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Attitudes towards mental illness among health care students at Swedish universities – A follow-up study after completed clinical placement

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SUMMARY

The aim of the study was to examine the changes in attitudes towards mental illness after theoretical education and clinical placement among students from university programmes preparing for different kinds of health professions. Three different questionnaires were used, measuring the level of familiarity with mental illness and attitudes towards mental illness in general and towards specific mental illnesses. The data were collected on two occasions, before the theoretical course and after the completed clinical placement. The result showed that the attitudes toward mental illness in general had changed in a less stigmatising direction after the clinical placement. On the other hand, attitudes toward specific mental illnesses did not show any major changes. A conclusion is that the clinical placement included in the university programmes to some extent could affect attitudes in a de-stigmatizing direction, possibly because of the interaction with persons suffering from mental illness and experienced supervisors.

Introduction

Negative public attitudes towards persons with mental illness have been identified as an obstacle for recovery from illness and from becoming full participants in the society (Thornicroft, 2006). The concept of stigmatization has been described and operationalized by many researchers (Link and Phelan, 2001). The term was originally used to refer to a brand or scar burned or cut into the body, used to identify slaves and criminals (Clausen, 1981). In modern times stigma has often been used to denote some form of community sanction that marks an individual as being unacceptably different from the general population with whom she or he interacts (Goffman, 1963). Stigmatization should therefore be seen as a social psychological phenomenon that originates in the relationships between individuals and between groups and constitutes a threat to the targeted individual's self-esteem and identity.

Even if a clear consensus about the term stigma is lacking, the concept is usually described in mental health research as a complex of problems that emanates from a lack of knowledge about mental health problems, negative attitudes and excluding or avoiding behaviours toward individuals with mental illness.

It has been shown that stigmatization contributes to limitations in opportunities in life that mental illness leads to. The negative effects include reduced access to mental health services and advances in psychiatric treatment (Schultze and Angermeyer, 2003), psychosocial stress and delay in appropriate help seeking (Link and Phelan, 2006). Other negative effects are related to the individuals' social network and quality of life (Yanos et al., 2001).

Interventions against stigma

Different programs to fight stigma have been initiated as a consequence of the massive body of findings that identify stigmatization as a factor that can obstruct the inclusion of people with severe mental illness as full members in the society. The ambitions have been to increase public knowledge about mental illness and treatment and the possibilities for recovery in order to create more positive attitudes towards people with mental illness. Crisp and colleagues conducted a population survey before the start of the Changing Minds campaign in UK and repeated the survey five years later. The results from the follow-up survey (Crisp et al., 2005) showed some reductions in stigmatizing opinions. Taking into

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consideration the difficulties in discerning the effects of the campaign, one important conclusion was, however, that the opinions about different psychiatric disorders differed greatly. The most negative opinions were towards drug addiction and alcoholism (about 70% of the respondents reported overall unfavourable attitudes). Overall negative opinions about schizophrenia were reported from about 20% of the respondents. The disorder that was least associated with negative attitudes was dementia, where only 3% of the respondents reported such opinions.

Preventing stigma

Although the aims of large anti-stigma campaigns to some extent have been achieved (Crisp et al., 2004; Sartorius and Schultze, 2005), the factors that impact on people's attitudes remain unclear (Thornicroft, 2006). It is, however, known that direct contact with people with a personal experience of mental illness is one way of changing attitudes. This strategy builds upon face-to-face contact that provides the opportunity for perceiving the mental disorder as a condition affecting a real person (Alexander and Link, 2003; Couture and Penn, 2003). As a consequence, there is a trend away from the implementation of large campaigns towards face-to-face interventions with specific groups in focus, such as school children and medical staff (Corrigan, 2004).

Another factor that can influence attitudes in a more tolerant direction is the experience of having a friend or relative with a mental illness (Thornicroft, 2006). Furthermore, the context where the contact with the service user takes place is important. If, for example, medical staff only has the opportunity to encounter patients when they are mentally ill and only in inpatient settings, their view is strongly influenced by a pessimistic perspective (Burti and Mosher, 2003). Professionals in the health services are important conveyors of attitudes through their roles as experts when meeting with patients, their relatives and the general population. Their attitudes are probably shaped by a variety of influences, one of which might be their professional training.

Aim

This study is part of a research project aiming at investigating attitudes towards mental illness among different categories of university students in Sweden, as they participate in theoretical and practical courses focused on mental health. The aim of this specific study was to examine the changes in attitudes towards mental illness among university students after completion of theoretical education and clinical placement.

The specific research questions were:

How familiar were the students with people with mental disorders prior to the combination of theoretical studies and clinical placement?

To what extent had the attitudes (generally and towards specific mental illnesses) changed after the combination of theoretical studies and clinical placement in comparison to those reported prior to these courses?

Were there associations between the students' sex, age, future profession and previous familiarity with mental illness and any changes in expressed attitudes?

Methods

The project as a whole was performed at six universities in Sweden. A sample of students preparing for a broad range of health professions was desired. Thus, universities with educational programmes for nurses, occupational therapists, physiotherapists, physicians, psychologists, public health workers and social workers were approached. The selection of student categories was based on the strategic reasoning that these form the vast majority of professionals working with health care and support for people with mental illnesses. Universities from all over Sweden were approached and asked for participation, and strategic sampling was used in order to obtain heterogeneity. The principles utilized in the sampling process were also those of age and size of the university and their geographical distribution in the country. Six universities were initially selected, four agreed to participate and two declined due to bad timing. A further two universities were approached and both were willing to participate, and by these measures the range needed was reached. This study complied with stipulations in the Swedish Act *Ethical Review of Research Involving Humans* (SFS, 2003), and the principle of informed consent was applied.

Procedure

The procedure for selection of subjects was the same at all universities. A member from the research team established contact with a teacher working with the targeted student group. The teacher asked for the students' consent and explained that participation was voluntary. The contact teacher scheduled the data collection, which was chosen in relation to the mental health course, or in some cases a more comprehensive course where mental health formed a part and the first data collection took place just before that course. The contact teacher distributed the questionnaires to the students at the beginning of an ordinary lesson, these were completed immediately and then the students placed their responses in a box, which was subsequently collected by or sent to the research team.

A second data set was collected immediately after the theoretical course, while the third set was collected after the clinical placement in mental heath care. The same procedure for administering the questionnaires was used on all occasions. The present study was based on the data collected on the first and third occasions.

Measures

The level of intimacy with people with mental illness was elicited using a translated version of the Level of Familiarity Questionnaire (Corrigan et al., 2001). The questionnaire contains 11 statements about familiarity with mental illness. Each statement can be answered by yes or no. If more than one statement is affirmative, the score of the statement ranked highest in terms of level of intimacy is recorded. The highest obtainable score is 11, which is obtained if the statement "I have a severe mental illness" is answered in the affirmative. If the lowest ranked statement, "I have never observed a person that I was aware had a severe mental illness", is the only one answered in the affirmative, the lowest rating, 1, is obtained.

In order to investigate opinions about persons with mental illness, a Swedish version of the Attitudes to Persons with Mental Illness questionnaire ("Changing Minds") was used (Crisp et al., 2000). The questionnaire elicits attitudes towards seven different mental disorders: severe depression, panic attacks, schizophrenia, dementia, eating disorders, alcohol addiction and drug addiction. Attitudes towards each mental illness are rated through responses to eight statements, expressing different opinions. The subject answers using a five-point scale where the endpoints are given, for example 1 = dangerous to others and 5 = not dangerous to others. A low rating always indicates a stigmatising attitude. A study of the psychometric properties of the Swedish version revealed dubious test–retest reliability for some of the disorders and attitudes items (Svensson et al., submitted for publication). Thus, in this