information about mental health, when its members reach adulthood, they will be better equipped to deal with mental illness both in themselves and in others.

Referring back to the issue of funding, especially in Rome, the lack of funding for

public facilities inhibits professionals from executing creative programming to facilitate users' integration into the community. The mental health service users in this city seem much more separated from their communities than do the service users in Arica. None of the professionals in Italy mentioned holding programs with both service users and non-user community members to bring everyone together in a neutral space to learn about each other. Although conferences and roundtable discussions work at times, they often do not draw the very people who need to hear their message most. By following Arica's example of hosting Christmas parties and talent shows for the entire community, where adults and children of all mental health conditions celebrate together, Italians can begin to come into contact with their neighbors who have psychiatric disorders and to see that they are people just like them. Some professionals' suggestions of letting everything happen naturally represent slow-acting processes. It is not every day that one knowingly comes into contact with someone with a mental illness and takes the opportunity to get to know that person. Thus, facilitating these connections would bring a higher chance of success by showing both those with and without mental illness that the other is not as bad as previously thought. Enacting these types of fun, relaxed community activities stands out as an extremely strong recommendation for the Italian mental health centers.

In Chile, professionals struggled with the fact that community members did not know that their facilities existed. In Italy, the widespread, intricate regional network that connects all inhabitants of a certain zone to the healthcare facilities for that zone, the issue is significantly diminished. Thus, in Arica, professionals should use the aforementioned community projects to make themselves more visible to the community. For these efforts to be most successful, the mental health facilities should hold these

celebrations, whether they be a holiday party, a festival or a community barbecue, at a time when people would most likely be available, even if that time falls outside of regular work hours of the professionals. Seeing as so many people use the newspaper as a source of information, these events should definitely be publicized in the paper, and care should be taken initially to avoid emphasizing that the hosts are mental health facilities, in order not to dissuade people from showing up. At these events, there could be informational pamphlets available for pick up by the food table, but they should not be forcibly distributed. In addition to these pamphlets, users could have booklets containing their own writing available to voice their feelings about living with a mental illness in their society. In this way, users could take ownership of their illness and ownership of dissipating the stigma that exists towards them, “Often those with a particular stigma sponsor a publication of some kind which gives voice to shared feelings [...] It is important to stress that in America at least, no matter how small and how badly off a particular stigmatized category is, the viewpoint of its members is likely to be given public presentation of some kind” (Goffman 25).

Considering that community members heavily rely upon the media for their information on mental health, some professionals cited the media as a powerful source to change the course of mental health stigma. However, although the media surely holds this power and influence, the feasibility of eliminating stereotypical representations of people with mental illness from television shows and movies or of balancing out sensationalized stories of homicides by individuals wrought with psychiatric disorder is doubtful. When thinking about the media, it is definitely possible to play television and radio commercials that speak out against stigma, but a complete media overhaul contradicts the

goals of many of these sources. That is to say, it is important to understand “how journalists and other media producers have to balance newsworthiness (which by its own nature dictates a simplistic message) and fairness (which requires some level of complexity) to the subjects of their stories and news reports” before utilizing the media as an effective tool for change (Stout et al. 2004). Thus, if a delicate balance can be struck between the media’s goals and justice for those with mental health problems, maybe positive change could follow.

Finally, recommendations for future research studies can also contribute to this discussion. The foremost recommendation is to conduct a research study to investigate the day-to-day functioning of different mental health centers to identify the available resources, gaps in effective management and other areas that could use improvement. By conducting primary research rather than relying on accounts from professionals, a researcher could compare services in greater depth and determine the transferability of certain programs to different facilities. Additionally, it would be interesting to conduct a community survey asking people why exactly they are reluctant to access treatment centers, with the hope of at least dispelling some misconceptions, such as that of the financial barrier to treatment. The research would then provide recommendations to overcome the barriers found. In another valuable study, the researcher could shadow a mental health professional to see how, where, and with what frequency the facility puts on community activities. If given the opportunity to propose and enact new programs, the researcher could then conduct a longitudinal project to determine the success rate of different types of programs in a particular community setting.

Therefore, from theory to policy to practice to future research, various steps can

be taken to attack the complex injustice that is stigma against mental illness. If more people dedicated themselves to mental studying, dissecting and dispelling mental health and illness stigma, millions of people in need of a better quality of life could actually hope to receive it. Only through knowledge can the chains of ignorance be broken, so curiosity and education are essential to foster change. At the end of it all, the hope is to live in a society where “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” (United Nations, Preamble 1948).

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Appendices

Chile General Population Informed Consent

You are invited to participate in a research study conducted by Nelly Kontchou, a student at Duke University in the United States and a student in the program SIT Chile: Public Health, Traditional Medicine and Community Empowerment.

Project Description and Purpose

I am interested in knowing how Aricans think and feel about mental illness. I am doing this study as a project for SIT Duke University. I hope to write a report that I can turn in for course credit.

What You Are Being Asked To Do

I will ask you questions in a quick 5-minute survey, and I will fill in your answers. None of my questions will ask you to disclose any information that is sensitive, but you can skip any questions you do not want to answer. I would also like to audio record our interview, if you agree. All interview notes and recordings will be used solely for the purposes of this study. After I have transcribed the interview, I will destroy the recordings.

Do You Have To Participate?

You do not have to participate if you do not want to. Whether you decide to complete the survey will not affect any relationships you may have with the SIT Program. Even if you agree to fill out the survey, you can stop at any time.

Your Information Will Be Private

Because I would like to use this information to write a report, I am not asking you to give me your name or any other information that may identify you. All the information I will present will be by groups and in general terms. I will never identify you personally in any way. I will also make an oral presentation. But again, no one will ever know how you answered the survey.

Information about participants' rights

If you have any questions about this study or your rights as a participant in my research, you may contact me at nkontchou@gmail.com or the Academic Director of the SIT program in Chile, Dr. Rossana Testa, at 56-58-252755 or rossana.testa@sit.edu.

If you agree please indicate how you would like to participate in this study, sign “I Agree” and date below.

- I agree to be interviewed.
 I agree to have my interview recorded.

Consent: _____ Date: _____

Chile General Population Survey

Fecha _____
Cuestionario # _____

1. Sexo: a) Hombre b) Mujer
2. Edad: a) 18-29 b) 30-45 c) 46-64 d) 65 o más
3. Estado civil: a) Soltero/a b) Casado/a c) Separado/a d) Divorciado/a e) Viudo/a
4. Nivel de estudios:
- | | | |
|-------------------------|-----------------------------|---------------------------|
| a) Sin escolaridad | b) Básico incompleto | c) Básico completo |
| d) Medio incompleto | e) Medio completo | f) Técnico incompleto |
| g) Técnico completo | h) Universitario incompleto | i) Universitario completo |
| j) Postgrado incompleto | k) Postgrado completo | l) No quiere contestar |
5. ¿Qué previsión de salud tiene Ud.?
- | | | |
|------------------|------------------------------|-------------|
| a) FONASA A | b) FONASA B | c) FONASA C |
| d) FONASA D | e) FONASA, no sabe qué tramo | f) ISAPRE |
| g) Sin previsión | h) No sabe | |
| i) Otra _____ | | |
6. ¿Entre la salud física y la salud mental, cuál considera Ud. más importante?
- | | | |
|--------------------|--------------------|----------|
| a) La salud física | b) La salud mental | c) Ambas |
| d) Ninguna | e) No sabe | |
7. ¿Hace Ud. algo para mantener o mejorar la calidad de su salud mental? (Se puede elegir más de una opción).
- a) Habla de sus preocupaciones con su familia y sus amigos
 - b) Habla con un profesional en salud mental
 - c) Hace ejercicio físico para disminuir el estrés
 - d) Se relaja y descansa
 - e) Trata de evitar drogas y alcohol
 - f) Otro _____
 - g) No cuida su salud mental
- 8) ¿Puede Ud. nombrar algunas enfermedades mentales?
- _____
- _____
- 9) ¿De los centros de salud mental que existen en Arica, puede Ud. nombrar los que conoce?
- _____
- _____

10) ¿Piensa Ud. que estos centros son necesarios para el tratamiento de enfermedades mentales?

- a) Sí b) A veces c) No d) No sabe

11) ¿Piensa Ud. que estos centros son efectivos en el tratamiento de las personas con enfermedades mentales?

- a) Sí b) A veces c) No d) No sabe

12) ¿Ya ha visitado un centro de salud mental en su vida?

- a) Sí b) No

13) ¿Cuáles son las fuentes principales desde las cuáles Ud. recibe información sobre las enfermedades mentales? (Elija todas las opciones que aplican).

- | | | |
|----------------|---------------------------|--------------------------|
| a) El radio | b) La televisión | c) El periódico |
| d) El Internet | e) Su experiencia escolar | f) Su trabajo |
| g) Su familia | h) Sus amigos | i) Los CESFAMs |
| j) Los ESSMAs | k) El hospital | l) Las clínicas privadas |
| m) Otra _____ | | n) Ninguna |

14) ¿Cuáles serían las barreras más importantes en la decisión de no buscar ayuda cuando uno la necesita? (Se puede escoger más de una opción).

- a) Creencia que el problema se resolverá solo
b) Creencia que la persona puede resolver su problema por sí mismo/a
c) Por miedo del diagnóstico
d) Creencia que el tratamiento no ayudará
e) Preocupación de lo que lo demás pensarán
f) Por falta de confianza en el equipo médico
g) Por razones financieras
h) Por falta de tiempo
i) No saber dónde ir para solicitar ayuda
j) No saber que tiene una enfermedad mental
k) No haber suficientes servicios en Arica
l) Otra _____

15) ¿A quiénes cree Ud. que afectan más las enfermedades mentales?

- a) A las mujeres, ¿por qué? _____
b) A los hombres, ¿por qué? _____
c) A ambos, ¿por qué? _____

16) En su opinión, ¿hay otros segmentos de la población que más suelen tener enfermedades mentales?

- a) Sí, ¿cuáles? _____
b) No
c) No sabe

17) ¿Conoce Ud. a alguien con una enfermedad mental? (Se puede elegir más de una opción).

- a) Un/a pariente b) Un/a amigo/a c) Un/a colega d) Un/a vecino/a
e) Otro/a _____ f) No conoce a nadie que tiene un trastorno mental

18) Para Ud., ¿cuán fácil es distinguir a las personas con enfermedad mental?

- a) Muy fácil b) A veces fácil c) Raramente fácil
d) Nunca es fácil

19) ¿Cuán posible es para las personas con enfermedades mentales cumplir las tareas del sector laboral?

- a) Siempre posible b) Frecuentemente posible c) A veces posible
d) Raramente posible e) Nunca posible f) Depende de _____
g) No sabe

20) ¿Cómo piensa Ud. que las personas con enfermedad mental (más severa que el estrés) se perciben en la sociedad chilena?

- a) Muy aceptadas b) Bastante aceptadas c) Aceptadas
d) Poco aceptadas e) No aceptadas f) No sabe

Chile General Population Survey (English)

Date _____
Questionnaire # _____

1. Sex: a) Male b) Female

2. Age: a) 18-29 b) 30-45 c) 46-64 d) 65 or more

3. Status: a) Single b) Married c) Separated d) Divorced e) Widowed

4. Level of Education:

- a) No schooling b) Primary/Middle School Not Completed c) Middle School Completed
d) High School Not Completed e) Completed High School
f) Technical School Not Completed g) Technical School Completed
h) University Not Completed i) University Completed j) Graduate School Not Completed
k) Graduate School Completed l) Do not want to answer

5. What medical insurance provision do you have?

- a) FONASA A b) FONASA B c) FONASA C
d) FONASA D e) FONASA, I don't know which track f) ISAPRE
g) No insurance h) I don't know
i) Other _____

6. Between physical health and mental health, which do you consider to be more

important?

- a) Physical health b) Mental health c) Both d) Neither e) Don't know

7. Do you do something to maintain or improve the quality of your mental health? (You can choose more than one option)

- a) You talk about my concerns with your family and friends
b) You talk with a mental health professional
c) You exercise to reduce stress
d) You relax and rest
e) You try to avoid drugs and alcohol
f) Other _____
g) You do not take care of your mental health

8) Can you name some mental illnesses?

9) Of the mental health centers that exist in Arica, can you name the ones you know?

10) Do you think that these centers are required to treat mental illness?

- a) Yes b) Sometimes c) No d) Do not know

11) Do you think that these centers are effective in treating people with mental illness?

- a) Yes b) Sometimes c) No d) Do not know

12) Have you visited a mental health center in your life?

- a) Yes b) No

13) What are the main sources from which you receive information about mental illness? (Choose all that apply).

- a) Radio b) Television c) The newspaper
d) Internet e) Your school experience f) Your work
g) Your family h) Your friends i) Primary health center
j) Specialized mental health clinic k) hospitals l) Private clinics m) Other _____
n) None

14) What are the most important barriers in the decision not to seek help when you need it? (You can choose more than one)

- a) Belief that the problem will solve itself alone
b) Belief that a person can solve the problem himself / herself
c) For fear of the diagnosis
d) Belief that treatment will not help

- e) Concern about what others will think it
 - f) Lack of confidence in medical team
 - g) For financial reasons
 - h) Due to lack of time
 - i) Due to not knowing where to go for help
 - j) Due to not knowing that you have a mental illness
 - k) Due to the lack of mental health services in Rome
 - l) Other
-

15) Who do you think mental disorders affect the most?

- a) Women, why? _____
- b) Men, why? _____
- c) Both, why? _____

16) In your opinion, are there other segments of the populations that tend to suffer more from mental disorders?

- a) Yes, which ones? _____
- b) No _____
- c) Don't know

17) Do you know anyone with a mental disorder? (You can choose more than one option).

- a) A relative b) A friend c) A colleague d) A neighbor e) Other _____
- f) Do not know anyone who has a mental disorder

18) For you, how easy it is to distinguish people with mental illness?

- a) Very easy b) Sometimes easy c) rarely easy d) It is never easy

19) How possible is it for persons with mental illness to fulfill their tasks in the workforce?

- a) Always possible b) Frequently possible c) Sometimes possible
- d) Rarely possible e) Never possible f) Depends on _____ g) Do not know

20) How do you think people with mental disorders (more severe than stress) feel in Italian society?

- a) Very accepted b) Fairly accepted c) Accepted
- d) Barely accepted e) Not accepted f) Do not know

Chile Select Mental Health Professionals Solicitation E-mails

World Learning  SIT Study Abroad

Sr. David Beltrán
Director del Centro de Salud Remigio Sapunar
La Ilustre Municipalidad de Arica
Presente

Estimado Sr.,

La presente carta tiene por objeto saludarla y presentar a usted a nuestra Institución y en particular a la estudiante **Nelly-Ange Kontchou**, estudiante universitaria Estadounidense que realiza un semestre de estudios de pre-grado en Chile, a través de **World Learning- SIT Study Abroad, en el Programa “Chile: Salud Pública, Medicina Tradicional y Empoderamiento de la Comunidad”**.

WL SIT-Study Abroad, es una reconocida institución de educación Norteamericana que, en el marco de su programa de estudios en el extranjero, profundiza los lazos de intercambio cultural y académico con nuestro país, teniendo entre sus principios básicos; la no discriminación, el respeto y la reciprocidad.

Dentro de las actividades curriculares, nuestros estudiantes realizan un proyecto de estudio independiente, relacionado a los temas del programa, el cual puede desarrollarse en cualquier ciudad de Chile, tanto en el área urbana como rural.

En el caso particular de la estudiante mencionada, ella desea realizar un estudio en el área de la salud mental, para lo cual necesita tener acceso a los pacientes en su centro de salud para realizarles un cuestionario relacionada al tema de su competencia.

Por las razones expuestas y considerando el cargo que su persona enviste, es que solicito a usted, facilite el acceso lo indicado, lo que sin duda apoyará a lograr con éxito los objetivos de esta actividad académica.

Nuestros profundos agradecimientos por el interés en apoyarnos y reciba mis sentimientos de la más alta estima.

Cordialmente se despide de usted,

Rossana Testa S. Ph.D.
Directora Académica
SIT Study Abroad
Programa “Chile: Salud Pública, Medicina Tradicional y
empoderamiento de la Comunidad”
Email: rossana.testa@sit.edu

World Learning  SIT Study Abroad

Sra. Eva Ticona
Enfermera

La Ilustre Municipalidad de Arica
Presente

Estimada Sra.,

La presente carta tiene por objeto saludarla y presentar a usted a nuestra Institución y en particular a la estudiante **Nelly-Ange Kontchou**, estudiante universitaria Estadounidense que realiza un semestre de estudios de pre-grado en Chile, a través de **World Learning- SIT Study Abroad, en el Programa “Chile: Salud Pública, Medicina Tradicional y Empoderamiento de la Comunidad”**.

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Directora Académica
SIT Study Abroad
Programa “Chile: Salud Pública, Medicina Tradicional y
empoderamiento de la Comunidad”
Email: rossana.testa@sit.edu

Chile Mental Health Professionals Informed Consent

You are invited to participate in a research study conducted by Nelly Kontchou, a student at Duke University in the United States and a student in the program SIT Chile: Public Health, Traditional Medicine and Community Empowerment.

Project Description and Purpose

The aim of this study is to identify the main factors that influence the various perceptions of Aricans about mental illness. The purpose of this study is also to teach students the planning, design and implementation of a study and the drafting of a comprehensive report. This report will be turned in to SIT Chile and Duke University for course credit.

You will be asked to answer questions that may help me to achieve the objectives of this study. I would like to take written notes and audio record our interview, if you agree. All interview notes and recordings will be used solely for the purposes of this study. After I have transcribed the interview, I will destroy the recordings.

This interview will last from 1 hour to 1½ hours, depending on your answers. None of my questions will ask you to disclose any information that may be harmful to you, but you can skip any questions you do not want to answer.

Voluntary Participation

Your participation in this project is voluntary, and whether you decide to participate or not will have no bearing on any relationships you may have with Duke University. You can stop the interview at any time. If you decide you want to withdraw your consent, I would still like to use any information I have gathered during the interview. Of course, I would ask for your permission to do this.

Use of Information and Data Collected

As already explained, I will use the information collected to write a report. This report will be submitted to SIT Chile and Duke University in the USA for course credit. I will also conduct an oral presentation summarizing the findings and present it to an academic committee of SIT Chile and other students participating the program.

Information about participants' rights

If you have any questions about this study or your rights as a participant, you may contact me at nkontchou@gmail.com or the Academic Director of the SIT program in Chile, Dr. Rossana Testa, at 56-58-252755 or rossana.testa@sit.edu. To contact the Duke University Institutional Review Board, please contact ors-info@duke.edu.

If you agree please indicate how you would like to participate in this study, and sign and date below.

- I agree to be interviewed.
- I agree to have my interview recorded.
- I agree for my name to be released in the findings of this study.

Signature of Participant: _____ Date _____

Chile Mental Health Professionals Interviews (Spanish)

1. ¿Podría Ud. dar su nombre y posición y explicar cuál es su rol en el equipo de salud mental?
2. ¿Cuántas horas trabaja Ud. por semana?
3. ¿Podría Ud. dar su definición de la salud mental?
4. En su opinión, ¿por qué es importante la salud mental con respecto a la salud integral de una persona?
5. ¿Cuáles son las enfermedades mentales más comunes que ha visto en Arica?

6. ¿Con qué tipo de previsión de salud pueden los ariqueños atenderse en los centros de salud para la salud mental?
7. ¿Cuáles son los beneficios e inconvenientes de tener previsión de salud pública o privada para recibir atención para la salud mental?
8. ¿Cómo se financia el sistema de salud mental, en el nivel nacional y municipal?
9. ¿Qué piensa Ud. de la cantidad de dinero que se dirige a mantener un buen sistema de salud mental?
10. ¿Cómo se financian los programas de salud mental?
11. En su opinión, ¿existen factores que limitan la gestión ideal en la salud mental?
12. ¿Cómo es el vínculo con este centro de salud mental y la atención primaria?
13. En su experiencia, ¿saben los ariqueños acerca de la salud mental?
14. ¿Cuáles son las actitudes de los ariqueños sobre las enfermedades mentales que Ud. ha visto en su posición como profesional en salud mental?
15. ¿Cómo se distribuye la información de salud mental a la comunidad? ¿Es efectiva esta distribución? ¿Por qué?
16. ¿Cuál sería la mejor manera de educar a la comunidad sobre la importancia de la salud mental?
17. ¿Sus pacientes le han contado algo de la discriminación que enfrentan en el día cotidiano?
18. ¿Piensa que existe un estigma sobre la salud mental, o no? ¿Por qué?
19. En general, ¿cómo afecta el estigma a las personas con enfermedades mentales?
20. ¿Qué propone como la manera más efectiva de disminuir el estigma en la sociedad chilena?

Chile Mental Health Professionals Interviews (English)

1. Could you state your name and position and explain your role in the mental health team?
2. How many hours a week do you work?
3. Could you give your definition of mental health?
4. In your opinion, why is mental health important with respect to the overall health of a person?
5. What are the most common mental illnesses you have seen in Arica?
6. With what type of insurance can Aricans be treated in health centers for mental health?
7. What are the pros and cons of having public or private health insurance to receive care mental health?
8. How is the mental health system funded at the national and local levels?
9. What do you think about the amount of money that goes into maintaining a good mental health system?
10. How are mental health programs financed?
11. In your opinion, are there factors that limit ideal management/administration in mental health?
12. How is the communication between this mental health center and primary health care?
13. In your experience, do Aricans know the facts about mental health?
14. What are the attitudes about mental illness of the Aricans who you have encountered in your professional position?

15. How is information about mental health distributed to the community? How effective is this distribution? Why?
16. What is the best way to educate the community about the importance of mental health?
17. Have your patients ever told you about the discrimination they face in everyday life?
18. Do you think there is a stigma about mental health, or not? Why?
19. In general, how does stigma affect people with mental illness?
20. What do you suggest as the most effective way to reduce stigma about mental illness in Italian society?

Italy General Population Survey Informed Consent

You are invited to participate in a research study conducted by Nelly Kontchou, a student at Duke University in the United States, who is studying in the Department of Psychology at the University of Rome—La Sapienza this summer.

Project Description and Purpose

I am interested in discovering how Italians think and feel about mental illness in this study for my honors thesis at Duke University. I hope to write up a final paper for academic credit. You will be asked to respond to some questions that can help me achieve the objectives of this study.

Directions

The following survey requires between 5 and 10 minutes. Please remember to write today's date before beginning. The survey consists of 18 questions requiring a yes/no response. Read the following questions and choose the answer that corresponds most with your opinions. If it is appropriate to explain your answer further, please do so in the indicated space. All of your responses will be used exclusively for the goals of this study.

Voluntary Participation

It is not necessary to participate if you do not wish to. Your participation in this research is voluntary, and it will help me with my academic research.

Confidentiality

As previously explained, I will use the information collected to write a thesis. I am not requesting any name or other personal information that could identify you. All the information that I will present in the thesis and oral presentation will be in general terms. No one will be able to know how you responded to the survey.

Information about participants' rights

If you have any questions about this study or your rights as a participant in my research, you may contact me at nkontchou@gmail.com. To contact the Duke University Institutional Review Board, please contact ors-info@duke.edu.

If you agree please indicate how you would like to participate in this study, sign and date below.

- ___ I agree to fill out this survey to completion.
 ___ I agree for the records to be used by the researcher in scientific publications and public presentations.

Signature of the participant: _____ Date: _____

Italy General Population Survey (Italian)

1-18) Indichi SÌ o NO. Spieghi quando è indicato.

| | | |
|--|----|----|
| È importante avere cura della mia salute mentale così come della mia salute fisica. Per favore, dia una ragione perché: | SÌ | NO |
| Chiunque può avere un problema di salute mentale. Per favore, dia una ragione perché: | SÌ | NO |
| Un membro della famiglia soffre di un disturbo psichiatrico. | SÌ | NO |
| Ho un/a amico/a che soffre di un disturbo psichiatrico. | SÌ | NO |
| Ho un/a collega che soffre di un disturbo psichiatrico. | SÌ | NO |
| Sarebbe difficile per me rapportarmi con qualcuno che soffre di disturbi psichiatrici. Per favore, dia una ragione perché: | SÌ | NO |
| Le persone affette da disturbi psichiatrici sono pericolose. Se risponde sì, per favore spieghi perché: | SÌ | NO |
| Le persone affette da disturbi psichiatrici sono imprevedibili. Se risponde sì, per favore spieghi perché: | SÌ | NO |
| Per la maggior parte, le persone affette da disturbi psichiatrici sono da biasimare per la propria condizione. Se risponde sì, per favore spieghi perché: | SÌ | NO |
| Le persone con disturbi psichiatrici dovrebbero avere gli stessi diritti di voto di chiunque altro. Se risponde no, per favore spieghi perché: | SÌ | NO |
| Le persone con disturbi psichiatrici dovrebbero avere gli stessi diritti di sposarsi come chiunque altro. Se risponde no, per favore spieghi perché: | SÌ | NO |
| Sarei d'accordo se un membro della mia famiglia si sposasse con qualcuno che soffre di un qualche tipo di disturbo psichiatrico. Se risponde no, per favore spieghi perché: | SÌ | NO |
| Le persone con disturbi psichiatrici dovrebbero avere gli stessi diritti di | | |

| | | |
|---|----|----|
| avere figli come chiunque altro. Se risponde no, per favore spieghi perché: | SÌ | NO |
| Le persone con disturbi psichiatrici dovrebbero avere gli stessi diritti di adottare bambini come chiunque altro. Se risponde no, per favore spieghi perché: | SÌ | NO |
| Le persone affette da disturbi psichiatrici possono avere successo negli stessi lavori come le persone comuni. Se risponde no, per favore spieghi perché: | SÌ | NO |
| Se avessi un problema di salute mentale, eviterei di raccontarlo a qualcuno. Se risponde sì, per favore spieghi perché: | SÌ | NO |
| Mi è già capitato di aver visitato un centro di salute mentale per una terapia. | SÌ | NO |
| I servizi di salute mentale comunitari sono più efficaci dei manicomi per la terapia per la malattia mentale. Per favore, dia una ragione perché: | SÌ | NO |

Italy General Population Survey (English)

1-18) Circle YES or NO. Explain your answer where indicated.

| | | |
|--|-----|----|
| It is just as important to take care of my mental health as my physical health. Please give a reason why: | YES | NO |
| Anyone can experience a mental health problem. Please give a reason why: | YES | NO |
| I have a family member with a mental health problem. | YES | NO |
| I have a friend with a mental health problem. | YES | NO |
| I have a colleague with a mental health problem. | YES | NO |
| I would find it hard to relate to someone with mental health problems. Please explain why: | YES | NO |
| People with mental health problems are dangerous. If yes, please explain why: | YES | NO |
| People with mental health problems are unpredictable. If yes, please explain why: | YES | NO |
| For the most part, people with mental health problems are to blame for | YES | NO |

| | |
|--|--------|
| their own condition. If yes, please explain why: | |
| People with mental health problems should have the same rights to vote as anyone else. If no, please explain why: | YES NO |
| People with mental health problems should have the same rights to marry as anyone else. If no, please explain why: | YES NO |
| I would be okay with someone in my family marrying an individual with a mental health problem. If no, please explain why: | YES NO |
| People with mental health problems should have the same rights to bear children as anyone else. If no, please explain why: | YES NO |
| People with mental health problems should have the same rights to adopt children as anyone else. If no, please explain why: | YES NO |
| Mentally ill people can be successful at all the same jobs as the average person. If no, please explain why: | YES NO |
| If I had a mental health problem, I would refrain from telling anyone about it. If yes, please explain why: | YES NO |
| I have visited a mental health center for treatment. | YES NO |
| Community health centers are more effective than mental institutions for treatment of mental illness. Please explain why: | YES NO |

Italy General Population Interview Informed Consent Form

You are invited to participate in a research study conducted by Nelly Kontchou, a student at Duke University in the United States, who is studying in the Department of Psychology at the University of Rome—La Sapienza this summer.

Project Description and Purpose

The objective of this research is to identify the principal factors that influence the different perceptions of Italians on mental illness. The study is part of a more

comprehensive project that looks to compare the intersection of mental health with the societies of Arica, Chile and Rome, Italy. I am interested in knowing how Italians think and feel about mental illness. This thesis will be turned in at Duke University for academic credit, and a copy will be available for your consultation.

You will be asked to respond to questions that can help me achieve the objectives of this study. I would like to take written notes and audio recording during the interview, if you agree. All the notes and recordings will be used exclusively for the goals of this study, and only my advisors in Italy and the U.S. will analyze them. In any case, they will be anonymous. After having analyzed the notes and completed the transcriptions, the recordings will be destroyed.

This interview will last from 10 to 20 minutes, depending upon your responses. You will not be asked to reveal any information that could be detrimental to you at any point in the interview, and you reserve the right to skip over any question you do not wish to answer.

Voluntary Participation

Your participation is voluntary, and your decision to participate or not will not have any bearing on your current or future relations with Duke University. You can stop the interview at any moment. If you decide to rescind your consent, I would like to still use the information collected up to that point, given that you agree.

Use of the data collected

As previously explained, I will use the information collected to write a thesis, which I will defend at Duke University for academic credit. I will also conduct an oral presentation that summarizes the results in front of a thesis committee, but I will not include any names in the thesis. All participants will remain anonymous.

Information about participants' rights

If you have any questions about this study or your rights as a participant in my research, you may contact me at nkontchou@gmail.com. To contact the Duke University Institutional Review Board, please contact ors-info@duke.edu.

If you agree please indicate how you would like to participate in this study, sign and date below.

- I agree to be interviewed.
- I agree to have my interview recorded.
- I agree for the records to be used by the researcher in scientific publications and public presentations.

Signature of the participant: _____ Date: _____

Italy General Population Interview Questions (Italian)

1. Sesso: a) Maschile b) Femminile
2. Et : a) 18-29 b) 30-45 c) 46-64 d) 65 o pi 
3. Stato: a) Celibe/Nubile b) Sposato c) Separato d) Divorziato e) Vedovo
4. Livello d'istruzione:
a) Nessuna scolarizzazione b) Scuola elementare incompiuta c) Scuola elementare
d) Scuola media incompiuta e) Scuola media f) Scuola media superiore incompiuta
g) Scuola media superiore h) Scuola tecnica incompiuta i) Scuola tecnica compiuta
j) Universit  incompiuta k) Laurea l) Formazione post-laurea incompiuta
m) Formazione post-laurea compiuta n) Non voglio rispondere
- 5) Da che parte d'Italia viene?
- 6) Da quanto tempo abita a Roma?
- 7) Tra la salute fisica e la salute mentale, quale considera pi  importante? Perch ?
- 8) Fa qualcosa nella vita quotidiana per occuparsi della sua salute mentale?
- 9) Potrebbe indicare tutti i disturbi psichiatrici che conosce (non necessariamente personalmente)?
- 10) Ha notato qualche differenza nelle caratteristiche personali delle persone affette da disturbi psichiatrici rispetto alla gente non affetta da questi disturbi?
- 11) Che crede che cause questi disturbi?
- 12) Crede che la maggior parte dei disturbi psichiatrici siano curabili? Perch ?
- 13) Ritiene che esistano categorie di persone maggiormente esposte a questi tipi di disturbi?
a) Le donne, perch ?

b) Gli uomini, perch ?

c) Entrambi, perch ?

- 14) Secondo lei, esistono altri gruppi di persone nella societ  che tendono a soffrire di pi  da disturbi psichiatrici? Perch ?

15) Dalle alternative seguenti, quali sono le fonti principali da cui lei riceve informazioni su questi tipi di disturbi? (Scelga anche più alternative).

- a) Radio b) Televisione c) Il giornale d) Internet e) La sua esperienza scolastica
- f) Il suo lavoro g) La sua famiglia h) I suoi amici i) I centri di medicina generale
- j) I centri di salute mentale k) Le campagne pubbliche l) Altro _____ m) Nessuno

16) Cosa pensa riguardo alla qualità e alla quantità delle informazioni erogate al pubblico riguardo la malattia mentale?

17) Ritieni che la maggior parte delle persone che hanno bisogno di terapia psichiatrica vadano a farsi curare? Perché?

18) Quali ritieni possano essere gli ostacoli che possono influenzare la decisione di non chiedere aiuto quando una persona ne ha bisogno? (È possibile scegliere più di una)

- a) La convinzione che il problema si risolverà da solo
- b) La convinzione che una persona può risolvere il problema da sola
- c) Paura della diagnosi
- d) La credenza secondo cui nessun trattamento li aiuterà
- e) La preoccupazione per ciò di gli altri ne penserebbero
- f) La mancanza di fiducia nei medici
- g) Ragioni economiche
- h) Mancanza di tempo
- i) Perché non sanno a chi rivolgersi per chiedere aiuto
- j) Perché non sanno di soffrire di un disturbo psichiatrico
- k) Perché mancano abbastanza servizi di salute mentale a Roma
- l) Altro _____

19) Conosce personalmente qualcuno affetto da disturbo psichiatrico? Se sì, è stato influenzato (lei) in qualche modo nel suo atteggiamento?

20) Conosce la Legge Basaglia? A suo parere, ha provocato un qualche tipo di cambiamento nell'atteggiamento della società italiana verso le persone affette da questi tipi di disturbi?

21) In che misura ritieni che le persone affette da disturbi psichiatrici siano accettate dalla società italiana? Perché?

- a) Molto accettate b) Abbastanza accettate c) Accettate d) Appena accettate e) Non accettate

22) Ritieni che il tipo di disturbo di cui soffre una persona influenzi l'atteggiamento degli altri? Perché?

Italy General Population Interview Questions (English)

1. Sex: a) Male b) Female
2. Age: a) 18-29 b) 30-45 c) 46-64 d) 65 or more
3. Status: a) Single b) Married c) Separated d) Divorced e) Widowed
4. Level of Education:
 - a) No schooling b) Incomplete elementary school c) Complete elementary school
 - d) Incomplete Middle School e) Complete Middle School f) Incomplete High School
 - g) Complete High School h) Incomplete Technical School i) Complete Technical School
 - j) Incomplete University k) Complete University l) Incomplete Post-Graduate School
 - m) Complete Post-Graduate School n) Do not want to answer
- 5) Which part of Italy are you from?
- 6) How long have you lived in Rome?
- 7) Between physical health and mental health, which do you consider to be more important? Why?
- 8) Do you do anything in your daily life to take care of your mental health?
- 9) Could you name all the psychiatric disorders you know (not necessarily personally)?
- 10) Have you observed any differences in the personal characteristics of individuals with these disorders with respect to people without these disorders?
- 11) What do you think causes these disorders?
- 12) Do you think the majority of psychiatric disorders are curable? Why?
- 13) In your opinion, are there certain groups of people who tend to suffer more from mental disorders?
 - a) Women, why?

 - b) Men, why?

 - c) Both, why?

- 14) In your opinion, are there others groups of people within Italian society who tend to suffer more from psychiatric disorders? Why?

15) From the following options, what are the main sources from which you receive information about mental illness? (Choose all that apply).

- a) Radio b) Television c) The newspaper d) Internet e) Your school experience
- f) The workplace g) Your family h) Your friends i) General health center
- j) Specialized mental health clinic k) Public campaigns l) Other _____ m) None

16) What do you think about the type and amount of information available to the public regarding mental illness?

17) Do you believe that most people in need of mental health treatment seek treatment? Why or why not?

18) What do you think could be the obstacles that influence a person's decision not to seek help when that person needs it? (You can choose more than one option).

- a) The belief that the problem will resolve itself
- b) The belief that the person can resolve the problem on his/her own
- c) Fear of the diagnosis
- d) The belief that no treatment will help
- e) Worry about what others may think
- f) Lack of trust in doctors
- g) Economic reasons
- h) Lack of time
- i) Because he/she does not know where to go to receive treatment
- j) Because he/she does not know he/she suffers from a psychiatric disorder
- k) Because there are not enough mental health services in Rome
- l) Other _____

19) Do you personally know anyone with a mental disorder? If so, has your relationship with this individual affected you in any way?

20) Do you know about Basaglia's Law? In your opinion, has it caused any changes in how Italian society views mentally ill individuals?

21) How completely do you think mentally ill individuals are incorporated into society? Why?

- a) Very accepted b) Rather accepted c) Accepted d) Barely accepted e) Not accepted

22) Does this acceptance vary according to the type of mental illness from which a person suffers? Why?

Italy Mental Health Professionals Informed Consent Form (English)

You are invited to participate in a research study conducted by Nelly Kontchou, a student at Duke University in the United States.

Project Description and Purpose

The aim of this study is to identify the main factors that influence the various perceptions of Italians about mental illness. The purpose of this study is also to teach students the planning, design and implementation of a study and the drafting of a comprehensive report. This report will be turned in to Duke University for course credit.

You will be asked to answer questions that may help me to achieve the objectives of this study. I would like to take written notes and audio record our interview, if you agree. All interview notes and recordings will be used solely for the purposes of this study. After I have transcribed the interview, I will destroy the recordings.

This interview will last from 30 minutes to 45 minutes, depending on your answers. None of my questions will ask you to disclose any information that may be harmful to you, but you can skip any questions you do not want to answer.

Voluntary Participation

Your participation in this project is voluntary, and whether you decide to participate or not will have no bearing on any relationships you may have with Duke University. You can stop the interview at any time. If you decide you want to withdraw your consent, I would still like to use any information I have gathered during the interview. Of course, I would ask for your permission to do this.

Use of Information and Data Collected

As already explained, I will use the information collected to write a report. This report will be submitted to Duke University in the USA for course credit. I would also like to do an oral presentation summarizing the findings will be presented to an academic committee of Duke University.

Information about participants' rights

If you have any questions about this study or your rights as a participant, you may contact me at nkontchou@gmail.com. To contact the Duke University Institutional Review Board, please contact ors-info@duke.edu.

If you agree please indicate how you would like to participate in this study, and sign and date below.

- I agree to be interviewed.
- I agree to have my interview recorded.
- I agree for the records to be used by the researcher in scientific publications and public presentations.

Signature of Participant: _____ Date _____

Italy Mental Health Professionals Interview Questions (Italian)

1. Potrebbe indicare il suo nome e posizione professionale e spiegare il suo ruolo nel team di salute mentale?
2. Quante ore alla settimana lavora?
3. Secondo lei, perché è importante la salute mentale rispetto alla salute globale di una persona?
4. Quali sono i disturbi psichiatrici più comuni che ha avuto la possibilità di incontrare durante la sua esperienza a Roma?
5. Qual è la sua opinione in merito alla quantità di finanziamento nazionale e locale che esiste per la ricerca e la terapia per la salute mentale?
6. A suo parere, ci sono fattori specifici che limitano la gestione / amministrazione ideale di questo servizio di salute mentale?
7. Quali sono i vantaggi e gli svantaggi dei diversi tipi di servizi di salute mentale a Roma (in termini dello spazio locale, il numero del personale, i tipi di terapie offerte, ecc.)?
8. Come descriverebbe il rapporto tra questo servizio di salute mentale e gli altri servizi di salute mentale a Roma?
9. Come descriverebbe il rapporto tra questo servizio di salute mentale e la comunità?
10. Secondo la sua esperienza quotidiana, quanto sono informati gli italiani sulla salute mentale?
11. Quali strutture e programmi esistono in questo centro di salute per diffondere l'informazione riguardo alla salute mentale alla comunità? Ritiene siano programmi efficaci?
12. I suoi pazienti hanno mai raccontato esperienze di discriminazione per il loro disturbo psichiatrico che si sono trovati ad affrontare nella vita quotidiana? Ha degli esempi?
13. Se sì, le forme di discriminazione ritiene che varino secondo la diagnosi del paziente?
14. I suoi pazienti parlano della loro diagnosi con amici, familiari, colleghi, ecc. Oppure, c'è la tendenza a tenerla nascosta?
15. Secondo Lei come e quanto sono integrati nella società e comunità romana? Ha degli esempi?
16. Crede che il recupero e l'integrazione dei pazienti dipendano dal tipo di diagnosi fornitagli?
17. C'è qualcosa che si fa ora per ridurre qualsiasi discriminazione contro la malattia mentale a Roma, o nella società italiana in generale?
18. Come descriverebbe la quantità e l'efficacia delle campagne di lotta contro lo stigma della malattia mentale?
19. In che misura ritiene che la legge Basaglia (la chiusura dei manicomi) abbia cambiato la percezione generale del pubblico verso le persone affette da patologie psichiatriche? Quali sono i suoi limiti?
20. Secondo la sua esperienza, quali suggerimenti ha per ridurre lo stigma contro la malattia mentale?

Italy Mental Health Professionals Interview Questions (English)

1. Could you state your name and position and explain your role in the mental health team?
2. How many hours a week do you work?
3. In your opinion, why is mental health important with respect to the overall health of a person?
4. What are the most common mental illnesses you have encountered during your experience in Rome?
5. What do you think about the amount of national and local funding that exists for research and treatment of mental health?
6. In your opinion, are there factors that limit ideal management/administration in mental health?
7. What are the advantages and disadvantages of the different types of mental health services in Rome (in terms of spatial location, number of personnel, type of treatments offered, etc.)?
8. How would you describe the communication between this mental health center and other mental health centers in the city?
9. How would you describe the relationship between your mental health center and the community?
10. From your daily experience, how informed are Italians about mental health and illness?
11. What structures and programs are in place in this health center to promote and diffuse information regarding mental health to the community? Are they effective?
12. Have this center's users ever told you about any discrimination they face in everyday life?
13. If so, do the types of discrimination vary according to the user's diagnosis?
14. Do your patients disclose their diagnosis with friends, family and coworkers, or is there a tendency to keep it hidden?
15. In your opinion, how and to what extent are mentally ill individuals integrated in the society and community in Rome? Can you provide any examples?
16. Do you think recovery and integration of patients depend on the diagnosis given to them?
17. Is there anything currently being done to reduce any discrimination against mental illness in Rome, or in Italian society at large?
18. How would you describe the amount and effectiveness of public campaigns fighting against mental illness stigma?
19. To what extent do you feel like the Basaglia Law has changed public perception towards people suffering from mental illness? What are its limitations?
20. With regards to your experience, what do you suggest as the most effective methods to reduce stigma?