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Stigma of Schizophrenia: Assessing Attitudes among European University Students

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abstract

Stigma creates a barrier in the recovery from severe mental illness such as schizophrenia. Although stigmatising behaviour can be observed both among the general public and healthcare professionals, little is known about stigmatisation towards people with schizophrenia (PwS) among university students. This study will target psychology students, medical students and students of subjects not directly associated with healthcare professions in seven European countries (Bulgaria, Denmark, England, Ireland, Malta, Slovenia and Switzerland). The aims of the current study are to explore the stigma held by students in the aforementioned countries, and any possible differences between students of health-related and non health-related subjects. Furthermore, potential differences between those that have taken a module in psychopathology and/or schizophrenia will be considered. Measures assessing knowledge, contact, negative emotions and desired social distance were distributed in an online format.

Keywords: stigma, negative attitudes, healthcare professionals, students

Stigma is considered by many researchers to be a social construct, a label attached by society, which is social context dependent rather than an inherent dynamic of the "marked" person (Crocker, Major, & Steel, 1998; Major & O'Brien, 2005). Currently, it is a term which encapsulates problems of knowledge or inaccurate stereotypes, prejudicial attitudes, and discriminatory behaviour towards individuals of various social groups, including members of racial and ethnic minorities, those with physical or intellectual disabilities, and individuals with

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chronic illnesses (Hinshaw & Stier, 2008; Thornicroft, Brohan, Rose, Sartorious, & Leese, 2009). Associated with poor mental health, physical illness, academic underachievement, and reduced access to education, jobs and housing, stigma poses to be an area of interest across multiple disciplines including sociology, public health, and psychology (Hinshaw & Stier, 2008; Major & O'Brien, 2005).

Although stigma is apparent across a plenitude of minorities and disabilities, mental illness is subject to an exceptional amount of stigma (Hinshaw, 2007; Świtaj et al., 2011; World Health Organization, 1998). According to Hinshaw and Stier (2008) a label of mental illness promotes rejection and suboptimal social interactions, which, to a degree, are unrelated to the actual attributes of those that experience stigma. Angermeyer and Matschinger (2003) demonstrated that a label of schizophrenia predicts a larger degree of stigmatisation compared to depression, indicating a variation in stigma depending upon illness diagnosis.

The stigma towards schizophrenia is expressed by individuals across different social levels and is evident in populations beyond the general public, including medical practitioners and legal professionals (Buizza et al., 2007). Previous research has also observed stigmatising attitudes towards PwS in students whose education involves dealing directly or indirectly with schizophrenia and other mental illnesses; for example, medical students (Ay, Save, & Fidanoglu, 2006; Corrigan, 2000; Mino, Yasuda, Kanazawa, & Inoue, 2000; Stuart, 2008), nursing students (Linden & Kavanagh, 2011) and social work students (Mason & Miller, 2006). Studies have also verified this stigma within non-specified student populations (Smith, Reddy, Foster, Asbury, & Brooks, 2011; Theriot, 2013). However, there appears to be limited research that compares variations in stigma according to subject major (Totic et al., 2012). Thus, it would be beneficial to measure and compare stigma toward PwS across course groups, ideally medicine and psychology, with courses that do not include modules on mental health and illness.

Notable efforts have been made in psychology to understand why the stigma of mental illness is so prevalent and, from this, explore mechanisms to combat its effects. A number of social cognitive processes have been hypothesized to explain the public stigma process, including fear of threat and disorder (Harmon-Jones et al., 1997), intergroup prejudice, and reception of stereotypes regarding "deviant" others, such as those with mental illness (Hinshaw & Stier, 2008). Attempts have also been made to understand the correlates of stigma, the processes underlying stigma and the mechanisms that sustain these processes (Link, Yang, Phelan, & Collins, 2004).

Existing literature frequently refers to the attribution theory, tracing a path from a signalling event (a label), to an attribution (or stereotype), to an emotion, and, ultimately, to a behavioural response (discrimination). This framework allows exploration of the emotional and behavioural dimensions of stigma, along with the cognitive processes involved in the development and maintenance of negative and stigmatising attitudes and stereotypes (Corrigan, 2000; Stuart, 2008). Using data from a study conducted in Germany, Corrigan, Kerr and Knudsen (2005) applied this model to investigate the effect of labelling schizophrenia and depression as mental illnesses. In the case of schizophrenia, labelling elicited the belief that those affected with this illness are dangerous and unpredictable, which led to negative emotional reactions such as fear and aggression, ultimately resulting in an increased desire for social distance.

The attribution theory has also been considered when exploring the effect of familiarity with mental illness on the attitudes towards PwS and depression. Angermeyer, Matschinger and Corrigan (2004) have demonstrated that, with growing familiarity, the tendency towards considering the ill person to be dangerous and unpredictable was decreasing, and people had less fear and social distance was desired less frequently. Other studies have also demonstrated positive correlations between previous contact and positive attitudes, less desired social distance and a reduction in stereotypes (Anagnostopoulos

& Hantzi, 2011; Couture & Penn, 2003; Phelan & Link, 2004). However, conflicting evidence by Durand-Zaleski, Scott, Rouillon, and Leboyer (2012) has indicated that contact with mental illness only partially diminished attitudes and discrimination towards schizophrenia. Further, Totic et al. (2012) observed that although prior to psychiatric placement medical students demonstrated equivalent levels of stigma as law students, upon completion of placement they exhibited higher levels of stigmatisation than legal students with no psychiatric component to their course. Thus, it is deemed pertinent to further explore the relationship between stigma and contact.

It has also been suggested by researchers who consider the social cognitive roots of stigma and stereotypes that an increase in objective knowledge about mental illness may reduce negative attitudes towards severe mental illnesses, such as schizophrenia (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). It was suggested that positive attitudes about psychiatric disability are primed in individuals with greater pre-education knowledge about mental illness. Further, Mino et al. (2000) reported that, following five years of education, medical students demonstrated significantly higher acceptance and favourable attitudes towards people with mental illness than prior to their education. Improved attitudes towards mental illness in final year medical students compared to second year students have also been observed within a Turkish sample (Ay et al., 2006). More recently, Smith et al. (2011) indicated that high knowledge was significantly related to tolerant attitudes towards schizophrenia. However, conflicting evidence is offered by Leiderman et al. (2011) who reported that knowledge was not reliably related to positive attitudes, with moderate knowledge of mental illness weakly related to desired social distance. However, the literature on this aspect is somewhat lacking with regard to theoretical foundation (Lee, 2002). It may be of value to consider the impact of knowledge on stigma within the framework of attribution theory.

It is also evident that the stigma towards schizophrenia manifests itself across different populations and in different countries (Major & O'Brien, 2005), however, it is not clear whether there is any variation in this stigma according to country. Mellor, Carne, Shen, McCabe, and Wang (2012) highlight that, as culture incorporates shared attributes, meanings, and perceptions, it is probable that cultural differences in stigma will arise between countries. Further research should be done to consider whether there are differences between countries.

As highlighted in the literature reviewed above, it is evident that a number of discrepancies exist within the research findings regarding the manifestation of stigma associated with schizophrenia and other mental illnesses. There is conflicting evidence concerning participant knowledge and contact, and the impact they have on stigmatisation. Typically, studies that consider this topic use a variety of populations including clinicians and students, yet more studies are required to consider the effect of subject of study on stigmatising attitudes within a student population. Furthermore, cultural variations in stigma also need to be considered.

Consequently, using attribution theory as a framework, this study will consider the relative contributions of both knowledge and contact to the stigmatisation, consisting of attitudes, affective reaction and desired social distance of schizophrenia. This study predicts that both level of knowledge and level of contact will affect the level of stigmatisation in a student population. Potential differences in levels of expressed stigmatisation between subjects of study and between European countries will also be explored. It is predicted that students in health-related courses who have attended a module on psychopathology will demonstrate less stigmatisation than those who have not attended such a module, due to a greater level of knowledge, and students of non health-related subjects.

Method

A cross-sectional survey design was employed to assess the stigma held by university students towards PwS. A battery of questionnaires assessing participants' familiarity and knowledge of mental illness, tolerance, attitudes, affective reaction to and desired social distance from a PwS was distributed online. The results across the participating countries and also within these countries will be compared. Correlations between variables and possible differences between students of health-related subjects and those of other subjects will be considered, as well as the impact of socio-demographic attributes, such as age and gender.

Design

Participants

The seven European countries included in the study are Bulgaria, Denmark, England, Ireland, Malta, Slovenia and Switzerland. Data collection in Slovenia will take place in September. At the time of this report, the participants (N = 722) were university students majoring in a range of subjects, including psychology (29.6%), medicine (6.7%) and health sciences (8.7%), as well as subjects not associated with career prospects in the domain of health or mental health care (55.6%). The majority of the sample is female (70.9%). The ages of participants range between 17 and 35 years (M = 23.6). This convenience sample contains 11.8% participants from Bulgaria, 36.3% from Denmark, 3.2% from England, 10.1% from Ireland, 27.1% from Malta and 12.2% from Switzerland. From the students surveyed, 60.6% are enrolled in a bachelor's programme, 37.9% in a master's programme and 1.5% in a PhD programme.

Materials

In addition to socio-demographic questions (age, gender, nationality, religion, subject of study, level of education, and parental education), three scales were used to compose the questionnaire used for the purposes of the current study. These scales were translated into German, Slovene and Bulgarian. In order to ensure valid translation, the scales were translated into the respective languages by the researchers and then back translated to English by an external person. The retranslated English version was then compared to the original scale and deviations were adjusted in the target language. In addition, the authors of "Schizophrenia knowledge, attitudes and perceptions scale revised" were provided with the translated versions of the scale.

Schizophrenia knowledge, attitudes and perceptions scale revised (SKAPS-R) (K. Foster, personal communication, March 1, 2013). The scale was designed to measure perceptions, general attitudes and knowledge of schizophrenia and mental illness. The knowledge subscale consists of 13 true/false items about schizophrenia and other mental illnesses. The attitudes measure uses a five-point Likert-scale (with a statement ranging from strongly agreeing to strongly disagreeing) comprising 13 items regarding tolerance towards PwS or other mental illness.

Level of Contact Report (LCR) (Holmes et al., 1999). This scale lists 12 situations in which the intensity of contact with severe mental illness varies from least intimate contact ("I have never observed a person that I was aware had a severe mental illness") to most intimate ("I have a severe mental illness"). Participants were required to indicate all forms of contact in which they have engaged during their lifetime from the list provided. The index for contact for a given participant is the rank score of the situation with greatest level of intimacy the participant has engaged in.

Social Distance Scale (SDS) and Affective Reaction Scale (ARS). (Penn et al., 1994). A vignette describing a fictional outpatient currently engaged in part-time janitorial work with a stable income was used. It was mentioned that this person suffers from schizophrenia. The SDS consists of seven questions referring to social interactions with a target individual. Each question was rated by the subject on a four-point Likert-scale (ranging

from 0 = definitely willing to 3 = definitely unwilling) based on how willing they were to engage in a given form of interaction with the target individual. A composite measure of social distance was derived by combining the sum of all items. The ARS required participants to indicate their emotional responses towards the target individual as assessed by ten adjective pairs. This was done on a seven-point scale with an extreme negative emotional response on one end of the scale and an extreme positive emotional reaction on the other with "neutral" being the midpoint emotion.

Ethics

It was essential that each researcher involved obtained ethical approval for the study before commencing data collection. Even though this goal was achieved, it proved to be a lengthy process mainly because the study was conducted independent of any university that the researchers involved are affiliated with. Each ethical committee at the target universities had different approaches to the provision of ethical clearance. Due to a significant amount of complications, such as concerns over the demands of students working with PwS exceeding their current professional capabilities, it was decided not to proceed with the previously proposed education and social contact interventions involving PwS. The final outline of the study was submitted to the ethical committees of the various universities as stated in the method section.

Researchers from Ireland, Bulgaria and Slovenia had to resubmit their applications due to minor issues such as the mention of anonymity in the consent form. Additionally, the research member from England applied for an extension due to the initial approval having expired before data collection commenced. Ultimately, all applications were accepted and data was collected from six countries. Data collection has not yet been completed in Slovenia, as the process of second acceptance took longer than anticipated.

Procedure

Following the ethical procedure described above, the survey was distributed in each country apart from Slovenia. Prior to the collection of data, a pilot study was conducted by the research team in order to correct any mistakes or to improve the survey before sending it out to participants. The survey was uploaded onto a web-based survey platform. In Ireland, SurveyGizmo was used, whereas researchers from the remaining countries chose SurveyMonkey. An email including a link to the online survey was sent to university students via course administrators and class representatives. In addition, the email included a brief description of the study and the contact details of one or more members of the research team. Social media was also utilized for the distribution of the questionnaire.

Informed consent was obtained from each participant prior to access to the survey. Information regarding the intent to assess the participants' level of stigma towards PwS was not given to reduce social desirability and self-preservation biases (Stier & Hinshaw, 2008). Upon completion of the survey, a debriefing form with further information regarding the purpose of the study and the correct answers of the SKAPS-R knowledge subscale was provided. Only fully completed responses will be used for analysis, as failure to finish the survey will be taken as withdrawal of consent.

Proposed Analysis

Socio-demographic properties of the sample will be explored with descriptive statistics. Bivariate Correlation will be calculated in order to investigate whether there is an association between education and knowledge. T-tests will be used to assess differences in the level of knowledge, affective reaction, attitudes and desired social distance between students of health-related and non-health-related subjects. In order to test whether there are differences between countries with regard to knowledge, contact, emotional reaction, tolerant attitudes and desired social

distance scores, ANOVA will be used. Further ANOVA will be conducted to assess possible differences in attitude and desired social distance scores between students of different subjects.

The study will also assess demographic diversity across samples and attempt to distinguish the contributions of these factors between and across countries. Regression models may be applied to examine the relative impact of variables such as level of contact, knowledge, affective reactions on attitude and desired social distance. The aforementioned factors may be used to help explain variance within the attitudes and desired social distance per country.

Practical

The initial project, developed at the European Summer School 2012, aimed to implement and evaluate two interventions with the intention of reducing stigmatising behaviour and attitudes towards PwS. Due to limitations of resources, time and ethical complications; it was decided to limit the study to the assessment of university students' attitudes towards PwS by distributing online questionnaires.

All members of the research group, apart from the supervisor and communications officer, have equal roles. Tasks have been distributed among members based on interests and availability. The communications officer has been in charge of the organisational aspects of the project, such as communicating with the Director of Research, Dr. Kai Ruggeri, and the Research Officer, Luís Miguel Tojo. Communication between group members and the supervisor mainly took place via e-mail and during bi-weekly Skype meetings. Social media has also been used as a means of communication and some group members have visited each other in person, which helped to strengthen the group`s commitment, and facilitated the exchange of study-related information. All authors of the scales were contacted and provided guidance where appropriate. All group members have also been in contact with academics within the field in order to receive advice and guidance on how to apply for ethical approval and to address any other possible concerns.

Current Status

At the time of writing, the researchers have collected data from six countries (Bulgaria, Denmark, England, Ireland, Malta, and Switzerland). Data has been coded and entered into SPSS. Analysis is pending. The researcher from the remaining country (Slovenia) will collect data in September.

Prospective Discussion

The design of the current study is both correlational and observational. The overarching goal of the study is to provide a general understanding of the extent of stigmatising attitudes towards PwS among university students and whether cultural variations exist. Although it will not offer the same depth of understanding as a qualitative study would, it will hopefully complement the existing literature on the topic.

Research indicates that many clinicians acquire a clinician bias (Andresen, Oades, & Caputi, 2011) and consequently demonstrate high levels of stigmatising attitudes towards their patients. It could be interesting to understand at which point during the professional development process this bias evolves and whether preventative strategies could be implemented during the initial stages of professional education in order to prevent this problem.

For future research, it may be beneficial to consider the influences that different questionnaires, based on different theoretical understandings of schizophrenia, have upon the assessment of stigma and their potential influence on the discursive understanding of schizophrenia.

The research team is convinced that the findings will potentially benefit educational institutions, local

policymakers and the general public, providing a greater understanding of the topic. It is hoped that the results will make future mental health professionals aware of their potential to hold stigmatising attitudes towards people with mental illness. Ideally, the study's conclusions will encourage both educators and students to establish preventive steps in order to tackle the stigma of schizophrenia, and other mental illnesses, via contact or educational programmes.

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