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# Public perceptions of stigma towards people with schizophrenia, depression, and anxiety<sup>☆</sup>



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## ABSTRACT

Stigma is one of the greatest challenges facing people with a psychiatric diagnosis. They are widely stigmatised by the general public in the western world. The aim of this study was to examine public stigma attitudes towards schizophrenia, depression and anxiety. The Office of National Statistics (ONS) 2008 opinions survey ( $n=1070$ ) was utilised. Percentage of endorsements for stigma items were initially compared to the previous 1998 and 2003 databases. Overall stigma attitudes had decreased (from 1998 to 2008) but increased since 2003. A principal components factor analysis identified that stigma attitudes have the same three factors structure across all diagnoses; negative stereotypes, patient blame and inability to recover. Schizophrenia was significantly associated with the most negative stereotypes, least blamed and viewed as least likely to recover compared to anxiety and depression. Public and individualised interventions that target diagnostic variability in stigma attitudes need to be developed and examined in future research.

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## 1. Introduction

### 1.1. Background

Stigma was originally defined as an attribute that is deeply discrediting which reduces the person from a whole person to a tainted or discounted one (Goffman, 1963, p. 3). It is widely acknowledged that psychiatric diagnoses are stigmatised and associated with negative public attitudes (Angermeyer and Matschinger, 2003). A breadth of literature has conceptualised stigma in various ways (Link and Phelan, 2001; Corrigan and Watson, 2002; Brohan et al., 2010) but arguably the most influential approach is outlined by Corrigan and Watson (2002) who described stigma as having two major dimensions: public stigma and self-stigma. Public stigma comprises negative attitudes (prejudice), beliefs (stereotypes) and behaviour (discrimination) towards the stigmatised person and self-stigma is the internalisation of these experiences by the stigmatised individual.

Survey results from 2000 members of the English public identified three dominant stigmatising attitudes towards people with a psychiatric diagnosis; fear and exclusion, irresponsibility and lack of control and benevolence (Brockington et al., 1993). Crisp et al., (2005, 2000) scrutinised the UK Office of National Statistics (ONS) opinions survey and found that people diagnosed with a mental health problem were most likely to be seen as unpredictable, hard to talk to and unlikely to recover. Similar attitudes have been identified across the western world in places such as Australia, Germany and the USA (e.g. Jorm et al., 1999; Angermeyer and Matschinger, 2003; Siltan et al., 2011).

A recent review has illustrated that public perceptions of mental health diagnoses vary across the diagnostic categories (Parle, 2012). People diagnosed with schizophrenia are viewed most negatively, and are considered more dangerous and unpredictable compared to other diagnoses (Angermeyer and Matschinger, 2003). Dinos et al. (2004) interviewed 46 people with experiences of mental health difficulties about their experiences of stigma and found that people diagnosed with schizophrenia were more likely than any other group to report overt experiences of stigma such as verbal abuse, physical abuse, loss of contacts, and overt discrimination. Vignette studies also illustrate the strong bias that the public have towards psychiatric diagnoses. Yang et al. (2013) presented college students with a vignette and randomly assigned a diagnosis that described the prodromal symptoms. Schizophrenia elicited more negative stereotypes and

<sup>☆</sup>The authors recognise that the terms and language used in this paper are not universally endorsed by all. Where differences of opinion arose in this paper, the team decided to use the term that was endorsed by the majority whilst also respecting the views of others.

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psychosis at risk elicited more social distance and less willingness to help compared to other diagnoses. This pattern has been identified in similar studies (Link et al., 1999; Angermeyer and Matschinger, 2003).

Public campaigns, which aim to educate the public about mental health and increase social contact, have been shown to reduce stigma. Crisp et al. (2000, 2005) study results highlighted a reduction in negative attitudes toward mental illness following the changing minds campaign. The changing mind campaign (Crisp, 2004) ran from 1997 to 2003 and aimed to develop public and professional understanding of mental health problems. A longitudinal study conducted by Mehta et al. (2009), who examined public attitudes towards psychiatric diagnoses, highlighted that there was a positive impact of the UK's changing minds campaign and Scotland's equivalent see me campaign but overall there was still a significant deterioration in public attitudes over time (1994–2003).

There is extensive evidence that people who have a mental health diagnosis are viewed negatively by the public with certain diagnoses being viewed more negatively than others. However, there is a need to examine prevailing public attitudes in the UK population. A more recent ONS database has been published (2008) with data following up from two previous studies (Crisp et al., 2000, 2005) allowing for the examination of further change in public attitudes. Examining public attitudes are essential in tackling stigma as these underlie discriminatory behaviour. Crisp and colleagues did not attempt to examine the factor structure of stigmatising attitudes and whether they differ significantly across diagnoses. This would be helpful to explore in order to tailor public stigma campaigns appropriately to specific diagnoses.

## 1.2. Aim

This research aimed to explore public attitudes towards psychiatric diagnoses, namely schizophrenia, depression and anxiety using the UK ONS opinions survey database (ONS, 2008) (National Statistics Opinions Survey, 2008). The main aims of the study were to:

1. Compare stigma attitudes to those found by Crisp et al. (2000, 2005) to examine any changes over time.
2. To conduct a factor analysis in order to determine the factor structure of stigma attitudes and examine them for significant differences across diagnoses.

## 2. Method

### 2.1. Participants

For the Office of National Statistics (ONS) opinions survey (July 2008), the sample was identified through multi-stage stratified random sampling. 1792 households were initially identified as eligible to take part in the survey. The households were identified using the Postcode Addresses File of the ONS. Full details of sampling methods can be found in the ONS opinions survey technical report (ONS, 2008). Sampling methods were consistent across the previous two studies (Crisp et al. 2000, 2005). From the total households contacted, 524 (29%) refused to take part in an interview, 192 (11%) were not contactable and 6 (0%) were of unknown eligibility. In total 1070 (60%) of households had an individual who took part in the interview.

### 2.2. Procedure

The opinions survey comprised face-to-face interviews conducted by interviewers trained on the administered measures. The interviews took an estimated 25min to complete per respondent. The interviewer made at least three calls to an address before they are coded as a non-contact. After the field period, a proportion of non-contacts and refusals were attempted to be contact by the telephone unit.

### 2.3. Materials

The opinions survey included five modules for respondents to answer, all of which were of multiple choice. These modules were identical to those used in Crisps et al. (2000, 2005) previous studies. Full details of all modules and questions can be found in the ONS opinions survey technical report (ONS, 2008). For the purpose of this study, two modules were examined:

#### 2.3.1. Module 01; CPS Core

Respondents were asked sixteen demographics questions which included age, sex, race, marital status, educational attainment and employment. All questions were multiple choice.

#### 2.3.2. Module M208; Stigma

This module included questions about attitudes towards psychiatric diagnoses. Respondents were requested to rate their attitudes towards each of the following diagnoses: severe depression, anxiety, schizophrenia, dementia, eating disorder, alcoholism, and drug addiction. They were asked to rate eight individual statements about each diagnostic category: *danger to others, unpredictable, hard to talk with, have only themselves to blame for their condition, would not improve if given treatment, feel different from the way we feel at times, could pull themselves together if they wanted, and will never recover fully*. Each item was rated on a five-point scale of extremes from positive to negative, for example: would improve if given treatment – would not improve if given treatment. Respondents were not asked whether they had experienced a mental health problem themselves. For the purpose of this study, only the rating scales of schizophrenia, depression and anxiety were used.

### 2.4. Statistical analysis

The 2008 database was downloaded by authors from the ONS website in June 2013 (ONS, 2008). The previous two databases used by Crisp et al. (2000, 2005) were no longer available for download.

The Statistical Package for the Social Sciences (SPSS) version 18 (SPSS, 2010) was used to conduct all data analysis. Data was reversed to ensure higher scores representing the most negative attitudes. All data were found to be normally distributed. Initially, endorsement percentages for the eight stigma items for each diagnostic category were compared to the previous two ONS databases, 1998 and 2003 (Crisp et al., 2000, 2005). Negative endorsements were calculated as outlined by Crisp et al. (2000). The stigma attitudes questionnaire was then subjected to a principal components factor analysis and a Direct Oblimin rotation for schizophrenia, depression and anxiety respectively. Direct Oblimin rotation was chosen because it is likely that the factors identified are going to be related (Field, 2009). The number of factors extracted were those with eigen values greater than one. The scree plot was also inspected to identify factors (Coolican, 2009). Factor loading values were taken as significant over 0.4 as recommended (Field, 2009). The factors identified were then entered into independent one-way Analysis of Variance (ANOVA) models. The extracted factors were entered as independent variables and the diagnostic subtype as the dependent variables.

## 3. Results

### 3.1. Sample demographics

Interviews were obtained with 1064 people aged 16 years and over. This response rate of 60% is slightly lower than that in Crisps et al.'s (2000) (65%) and Crisps et al. (2005) (67%) papers. The average age of the sample was 50.95 (16–94; S.D. 18.85). Participant demographics can be seen in Table 1. These demographics are similar to those identified in Crisps et al. (2000) study (45% males, 24% singles and 95% white). Their 2005 study does not report participant demographics.

### 3.2. Opinions of people with mental illness

Percentages of public agreement with the negative stigma statements were compared to the 1998 and 2003 findings of Crisp et al. (2000, 2005), results can be seen in Table 2. Broadly, the results for the 2008 database follow the same trend as the previous two databases. Schizophrenia's items of dangerous to others, unpredictable and hard to talk to have all continued to decrease over time. Interestingly, selves to blame, not improved if treated and feel different from us had previously lowered in 2003

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