International Journal of Health Sciences
September 2016, Vol. 4, No. 3, pp. 19-26
ISSN: 2372-5060 (Print), 2372-5079 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/ijhs.v4n3a4
URL: https://doi.org/10.15640/ijhs.v4n3a4

Perceived Discrimination and Depressive Disorders in Europe: Individual and Societal Perspectives

Raphaela Stadelmann, MA[1] & Prof. Dr. Nils Mevenkamp[2]

Abstract

Background: Discrimination is still a neglected determinant when assessing the contributors to mental illness, particularly in Europe. In the present study perceived discrimination is discussed as risk factor for developing depressive disorders. A low self-esteem caused by the internalisation of negative appraisals is suggested as pathway between discrimination and depression. On a macro-level, cross-national variations regarding tolerance towards minorities and its impact on mental health are analysed. **Methods:** Using data from the European Social Survey 2012 and Eurobarometer 2012 logistic regression analysis and Mann-Whitney-U-test were applied. **Results:** Victims of discrimination were found to be almost 80% (OR = 1.787, CI= 1.574 – 2.029) more likely to be depressive than those not exposed to discrimination. Minorities reported to feel significantly less positive about them ($p < 0.01$). The risk for being depressive is significantly higher in EU member states with low tolerance levels (OR= 1.417, CI = 1.240 – 1.619). **Conclusion:** Perceived discrimination proves to be an additional stressor for the mental health of individuals at both the individual and societal level. Discrimination and its impact on self-esteem should get more attention in research, prevention, and treatment of mental disorders.

Keywords: discrimination, depression, self-esteem, Europe, European Social Survey

1. Introduction

Just as with physical health status the risk factors associated with various mental disorders are correlated with social inequalities, even though there exists considerably less consensus regarding the impact of the social environment on the mental health status (Todman, 2011). It is, however, generally well known that continuing exposure to distress promotes the emergence of mental illness (Fisher, 2010), but questions remain about which factors exactly lead to the activation of stress systems and subsequently to poorer well-being. In the present study it is suggested that discrimination is a neglected stress factor, leading to depressive symptoms through the process of internalisation of negative appraisals.

The prevalence of hate crimes based on intolerance towards certain religions, ethnicities, and sexual orientations has risen in the last two decades in not only the United States but also worldwide (Cox, Abramson, Devine, & Hollon, 2012) and thus emphasises the significance of the topic.

[1] MCI Management Center Innsbruck, Dept. of International Health and Social Management, Universitätsstraße 15, A-6020 Innsbruck, Austria.
[2] MCI Management Center Innsbruck, Dept. of International Health and Social Management, Universitätsstraße 15, A-6020 Innsbruck, Austria. Phone: +43 512 2070 3732, Email: nils.mevenkamp@mci.edu

Special Eurobarometer about discrimination in the European Union in 2012 found that 17% of the participants define themselves as part of a group that is a minority, and also roughly 17% state to have been exposed to personal discrimination during the last 12 months because of their sexual orientation, disability, gender, religion, ethnicity, or age. In some countries (Austria, Italy, Hungary, Slovakia, Cyprus) nearly one out of four residents reported to be affected (Eurobarometer 2012).

Rejection leads to various negative emotions which were found to be closely linked to decreases in reported self-esteem (Smart Richman & Leary, 2009). Since discrimination is a serious form of rejection it is assumed that the chronic exposure results in a devalued self-concept (Ecclestone & Major, 2006) and consequently in depressive symptoms. According to the vulnerability model of depression a low self-esteem is a risk factor for developing depressive disorders (Orth, Robins & Roberts; 2008). Members of out-groups who experience mistreatment are aware of appearing in an unfavorable light to others and, as a consequence, they may include those negative appraisals into their self-perception, finally leading to a decreased self-esteem (Carr & Friedman, 2005). Cox et al. (2012) suggested that these internalised appraisals may lead to depressive symptoms, independent whether they originate from the self or another person. According to their theoretical suggestion a person suffering from a cognitive depression (see Beck 1967) is a person holding prejudice towards him-/her. A victim of prejudice can end up as Beckian depressive if the negative appraisals from other persons were internalised and harmed the self-esteem. It is interesting to note that women and ethnic minorities often have the same implicit prejudices against their own group which men respectively white people have against them (Bagenstos, 2007).

It is estimated that roughly 35% of the population is affected by at least one mental disease annually, with increasing tendency (Vieht, 2009; WHO, 2009); a great many of them suffer from subclinical symptoms such as a persistent depressive mood. Thereby, mental disease is one of the major public health challenges in the European Union in terms of prevalence, burden of disease, and disability (WHO, 2009). Particularly, depressive disorders are a huge burden for Europe, with a lot of adverse consequences for individuals and the economy. Depressive disorders do not only impair the life quality of those affected, they are also stated to be the most expensive of all mental diseases, costing the EU 118 billion Euros in 2004 (Sobocki, Jönsson, Angst, & Rehnberg, 2006). If depression was prevented at an early stage and treated appropriately overall health improvements and significant cost reductions could be achieved.

In the present paper it is suggested that distress of discrimination itself leads to poorer mental health status and increasing vulnerability of minority groups independent of additional adverse socioeconomic factors.

Hypothesis 1: People who report to be exposed to discrimination are more likely to report depressive symptoms.

Moreover, a low self-esteem caused by the internalisation of devaluating appraisals is discussed as the pathway between discrimination and depression on an individual level.

Hypothesis 1b: Members of discriminated groups report to feel less positive about them.

Variance of tolerance levels within societies is relatively small whereas tolerance levels between countries vary with regard to all types of prejudices (Eurobarometer, 2012; Zick, Pettigrew, & Wagner, 2008; Zick, Küpper, & Hövermann, 2011). Moreover, prejudices against different groups were found to be positively correlated within countries. Countries with low levels of tolerance against one minority (e.g. homosexuals) tend to have similarly low tolerance levels with regard to other minority groups such as women, disabled persons, ethnic minorities, or transgender persons. Thus, European countries can be clustered into cultures of different tolerance levels. This allows for examining an additional societal effect:

Hypothesis 2: The likelihood for reporting depressive symptoms in Europe correlates with the countries' tolerance level.

While hypotheses 1/1a refer to the relationship between discrimination and depression at the micro level, hypothesis 2 addresses the relationship between societal tolerance and depression at the macro level.

2. Methods

Data for the present study was obtained from the sixth wave of the European Social Survey conducted in 2012 (European Social Survey, 2012a, b). Data was weighted by the product of population size weight and design weight (European Social Survey, 2014). The Special Eurobarometer Survey on discrimination conducted in 2012 was used to cluster the countries according to their level of tolerance towards minorities (Eurobarometer 2012). Only those countries were included in the final analysis which participated in both the European Social Survey and the Eurobarometer. The final sample comprised of 21 countries, namely Sweden, Denmark, United Kingdom, Ireland, Estonia, Netherlands, France, Poland, Slovenia, Portugal, Italy, Belgium, Germany, Finland, Lithuania, Estonia, Bulgaria, Hungary, Slovakia, Czech Republic, and Cyprus (see Table 1).

Depression as outcome variable was operationalised by the question 'How much of the time during past week you felt depressed?' Answers were dichotomised as [no symptoms = none/almost none/some of the time; depressive = most/all of the time/always]. Self-rated depressive symptoms were considered as suitable item for the present study since the presence of self- reported depressive symptoms was found to be a reliable predictor for the onset of a major unipolar depression (Horwath, Johnson., Klerman, & Weissman, 1994; Ayuso-Mateos, Nuevo, Verdes, Naidoo, & Chatterji, 2010).

Discrimination as dichotomous exposure variable was measured by the question 'Are you member of a discriminated group in your country?' with two answers [yes; no]. Self-esteem was operationalised by the grade of agreement to the statement 'In general I feel very positive about myself'. Respondents could answer on a five point scale from 1 [agree strongly] to 5 [disagree strongly].

Classification of the European countries' tolerance levels was based on the Euro barometer (2012) survey. Respondents were subsequently asked to tell how they would feel about having (1) a person with disability, (2) a transgender/transsexual, (3) a gay/lesbian/bisexual, (4) a woman, or (5) a member of an ethnic minority in the highest elected political position in their country. Answers where collected on a ten-point scale from 1 [totally uncomfortable] to 10 [totally comfortable] (ibid. p. 15ff). Countries were initially classified into low, medium, and high tolerant countries with respect to each minority group separately according to their 33%- and 66%-quantile boundaries (Table 1). Class boundaries for the group of transgender/transsexuals were slightly adapted manually due to clear natural gaps. Countries were finally mapped to the class which they were assigned to in at least three out of five classifications. This rule was applicable for all countries without exception.

Ten countries were classified as low tolerant, nine countries as medium tolerant, and eight countries as high tolerant. Since some countries did not participate in ESS the final dataset comprised of seven countries in each class (Table 1).

Analysis was adjusted by the following confounders: age [15–25; 26–40; 41–60; 61+], gender [male; female], main activity [unemployed = sick, retired, unemployed; employed = paid work, education, military, housework], subjective household income [sufficient = living comfortably/coping with present income; insufficient = difficult/very difficult to cope with present income], and educational level [low = lower secondary education and below; medium = upper secondary education and advanced vocational sub-degrees; high = lower tertiary education (BA) and all forms of higher tertiary education (MA, doctoral degree)]. Educational level was categorised according to the International Standard Classification of Education provided by ESS (European Social Survey 2012b, p. 43).

Table. 1: Assignment of European countries to different tolerance levels according to the special Eurobarometer survey on discrimination (Eurobarometer 2012, 15ff.)

Tolerance level	Person with Disability	Transgender/ Transsexual	Gay, Lesbian, Bisexual	Woman	Ethnic Minority	Final Cluster
High	8.1 – 9.1 IE, DK, SE, LU, UK, PL, MT, ES, FR	6.2 – 7.6 DK, SE, LU, IE, ES, UK, NL, BE	7.3 – 8.9 DK, SE, LU, NL, IE, ES, UK, BE, FR	9.0 – 9.7 SE, DK, IE, LU, SI, ES, FR, LT, NL, UK	7.2 – 7.8 SE, DK, UK, LU, IE, ES, PL, NL, FR,	SE, DK, UK, (LU), IE, ES, NL, FR
Medium	6.9 – 7.9 NL, BE, DE, EL, CY, IT, PT, SI, AT	4.8 – 5.6 PL, PT, FR, IT, SI, DE, MT, AT	4.9 – 6.8 MT, DE, SI, IT, PL, AT, PT, FI, CZ	8.5 – 8.9 MT, PL, CY, BE, BG, DE, EE, LV, FI	5.4 – 6.9 SI, PT, IT, LT, BE, EE, DE, RO, FI, BG	PL, SI, PT, IT, BE, DE, FI, (MT), (AT)
Low	5.4 – 6.8 LT, BG, LV, EE, FI, HU,RO, SK, CZ	2.4 – 4.3 EE, CZ, FI, HU, EL, LT, BG, RO, CY, SK, LV	3.2 – 4.7 EE, EL, HU, CY, LT, BG, RO, SK, LV	7.8 – 8.4 AT, PT, IT, RO, EL, CZ, HU, SK	3.5 – 5.3 AT, HU, LV, SK, CZ, EL, CY, MT	LT, EE, (RO), BG, HU, (LV), SK, (EL), CZ, CY
EU-Average	7.7	5.7	6.6	8.6	6.5	
() Countries in parentheses did not participate in ESS and were not included in the final dataset						
Country	AT Austria BE Belgium BG Bulgaria CY Republic of Cyprus CZ Czech Republic DE Germany DK Denmark EE Estonia EL Greece		ES Spain FI Finland FR France HU Hungary IE Ireland IT Italy LT Lithuania LU Luxembourg LV Latvia		MT Malta NL Netherlands PL Poland PT Portugal RO Romania SE Sweden SI Slovenia SK Slovakia UK United Kingdom	

3. Results

For the present study, data of 39,049 respondents was used. The average age was 47 years and 47.2% were male. One third was living in a country classified as low (33.3%), medium (32.7%), and high tolerant (34.0%), respectively. Depressive symptoms were reported by 8.0% and 7.1% described themselves as member of a discriminated group. The latter reported depressive symptoms more often (13.9%) than members of non-discriminated groups (7.3%) which equates to a crude odds ratio of 1.9. Discriminated groups thus have a 90% higher unadjusted chance of being depressive.

Table 2: Processed cases (unweighted)

		Count	%
Depression	no symptoms	35 913	92,0
	depressive symptoms	3 136	8,0
Education	low	11 932	30,6
	medium	19 075	48,8
	high	8 042	20,6
Main Activity	unemployed	13 713	35,1
	employed	25 336	64,9
Household Income	insufficient	12 017	30,8
	sufficient	27 032	69,2
Age	15 – 25	4 832	12,4
	26 – 40	8 814	22,6
	41– 60	13 584	34,8
	61+	11 819	30,3
Member of a group discriminated against in country	yes	2 766	7,1
	no	36 283	92,9
Gender	male	17 931	45,9
	female	21 118	54,1
Tolerance level of country	low	13 005	33,3
	medium	12 764	32,7
	high	13 280	34,0
Valid		39 049	100,0

In order to adjust this crude odds ratio for potential confounders a logistic regression model was estimated. Results in Table 3 show that individuals with low education were more likely to report depressive symptoms than those with high education (OR = 1.847, CI = 1.617 – 2.109), just as the unemployed compared to the employed (OR = 1.789, CI = 1.622 – 1.974). Men were at lower risk for depression than females (OR = 0.582, CI = 0.536 – 0.632). The likelihood of being depressive almost tripled for people who had difficulties to cope with their households income (OR = 2.716, CI= 2.493 – 2,960). As to age, the likelihood of reporting depressive symptoms was highest for the population aged 41 to 60 (OR=1.164, CI= 1.043 – 1.300), whereas no significant differences between the younger and the older population were found. Those who reported to be victims of discrimination were still almost 80% (OR = 1.787, CI= 1.574 – 2,029) more likely to be in the depressive group than the non-discriminated population. Finally, the likelihood to report depressive symptoms was significantly higher in societies with low tolerance towards minority groups (OR= 1.417, CI = 1.240 – 1.619).

A Mann-Whitney-U Test revealed that self-esteem was significantly lower ($p < 0.01$) among victims of discrimination than among all others, i.e. victims of discrimination were significantly more likely to disagree to the statement ‘In general I feel very positive about myself’ than others.

Table 3: Parameter estimates of a logistic regression model with 'depression' as binary outcome variable. The odds ratios refer to the likelihood of having depressive symptoms rather than no symptoms.

	p	OR	95% CI
[Gender = male]	0.000	.582	.536 – .632
[Gender = female]			
[Age = 15-25]	0.091	.877	.752 – 1.021
[Age = 26-40]	0.558	.961	.843 – 1.097
[Age = 41-60]	0.007	1.164	1.043 – 1.300
[Age = 60+]			
[Education = low]	0.000	1.847	1.617 – 2.109
[Education = medium]	0.019	1.168	1.026 – 1.330
[Education = high]			
[Main Activity = unemployed]	0.000	1.789	1.622 – 1.974
[Main Activity = employed]			
[Household Income = insufficient]	0.000	2.716	2.493 – 2.960
[Household Income = sufficient]			
[Discrimination = yes]	0.000	1.787	1.574 – 2.029
[Discrimination = no]			
[Tolerance = low]	0.000	1.417	1.240 – 1.619
[Tolerance = medium]	0.012	1.115	1.024 – 1.214
[Tolerance = high]			

4. Discussion

Even after adjusting the correlation between discrimination and mental health status for socioeconomic confounders the odds ratio for discriminated groups being more depressive than others are remained nearly constant. More precisely, it decreased only slightly from 1.9 (crude OR) to 1.8 (adjusted OR). In line with hypothesis 1 it can be argued that distress of discrimination itself leads to poorer mental health status and increasing vulnerability to unipolar depression of minorities independent of additional adverse socioeconomic factors. Being a member of a discriminated group thus bears the risk to develop depressive symptoms similar to being unemployed or having a low level of education. The present study found evidence for the expected pathway between discrimination and depression as members of discriminated groups reported to feel less positive about themselves than others did. This gives rise to accept that a low self-esteem might be caused by the internalisation of devaluating appraisals according to hypothesis 1b.

In addition to the effects of discrimination at the individual level, the present study revealed a societal effect as suggested by hypothesis 2. Depressive symptoms were more likely to occur in countries where tolerance towards minority groups was generally low. Similarly, personally experienced discrimination in low-tolerance countries was found to be higher than EU-average (Eurobarometer 2012). These findings support Weldon (2006), who hypothesised an association between the level of tolerance of the population for ethnic minority groups and the type of citizenship regimes.

Laws, policies, and federal institutions determine and represent the culture of a country and define who is allowed to call himself a legitimate member of the country. Thus, understanding regional historical and political conditions is a mandatory prerequisite for understanding intolerance.

However, the results should be treated with caution, because other factors than the prevailing citizenship regime may as well be responsible for the higher amount of self-reported depressive symptoms in low-tolerance countries. The countries defined as less tolerant in the present study (Lithuania, Estonia, Bulgaria, Hungary, Slovakia, Czech Republic, and Cyprus) are mainly part of Eastern Europe and underlie adverse economic and political developments that may influence the mental health of the population. In turn, high-income countries with comparatively well-working economic and social systems are more likely to be classified as high-tolerant countries, such as Sweden, Denmark, Netherlands, United Kingdom, Ireland, France and Spain. While well-working systems might cause higher tolerance towards minorities, scarce resources might lead to hostility against out-groups, respectively. This linkage is described by realistic group conflict theory which argues that conflicts between groups arise from the necessity to share limited resources. Under this condition, members of the in-group perceive the out-group members as serious threat to their existence and an increase of prejudices, violence, and discrimination can be observed among in-group members (Piontkowski, 2011). Thus, variations in citizenship regimes can at least partly explain why some populations were more prejudiced than others were. Nevertheless, realistic group conflict theory would solely explain prejudice and discrimination towards immigrants in low-tolerance countries; prejudices against other minorities, such as homosexuals or the disabled, who do not claim resources, remained unexplained.

The main challenges to develop an understanding of the underlying mechanisms linking discrimination with health are to effectively measure, operationalise, and model the concept of discrimination. Being affected personally may lead to excessive vigilance and subsequently to an overestimation of stigmatisation, and vice versa may habituation, inattention, or lack of interest lead to overlooking of existing discrimination (Zick et al., 2011). Moreover, hypervigilance and the expectation of discrimination might be as strongly correlated with psychological disease symptoms as with actually experienced discrimination because hypervigilance may function as stressor itself.

In the present paper these restrictions were neglected and modelling was performed as simple as possible. In favour of methodological simplicity, however, two major characteristics of the examined hypotheses were disregarded, namely the interpretation of self-esteem as mediator between discrimination and depression at the micro level and the existence of different levels of analysis as such. From a strict methodological perspective, it appeared more appropriate if a multilevel path model was estimated.

Conclusion

Marginalised groups in society have to bear a disproportional amount of both physical and mental health issues. This affects not only migrants but also, besides others, homosexuals, the handicapped, or women. Besides the already well understood socioeconomic determinants of mental health discrimination proves to be an additional stressor at both the individual and societal level. Discrimination as a risk factor for mental disorders should get the same attention as other environmental factors, such as low education, unemployment, or low income. Hence, special emphasis should be placed on research, prevention, and treatment of mental disorders due to discriminatory experiences.

References

Ayuso-Mateos, J., Nuevo, R., Verdes, E., Naidoo, N., & Chatterji S. (2010). From depressive symptoms to depressive disorders: the relevance of thresholds. The British Journal of Psychiatry, 196, 365-371.

Bagenstos, S.R. (2007). Implicit Bias, "Science," and Antidiscrimination Law. Harvard Law and Policy Review, 1, 478-493.

Beck, A. T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Harper & Row.

Carr, F., & Friedman, M.A. (2005). Is Obesity Stigmatizing? Body Weight, Perceived Discrimination, and Psychological Well-Being in the United States. Journal of Health and Social Behavior, 46, 244–259.

Cox, W.T.L., Abramson, L.Y, Devine, P.G., & Hollon, S.D. (2012). Stereotypes, Prejudice, and Depression: The Integrated Perspective. Perspectives on Psychological Science, 7(5), 427 –449.

Ecclestone, C., & Major, B. (2006). Attributions to Discrimination and Self-Esteem: The Role of Group Identification and Appraisals. Group Processes & Intergroup Relations, 9(2), 147–162.

Eurobarometer (2012). Discrimination in the EU in 2012. [Online] Available: http://ec.europa.eu/public_opinion/archives/ebs/ebs_393_en.pdf (January 7, 2015)

European Social Survey (2012a). Documentation report. [Online] Available: http://www.europeansocialsurvey.org/docs/round6/survey/ESS6_data_documentation_report_e02_1.pdf (January 20, 2015)

European Social Survey (2012b). ESS Round 6 Source Questionnaire. [Online] Available: http://www.europeansocialsurvey.org/docs/round6/fieldwork/source/ESS6_source_main_questionnaire.pdf (January 20, 2015)

European Social Survey (2014). Weighting European Social Survey Data. [Online] Available: http://www.europeansocialsurvey.org/docs/methodology/ESS_weighting_data_1.pdf (February 2, 2015)

Fisher, M. (2010). The Social Determinants of Mental Health: Implications for Research and Health Promotion. Aust N Z J Psychiatry, 44 (12), 1057-1063.

Horwath E.M.D., Johnson, J., Klerman, G., & Weissman, M. (1994). What are the public health implications of subclinical depressive symptoms? Psychol Quart, 65(4), 323-337.

Orth, U., Robins, R., & Roberts, B., (2008). Low Self-Esteem Prospectively Predicts Depression in Adolescence and Young Adulthood. Journal of Personality and Social Psychology, 2008, 95 (3), 695–708.

Piontkowski, U. (2011). Beziehungen zwischen Gruppen und Kulturen. In U. Piontkowski (Ed.), Sozialpsychologie (p. 165- 218). München: Oldenbourg Verlag.

Smart Richman, L., & Leary, M. (2009). Reactions to Discrimination, Stigmatization, Ostracism, and Other Forms of Interpersonal Rejection. Psychol Rev. 116 (2), 365–383.

Sobocki, P., Jönsson, B., Angst, J., & Rehnberg, C. (2006). Cost of depression in Europe. The Journal of Mental Health Policy and Economics, 9(2), 87-98.

Todmann, L. (2011). The social determinants of mental health. The SES Indicator, August 2011. [Online] Available: http://www.apa.org/pi/ses/resources/indicator/2011/08/lynn-todman.aspx (February 24, 2015)

Weldon, S.A. (2006). The Institutional Context of Tolerance for Ethnic Minorities: A Comparative, Multilevel Analysis of Western Europe. American Journal of Political Science, 50 (2), 331–349.

WHO (2009). Global health risks: Mortality and burden of disease attributable to selected major risks. Geneva, Switzerland: World Health Organization. [Online] Available: http://site.ebrary.com/lib/academiccompletetitles/home.action (May 26 2015)

Vieht, H. (2009). Mental health policies in Europe. Euro Observer, 11(3). [Online] Available: http://www.euro.who.int/__data/assets/pdf_file/0017/80333/EuroObserver-Autumn-2009_web.pdf (February 10, 2015)

Zick, A., Pettigrew, T.F., & Wagner, U. (2008). Ethnic Prejudice and Discrimination in Europe. Journal of Social Issues, 64 (2), 233-251.

Zick, A., Küpper, B., & Hövermann, A. (2011) Intolerance, Prejudice and Discrimination. A European Report. [Online] Available: http://library.fes.de/pdf-files/do/07908-20110311.pdf (December 20, 2014)