Personal and Perceived Stigma Towards Mental Illness Between Psychology and Non-Psychology Participants

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And finally, to my dog Oscar, who made me go for nice walks and have a good break between sections of this thesis, and for not eating my work.

"Men are so necessarily mad, that not to be mad would amount to another form of madness."

Pascal

"If you talk to God, you are praying.
If God talks to you, you have schizophrenia."

(Unknown)

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ABSTRACT

The present study examined whether psychology and non-psychology participants would differ in relation to levels of stigma towards people with mental illness based on given vignettes. Questionnaires were given to 112 participants of which 62 were psychology students and 50 non psychology. The questionnaires consisted of three different vignettes on early schizophrenia, depression and troubled person, which participants were asked to diagnose, followed by questionnaires on helpful interventions, personal distance, perceived stigma, perception of dangerousness and GHQ-12. As predicted, psychology students showed significantly lower levels of stigma towards mental health than non-psychology students. The study also showed that psychology students diagnosed the person depicted in the vignette more accurately than non-psychology participants. The findings were discussed in relation to how mental health is perceived both by mental health professionals and the general population, as well as an understanding of mental illness and its diagnoses. Some possible interventions to reduce levels of stigma are also discussed.

INTRODUCTION

Defining Mental Health

Mental health can be described as a medical condition that can disturb a person's daily functions, the way they relate to others, their mood, and thinking (Smith, 2008). According to the National Institute of Mental Health in the United States of America, it is estimated that 1 in 17 people will suffer from some sort of mental disorder ("The Numbers Count", n.d.). In Ireland, the population suffering from mental health is approximately one in every three that attends a family doctor, and, of those who live to 65, it is very likely that one in nine will spend some time in mental health care ("About Mental Health Ireland", n.d).

With that in mind, it is important to understand what mental health is, and how it is viewed by the population, in order to find ways to best help those who suffer from it.

History of Madness

In the past, when someone suffered from a mental health problem such as what is now called schizophrenia, they were considered "mad". Mental health used to be associated with madness, and patients that were not violent, or that suffered from what would now be called "depression", were left on their own with no care, sometimes on the streets, while those considered to be dangerous, like paranoid or schizophrenics, were locked up in a mental institution and were subjected to very harsh treatment and mechanical restraint (Bewley, 2008).

People were locked up in institutions known as asylums, that were designed not only to remove them from the society, but also to provide them with some sort of order that was thought could bring balance back to their disordered mind (Link, Phelan, Bresnahan, Stueve

& Pescosolido, 1999). When locked up in those institutions, the mentally ill were treated in a terrible way, with no dignity and no proper care, just waiting for their death. People believed they were possessed by demons (Schultz & Schultz, 2008), and perhaps thought they were being punished by God. Part of their "cure" was a routine of purging, bleeding and blistering, only to be locked up again if they survived (Schultz & Schultz, 2008). Lobotomy was also used for many cases – and it is still used today (Smith, VanderGriff & Kostas, 2004).

In the late 18th early 19th century, a French physician called Philippe Pinel was responsible for releasing the "lunatics" from their chains, as he believed those who suffered from mental illness should be treated with dignity, making him a pioneer on the humane treatment of the mentally ill (Sanjurjo Castelao & De Paz Ranz, 2013). He believed those who suffer from a mental illness should be treated with respect, as they were still human, and that part of their treatment was to talk about their problems with the carers. He also believed that there were causes unrelated to demonic possession that caused someone to fall ill: hereditary, physical conditions, stress or some sort of psychological damage (Schultz & Schultz, 2008; Falccinetti, 2008). There are those who consider Philippe Pinel to be the pioneer of psychiatry, but since a lot of his work involved talking to his patients and getting to know them, he could perhaps also be considered the pioneer of psychotherapy.

In the United Kingdom, it was only in 1841 that a foundation was created in order to help those in need of mental health assistance: the Association of Medical Officers of Asylums and Hospitals for the Insane (Bewley, 2008). A major factor for this attention doctors and politicians were then paying to mental health was due to King George III, who suffered from recurrent periods of "mania" (Bewley, 2008). The law was then questioned in relation to how patients were being treated by those who worked in those asylums, and the treatment began to change. Many asylums being built at that time and had better facilities than before, especially when compared to St Mary of Bethlem in London, better known as

Bedlam (Bewley, 2008). The way mental health was treated began to improve thanks to many physicians like Pinel. However the way it was regarded by the general population has not changed much in nearly three centuries.

Those who suffered from a psychological disorder in the past also suffered a lot from stigmatizing attitudes from others and possible from themselves (for example thinking themselves as worthless). However, as mentioned before, this is a current issue; people still suffer from stigma when they are diagnosed with a mental disorder, or if their behaviour deviates from the norm society imposes on people (Phelan & Basow, 2007). Stigmatizing attitudes towards others that have a mental issue is a serious, ongoing problem that needs to be addressed.

According to Link et al. (1999), in the history of psychiatry it is possible to see that cultural conceptions of mental illness have major consequences for stereotyping, help seeking and treatments that was supposed to help those suffering from mental illness.

Stigma in Society

The term "stigma" was adopted in 1963 by Goffman and has its roots from the Greek, who defined it as a mark that represented immoral status, so that everyone in the population would know that the person marked was considered worthless (Davis, 2006), which in turn leads to prejudice (Link & Phelan, 2001).

Corrigan and O'Shaughnessy (2007) distinguish between three types of stigma, self-stigma, structural stigma, and public stigma. Self-stigma is when the prejudice is turned against those who suffer from mental illness themselves, because they are part of that different group in society. Structural stigma is related to private and governmental institutions

and their policies, which normally restrict opportunities for people with mental illness, reducing their chances of getting a job, for example, so they are left out of the community. The last type of stigma is Public stigma, which is the way members of one group react based on stigma towards another group.

Even though a lot is currently known about mental health, and years of research has come up with several therapies and ways to help people to deal with what bothers them in that regard, there is still a lot of improvement to be made. One definition of mental health given by the World Health Organization is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" ("Mental health: a state of well-being", 2013).

Study by Phelan and Basow (2007) found that in some cases, labelling a disorder can increase stigmatizing attitudes towards that person, by increasing negative stereotype. According to Phelan and Basow (2007), those participants that labelled the person in the study as mentally ill were more likely to view them as being dangerous, which in turn led to an increased desire for social distance.

Angermeyer (2003) found similar results to the study above. While labelling for the vignettes that described mental illness, there was a correlation between the label of schizophrenia and participants considering the person depicted as being dangerous, which in turn increased social distance. However labelling was found to have no effect on attitudes towards major depression, so participants did not consider those who suffer from depression to be dangerous and did not fear social distance.

There are many factors that can influence a person's stigma towards mental health. Although everyone can all suffer from mental health at any point in their lives, and it is very

likely that people will suffer from at least one disorder before age 65 (Bijl, Ravelli & Zessen, 1998), the stigma towards it is still very significant, making it harder for those who suffer from those disorders to seek help and be willing to tell anyone about their problems. It is believed that certain attitudes towards people can affect their self-esteem, but it can also decrease their help seeking behaviour (Lundberg, Hansson, Wentz & Bjorkman, 2009). Stigma can also affect personal relationships and a persons' ability to achieve educational and vocational goals (Reavley & Jorm, 2011b). Stigma interferes with mental health care in many ways; people who have some sort of mental illness might never seek help in order to avoid the label, and might never participate in care, denying that they have a mental disorder (Corrigan, 2004).

Stigma Among Mental Health professionals

Stigma is not only found among the general population, however. Several studies such as one by Westwood and Baker (2010) have found that registered nurses hold negative attitudes towards their patients when they suffer from bipolar disorder. It was found that they are more socially distance, reject their patients and perceive them as being dangerous. It was also found that they are less optimistic about changes or improvement, which can lower the patient's self-esteem and self-efficacy even more (Lundberg, Hansson, Wentz & Bjorkman, 2009).

In contrast, another study has shown that mental health professionals had less stigmatizing attitudes towards those who suffered from mental illness than people who were not mental health trainees and professionals (Smith, 2008). However, the same study suggests that, even though mental health professionals had less stigma towards patients and understand

mental illness more than general population, they still treated them in a stigmatizing way, believing for example that they would not get better or that they are acting out (Smith, 2008). Public health practitioners have a very important role that is monitor public beliefs about mental illness (Link et al., 1999), therefore they should focus on reducing their own stigma and attitudes towards mental health to be able to act on that discrimination when faced with it.

Research has found that medical student's attitudes towards patients that suffer from mental illness deteriorates as they progress through their medical college (Korszum, Dinos, Ahmed & Bhui, 2012). According to this study, medical students' attitudes towards people who suffer from pneumonia did not change from first to fifth year of college, but their attitudes towards those with chronic abdominal pain increase significantly. The chronic abdominal pain did not necessarily had to be a symptom of an organic disease, but of an imaginary symptom. It was found then that the closer medicine students were to graduate, the higher their stigma towards mental health was, which in turn result in practicing professionals with negative attitudes towards mental health that might have been worsened by their education.

Another study performed on people training to become mental health professionals showed that participants who received health education, training, and experience did not reduce their levels of stigma or their attitudes toward those who suffer from a mental disorder (Sadow, Ryder & Webster, 2002). Even if they had a co-worker who suffered from mental health disorders, their attitude did not change. However in cases where those participants had close friends who were mentally ill, their levels of stigma and attitudes improved significantly.

Reducing Stigma and Related Attitudes

It is very important to understand stigma's causes and effects, in order to identify factors that can contribute to its reduction. Studies have found that role play intervention in medical students do enhance knowledge of mental illness, but only in the short term, while a lecture given by mental health professionals, caregivers and testimonies from those who suffer from mental illness was proven to be the most effective way to improve the student's knowledge of stigma and discrimination towards those patients (Kassam, Glozier, Leese, Loughran & Thornicroft, 2011). According to Kassam et al., evaluation of attitudes and behaviour, lessons on mental health stigma and knowledge should be included in the student's curriculum in order to have a bigger impact on them.

A Swedish study has also shown that, when compared to the general population, mental health professionals do not show consistently less or more positive stereotypes when it comes to those suffering from a mental illness (Lauber, Nordt, Braunschweig & Rossler, 2006). It was suggested that mental health professionals should improve their attitudes either by increased quality of professional contacts, by having more education in the area, or include regular supervision to prevent burn-out (Lauber et al., 2006).

Even though doctors and nurses themselves can experience stigma towards mental health, they are in a special position to be able to identify whether patients experience stigma, and to understand the consequences it can have on them (Lundbert et al., 2009). Therefore it is important for doctors and nurses to be aware of stigmatizing attitudes and how to help patients cope with it, as well as find ways to increase their self-esteem and self-efficacy, perhaps by referring them to a therapist.

The way media reports information on mental health and on crimes committed by those with a disorder is of extreme importance. A study shows that people who read the same

report in different context, such as a report on recovery of mental illness, had completely different view on mental health (Corrigan, Powel & Michaels, 2013). The article that suggested the person had recovered reduced participants stigma, whereas the article that regarded them as being dysfunctional increased stigma. Not only reporters must be careful with what they write, but also the population must be aware of any bias in reports.

In order for stigma to be reduced in the general population, previous studies have found that the best way of doing so is by increasing the contact between those who suffer from mental illness and the general public (Corrigan & O'Shaughnessy, 2007). This can be understood in the context of familiarity, when the public is interacting directly with those who suffer from mental illness, they experience the effect of stigma first hand, which leads to improvements in their attitudes (Corrigan & O'Shaughnessy, 2007). That was found to be more effective than trying to educate the population.

Another way to reduce stigma was suggested by Corrigan et al. (2010), and consists of coming out about the illness. According to their study, those who are open about their illness report more life satisfaction and feel more in control of their lives, even though sometimes they can experience more negative attitudes from coming out about their condition. It is important for patients to be encouraged to talk about their issues and feelings, as well as their experience to stigma, in order for them to receive appropriate help in relation to that and become less sensitive to stigmatising attitudes from others (Depla, Graaf, Weeghel & Heeren, 2005).

It was found that, to reduce stigma in a more effective way, the interventions should be more focused on individual disorders rather than on mental illness in general (Reavley & Jorm, 2011a). One way of improving people's knowledge and acceptance of those who are

diagnosed with a mental disorder is again to increase personal contact with them (Corrigan, 2004).

Stigma can be more harmful than the mental illness itself, and it can lead to an internalised stigma, that can make the person suffering from mental illness to have diminished self-efficacy and self-esteem (Corrigan et al., 2010). Anti-stigma campaigns should take into account the different components of stigma, such as stereotype, prejudice and discrimination, in order to tailor an intervention to target stigma in society (Angermeyer, 2003).

Current Study

The current study aims to examine whether there is a difference in personal and perceived stigma towards mental health between psychology and non-psychology participants, and if participants' level of health (as measured by GHQ-12) might affect how they perceive those who have a history of mental illness and their levels of stigma. Significant differences between psychology and non-psychology participants in relation to stigma and perceptions of dangerousness, and perceived and personal stigma will also be explored.

This research includes elements of several different research, plus a comparison to the person's own mental health via the use of GHQ-12 questionnaire. It builds up on previous research, by putting together five different studies (Link et al., 1999; Reavley & Jorm, 2011a, 2011b; Jorm et al., 2005) and their questionnaires into one, in order to come up with a broader understanding of mental health in Ireland, using psychology students where previous research used mental health professionals, and the general population, in order to compare not only knowledge of mental health, but also discrimination, perceptions and prejudices.

Studies such as the one by Link et al (1999) show that in the population there is a strong negative stereotype towards mental health. The results of their study demonstrated how general population regard those who suffer from mental health as being dangerous, especially if they are labelled with schizophrenia, and have a desire for social distance. This lack of understanding of mental health can limit how people can be helped in the best possible way, and make their lives even harder (Jorm et al, 2005).

Many studies suggested that mental health professionals have different stigma and attitudes towards mental illness than the general population (Reavley & Jorm, 2011b; Smith & Cashwell). Therefore current research aims to examine the relationship between psychology and non-psychology students towards mental health, hoping to find similar results from Smith and Cashwell's (2010) and Reavley and Jorm's (2011b) study.

Hypotheses

(1) Psychology students will have less levels of personal and perceived stigma towards mental health than non-psychology participants.
(2) Psychology students will diagnose correctly the person depicted on the vignettes more often than non-psychology participants will.
(3) Psychology students will have significantly less perception of dangerous and social distance towards people who suffer from mental health when compared to non-psychology participants.
(4) There will be a negative correlation between participants with a history of mental issues and their level of stigma towards mental health when compared to those with no history. (Research?)

(5) Non-psychology participants will have significantly higher desire for social distance and personal and perceived stigma towards those who have a mental disorder than psychology students would.

(6) The vignette that depicts a person suffering from early schizophrenia will be considered to be more dangerous than the vignettes of depression and troubled person.

(7) In general, psychology students will perceive those depicted in the vignettes as being less dangerous and have lower levels of perceived discrimination than non-psychology participants.

Methods

Participants

The present study had a total of 110 participants, of which 62 were psychology undergraduate students from a college in Dublin, 19 were business undergraduate students from the same college, and 32 were part of a general population with no relation with psychology or mental health, who worked with finance or consultancy. Students from the college were selected by either being in class and, with permission from lecturers and college coordinator, asked to participate in the study, or were approach during their break and asked to fill up a questionnaire for an undergraduate research project. Participants from companies were approached by their co-workers and asked if they were willing to participate in the study.

Participants ranged in age from 18 to 57 (M = 24.9, SD = 8.306). A total of 40 males and 72 females participated in the study. For the different vignettes, a total of 35 participants answered the depression questionnaire, 35 answered early schizophrenia and 42 answered troubled person.

Design

The current study is a mixed method design survey questionnaire with two open ended questions at the start. The Independent Variables (IV) for this study were whether participants were from a psychology background or not and which vignettes they answered on the questionnaire (as well as gender). The Dependent Variables (DV) were the helpfulness of interventions, perception of dangerousness, social distance, perceived discrimination, GHQ-12 questionnaire, and personal stigma.

Materials

The present study made use of a printed questionnaire that was handed to participants to be filled up. The first questions were demographic, it asked for their age, course if any, and gender. Following that, the questionnaires consisted of one of three vignettes (one of a character with depression, one of a character with early schizophrenia, and one of a troubled or stressed character) that were taken from two different studies by Link et al. (1999) and Jorm et al. (2005) and randomly assigned to each participant. The vignettes were in accordance with diagnosis of the DSM IV and ICD-10. The character depicted was a 30 or 24 year old male called John. The vignettes were used in order to assess whether participants would correctly diagnose the person depicted on the vignette, and for them to have a description of symptoms in order to answer the questions that followed.

Open ended questions ("What would you say, if anything, is wrong with John?" and "How do you think John could be best helped") were taken from Reavley and Jorm's (2011) study, and were coded as right or wrong diagnosis, and put into categories. In order to assess which interventions would best help the person in the vignette, there was a list with possible interventions for participants to assess as being helpful, harmful or neither. Those were transferred to a table.

The question on perceived dangerousness ("In your opinion, how likely it is that John would do something violent toward other people?") was taken from Link et al. (1999) and coded into a 4-point Likert scale, ranging from very unlikely to very likely. Questions on social distance ("how willing would you be to…") were also taken from Link et al.'s (1999) paper and replicated in Reavley and Jorms's (2011) study.

Questions on personal stigma ("do you believe that…") were taken from Reavley and Jorm's (2011) study, and made on a 5-point Likert scale ranging from strongly agree to strongly disagree. Perceived discrimination asked whether participants thought the person would be discriminated against by others, and was taken from the same study by Reavley and Jorm (2011). Responses were "yes", "no" and "I don't know".

In addition to that, a GHQ-12 questionnaire was added to measure participant's own health to observe if their own health would affect levels of stigma, as well as to assess whether the groups differed or could be considered similar, for a more reliable comparison and assessment of stigma.

A test on reliability was performed on the scale measures (GHQ-12, personal stigma, and social distance). For the three items, Cronbach's Alpha was 0.143 and based on standardized items 0.31 (M = 19.003).

Procedure

Groups were selected prior to giving out the questionnaires. The first group is made up by psychology students and the second group by a mixture of business students and professionals. The latter group were categorized together under non-psychology group. This study used convenient sample, however the questionnaires were intercalated, each participant getting a different one each time, so it was randomized.

When participants were approached, they were told participation was voluntary, and that the study that was looking at perceptions on mental health. Questionnaires were then handed in intercalating the 3 different ones. Participants were given a small sheet with

information of support services in case they feel distressed or need to talk to someone after the questionnaire.

The questionnaire took between 15 to 20 minutes to be completed. After that, they were debriefed, then asked if they had any questions about the study and had their questions clarified. Participants were then thanked for taking part in the study.

RESULTS

Participants

The present study obtained a total sample of 112 participants, of which 35.7% were male (n = 40) and 64.3% were female (n = 72). Their age ranged from 18-57 (M = 24.9, SD = 8.306). From those participants, 54.5% were psychology students (n = 61) and 45.5% were non-psychology (n = 51). In total, 31.3% of participants answered the Depression questionnaire (n = 35), 31.3% answered the early schizophrenia questionnaire (n = 35), and 37.5% answered the troubled person questionnaire (n = 42).

Recognition of Disorder

A Chi-square test for association found that there was a weak positive significant relationship between the variables of correct/incorrect diagnoses and psychology/non-psychology groups (X2 (1, n = 112, p = .04). Therefore the null hypothesis can be rejected.

For correct diagnoses for the vignettes, 51.8% of participants diagnosed correctly (n = 58), and 48.2% incorrectly (n = 54). However, when separating into groups, psychology students diagnosed correctly 63.8% of the time, while non-psychology group diagnosed correctly 36.2% of the time. The vignette on Depression was the one that was diagnosed correctly more often, with 37.9%, against 34.5% for troubled person and 27.6% for early schizophrenia

The qualitative part of this study showed that for the “Depression” vignette, the term used to describe the person more often was “depression”, and the second most used term was “anxiety”. For the “Early Schizophrenia” vignette, the most common answer was “schizophrenia”, followed by “paranoia” and “psychosis”. For the “Troubled Person”

vignette, most participants said the person was suffering from “stress”, “depression” and “anxiety”.

Helpfulness of Interventions

Table 1 shows the percentage of interventions considered helpful for each vignette. Among the helpful options for the “Depression” vignette, close family and Psychologist received the highest ratings (29.5%). For “Early Schizophrenia” vignette, “becoming more active” received the highest score (29.5), followed by “counsellor” and “psychologist” (28.6% each). For the “Troubled Person” vignette, help from friends received the highest score (35.7%).

Medications (tranquilizer and sleeping pills) were considered the most harmful for the three vignettes, together with John trying to deal with it on his own.

Table 1

		Vignette Answered		
		Depression	Early Schizophrenia	Troubled Person
		%	%	%
Typical GP or family doctor	Helpful	22.3	22.3	24.1
	Neither	7.14	6.3	13.4
	Harmful	1.8	2.7	0
Typical Chemist (pharmacist)	Helpful	11.61	9.8	14.3
	Neither	13.4	15.2	17
	Harmful	6.3	6.3	6.3
A Counsellor	Helpful	24.1	28.6	33
	Neither	4.5	2.7	3.6
	Harmful	2.7	0	0.9
A Social Worker	Helpful	17.9	18.8	27.7
	Neither	8.9	11.6	9.8
	Harmful	4.5	0.9	0
A Telephone Counselling Service	Helpful	20.5	22.3	25.9
	Neither	6.3	8.9	10.7
	Harmful	4.5	0	0.9
A Psychiatrist	Helpful	25.9	25.9	25.9
	Neither	2.7	1.8	6.3

	Harmful	2.7	3.6	5.4
	Helpful	29.5	28.6	32.1
A Psychologist	Neither	0.9	1.8	5.4
	Harmful	0.9	0.9	0
	Helpful	29.5	23.2	34.8
Help From Close Family	Neither	0	5.4	0.9
	Harmful	1.8	2.7	1.8
	Helpful	28.6	22.3	35.7
Help From Close Friends	Neither	1.8	7.1	0.9
	Harmful	0.9	1.8	0.9
	Helpful	6.3	8.9	10.7
A Naturopath or Herbalist	Neither	18.8	16.1	19.6
	Harmful	6.3	6.3	7.1
	Helpful	8	6.3	17.9
A Clergy, Minister or Priest	Neither	13.4	14.3	10.7
	Harmful	9.8	10.7	8.9
	Helpful	6.3	8	8
John Trying to Deal on his own	Neither	8.9	3.6	9.8
	Harmful	16.1	19.6	19.6
	Helpful	14.3	12.5	16.1
Vitamins and Minerals	Neither	16.1	17	19.6
	Harmful	0.9	1.8	1.8
	Helpful	7.1	8.9	11.6
Tonic or Herbal Medicines	Neither	22.3	15.2	19.6
	Harmful	1.8	7.1	6.3
	Helpful	1.8	4.5	5.4
Pain Relievers such as Aspirin, Codeine or Panadol	Neither	9.8	7.1	6.3
	Harmful	19.6	19.6	25.9
	Helpful	13.4	17.9	9.8
Antidepressants	Neither	2.7	5.4	6.3
	Harmful	15.2	8	21.4
	Helpful	2.7	2.7	6.3
Antibiotics	Neither	12.5	11.6	8.9
	Harmful	16.1	17	22.3
	Helpful	10.7	6.3	7.1
Sleeping Pills	Neither	5.4	9.8	6.3
	Harmful	15.2	15.2	24.1
	Helpful	4.5	17	6.3
Anti-psychotics	Neither	11.6	5.4	5.4
	Harmful	15.2	8.9	25.9
	Helpful	3.6	9.8	4.5
Tranquilizers such as Valium	Neither	8	6.3	7.1
	Harmful	19.6	15.2	25.9

Becoming more active	Helpful	28.6	29.5	34.8
	Neither	1.8	1.8	2.7
	Harmful	0.9	0	0
Reading about people with similar problem	Helpful	28.6	27.7	31.3
	Neither	1.8	1.8	6.3
	Harmful	0.9	1.8	0
Getting out and About more	Helpful	23.2	26.8	33.9
	Neither	5.4	4.5	1.8
	Harmful	2.7	0	1.8
Attending Courses of relaxation, stress management, meditation or yoga	Helpful	26.8	25	33.9
	Neither	3.6	5.4	3.6
	Harmful	0.9	0.9	0
Cutting out Alcohol altogether	Helpful	18.8	25	24.1
	Neither	12.5	3.6	10.7
	Harmful	0	2.7	2.7
Psychotherapy	Helpful	22	25.9	32.1
	Neither	3.6	2.7	2.7
	Harmful	2.7	2.7	2.7
Hypnosis	Helpful	10.7	11.6	11.6
	Neither	14.3	14.3	20.5
	Harmful	6.3	5.4	5.4
Admitted to a Psychiatric Ward	Helpful	3.6	10.7	8.9
	Neither	10.7	8.9	4.5
	Harmful	17	11.6	24.1
Undergo Electro-Convulsive Therapy (ECT)	Helpful	5.4	3.6	6.3
	Neither	11.6	12.5	8
	Harmful	14.3	15.2	23.2
Having Occasional Drink to Relax	Helpful	7.1	7.1	16.1
	Neither	16.1	11.6	12.5
	Harmful	8	12.5	8.9
Going on a special diet or avoiding certain foods	Helpful	12.5	15.2	20.5
	Neither	14.3	16.1	16.1
	Harmful	4.5	0	0.9

Recovery and Relapse

When it comes to the outcomes of the vignette, the majority of people said they would recover fully, but problems would be likely to re-occur (45.5% of participants), while without

that sort of intervention, 48.2% of participants said the person depicted in the vignette is more likely to get worse.

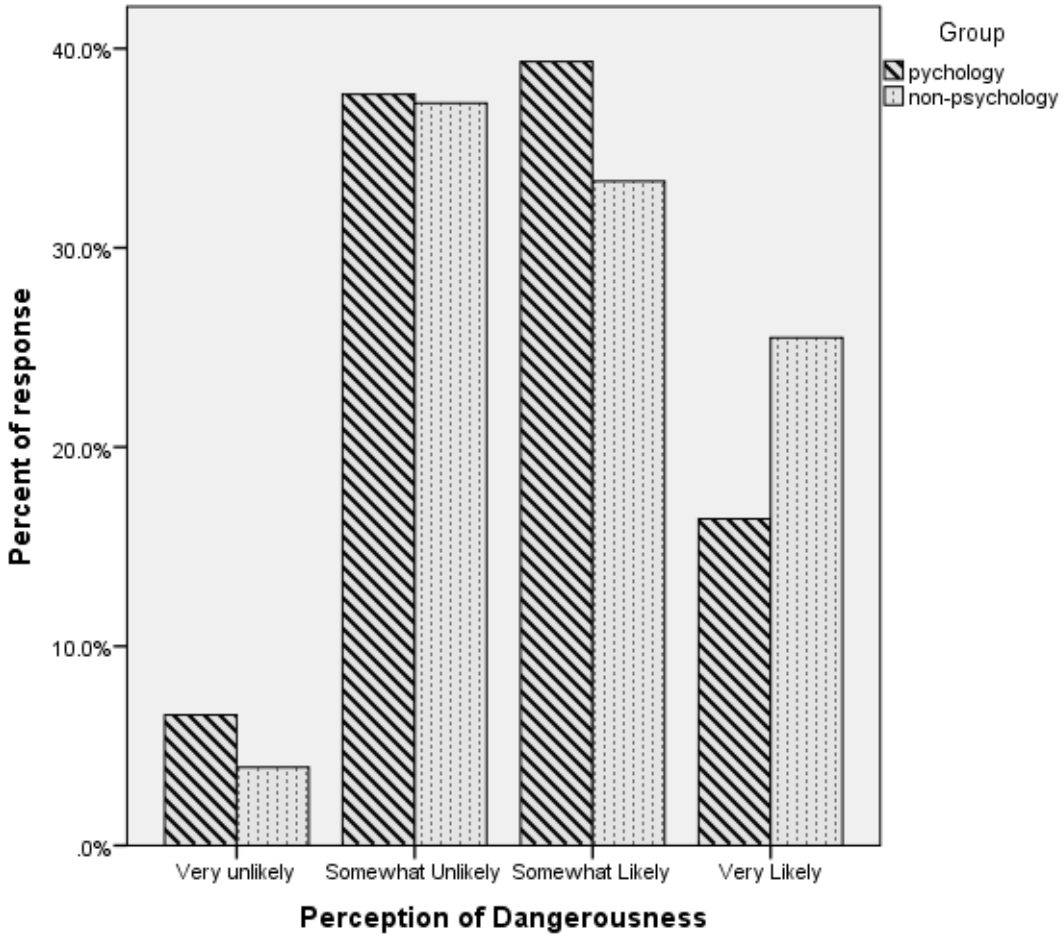
Perceived Discrimination

A Chi-square test for association found that there was a weak positive not significant relationship between the variables perceived discrimination and psychology/non-psychology groups (X2 (2, n = 110, p = .084). Therefore the null hypothesis cannot be rejected.

A Chi-square test for association found that there was a weak but almost moderate positive significant relationship between the variables perceived discrimination and depression, early schizophrenia and troubled person vignettes (X2 (4, n = 110, p = .001). Therefore the null can be rejected.

Perception of Dangerousness

A Mann-Whitney U test was used to test the hypothesis that there will be a significant difference between the ratings given by participants in the psychology and non-psychology groups. Psychology group had a mean rank of 54.3, compared to the mean rank of 59.13 for non-psychology. The Mann-Whitney revealed that the psychology group and non-psychology group did not differ significantly (U= -.83, p = .41).



Perception of Dangerousness in Vignette

A Kruskal-Wallis one-way ANOVA showed that the vignettes for depression, early schizophrenia and troubled person differ significantly with perceptions of dangerousness ($X^2(2) = 10.16$, $p = .006$).

However, a Chi-square test for association found that there was a weak positive not significant relationship between the variables of perceptions of dangerousness and psychology/non-psychology groups ($X^2(3, n = 112, p = .63)$).

Groups' GHQ, Social Distance and Personal Stigma

Even though Psychology group (M = 25.69, SD = 7.64) was found to have higher levels of health than non-psychology group (M = 23.37, SD = 6.52), the 95% confidence limits shows that the population mean difference of the variables lies somewhere between -.373 and 5, which means the result is insignificant. An independent samples t-test found that there was no statistically significant difference between health levels of psychology and non-psychology participants (t (110) = 1.71, p = .08). Therefore the null cannot be rejected.

Psychology students were found to have lower levels of personal stigma (M = 19.17, SD = 4.6) than non-psychology participants (M = 27.12, SD = 5.95). The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -6.94 and -2.96. An independent samples t-test found that there was a statistically significant difference between personal stigma level of psychology and non-psychology participants (t (110) = -4.94, p < .001). Therefore the null can be rejected.

Psychology students were found to have lower levels of desire for social distance (M = 10.23, SD = 2.53) than non-psychology participants (M = 11.78, SD = 3). The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -2.59 and -.519. An independent sample t-test found that there was a statistically significant difference between levels of social distance of psychology and non-psychology participants (t (110) = -2.97, p = .004). Therefore the null can be rejected.

DISCUSSION

The goal for the present study was to identify levels of stigma towards mental illness between psychology and non-psychology participants. In order to achieve that, a quantitative review of the relationship among measures of perceived discrimination, social distance, personal stigma, and GHQ-12 for psychology and non-psychology students was performed. Two other qualitative questions were used to ask what if anything the person depicted in the vignette had, and how they could be best helped. The demographics for the study included gender, age and background (psychology or non-psychology). The research objectives will be divided into different sections for better understanding of each.

Recognition of Disorder

As predicted, the current study found that psychology students diagnosed the disorders in the vignette correctly more often than non-psychology participants. Percentage for overall correct diagnosis for both groups was 51.8%, with very few people diagnosing the "Troubled Person" vignette correctly. Nonetheless, the fact that more than half of participants diagnosed the vignettes correctly shows that the current understanding of mental health might be going in the right direction.

It was found that the vignette diagnosed correctly more often was Depression, and the least often was schizophrenia. In the qualitative part of the study, it was found that, similar to previous studies, the term "depression" was used to describe the person depicted in the vignette very often, even when they were suffering from schizophrenia or normal stress (troubled person). This can mean that the term "depression" is becoming over-generalized (Reavley et al., 2005), and the danger is that mental health professionals are also generalising depression, which can lead to more incorrect diagnosis. Perhaps it is important to build on public knowledge of schizophrenia, anxiety and depression, as the current study showed that

those categories were often recognized incorrectly. It is also important for future research to measure recognition of other disorders in the general population, as being able to recognise different range of anxieties and other disorders is important so they are not perceived as needing less treatment or being of less importance (Reavley et al., 2011b).

Helpfulness of Interventions

Results from the current study were similar to previous studies, suggesting that participants perceived the Troubled Person vignette, which was depicted as a normal person's daily stress, as needing less help from professionals such as GP and counsellors (Reavley & Jorm, 2011a) and more help from close friends.

The interesting finding about the study is that participants rated medication interventions (such as anti-depressants and sleeping pills) as harmful more often than helpful for the any of the three vignettes. This finding was different from Reavley and Jorm's (2011a) study, where participants rated medications as being very helpful. However, the result is similar to that of Reavley and Jorm (2011a) when it comes to lifestyle interventions. Interventions such as meditation, get more active and, practice sports received the highest ratings for all three vignettes. Counselling, psychotherapy, psychiatry and psychologist also received very high ratings, which can mean that the population is more understanding of causes of mental illness and that they believe that talking about problems is more helpful than medication.

Likely Outcomes for Vignette

Similar to findings from Reavley and Jorm (2011a), the current study found that participants believed the likely outcome for those in the vignette was to fully recover but with

the possibility of problems reoccurring when they receive the intervention for the disorder. Also, that without the treatment, participants were more likely to get worse. In that regard, it was found that participants were not very optimistic about recovery rates for those who suffer from a mental illness, similar to some mental health professionals from Reavley and Jorm's (2011a) study.

Perception of Dangerousness

The present study also found that perception of dangerousness for each vignette differed significantly, but between groups (psychology and non-psychology) it was insignificant; psychology students did not consider the person depicted in the vignette as being more or less dangerous than the general population. However, when analysing responses for the vignettes in relation to perception of dangerousness, participants differed significantly. Participants rated "troubled person" as being "very likely" to do something violent toward other people more often than the other vignettes. Those results were different from expected, since many people believe that those who suffer from schizophrenia are more likely to be dangerous – which is not correct (Penn, Kommana, Mansfield & Link, 1999).

According to Link et al. (1999), perception of dangerousness in the public can be due to the thought that those who suffer from mental illness are more likely to commit a crime than those who do not. This is an issue with information given to the public by media, be it news, magazines or television programmes (Corrigan et al., 2013).

As a study from Phelan and Basow (2007) suggests, perception of dangerousness can be due to participants having to label the person in the vignette as having a disorder. The current study had similar findings to Phelan and Basow's study, where labelling explained the variance in perception of dangerousness for the common stress scenario, in the current study's case, the troubled person.

Attitudinal Social Distance

It was found that psychology students had lower levels of desire for social distance towards those who suffer from mental health than non-psychology students. Those findings were similar to previous research. A possible explanation for that desire of social distance that some participants showed toward those who suffer from a mental illness, is that the symptoms themselves might represent personal attributes that are undesirable and that others want to avoid, and might induce fear in others (Link et al., 1999).

Personal Stigma

The results from the present study show that psychology students had significantly lower levels of personal stigma than non-psychology participants. The findings were similar to those found in Corrigan and O'Shaughnessy's (2007) study, in which people with more contact with those who suffer from a mental illness and have more information on the subject show lower levels of stigma and prejudice.

As with previous studies, a significant difference in scores of personal and perceived stigma was found. Perhaps it was due to a social desirability effect, and participants wanted to show lower levels of stigmatizing attitudes than there actually was (Reavley & Jorm, 2011b). Also, future research could look at whether empathy, the ability to take other person's perspective into account, have a relationship with levels of stigma, by impacting their tolerance for mental illness (Phelan & Basow, 2007).

Perceived Discrimination

Results for perceived discrimination between the two groups was found not to be significant. However when analysing perceived discrimination against the three vignettes, the results were significant. 25.5% of participants thought that the person depicted on the early schizophrenia vignette was more likely to be discriminate against by others in the community. This result is similar to previous study, and shows that stigma reduction campaigns should focus more on bringing together public's perception of stigma and their belief (Reavley & Jorm, 2011b)

GHQ-12 and Stigma

The current study is the only one of its kind (as far as the author is aware) to include a comparison of participant's own health to their level of stigma towards mental health. This was included first to assess whether there was a difference in health levels between groups, or if they could be considered equals. Psychology students had slightly better health than non-psychology participants. However, no significant result was found when comparing their health levels with levels of stigma. More research is needed in order to assess whether personal health can influence levels of stigma.

Limitations

As the study was probably the first to assess participants' health and their level of stigma, the questionnaire used might not have been ideal. A GHQ-12 questionnaire was used, which could have been too short and not able to measure more aspects of participants' health. Perhaps future research could use another version of GHQ, or different questionnaires altogether, and maybe even a qualitative assessment of their health.

Previous studies have found that gender can influence likelihood and type of diagnosis (Hartung & Widiger, 1998; Eriksen & Kress, 2008), especially when the person is suffering from depression. In cases where a person is showing the same symptoms of depression, women are more likely to be diagnosed with the disorder than men (Bertakis, Helms, Callahan. Azari, Leigh & Robbins, 2001; Potts, Burnam & Wells, 1991). Therefore, future research could try to control for gender differences in diagnosis by using males and females in the vignettes, in order to compare specially perception of dangerousness and which gender would be diagnosed with a disorder more often in which scenarios.

Another limitation to the current study might be that it used psychology students as samples as well as some business students, which might limit the findings to be generalised. Also, the current study investigates only three conditions of mental disorder in the vignettes, and maybe future research should look for more conditions and different disorders that are not really known by the general population.

Finally, previous study have shown that university students had moderate to good attitudes towards those who suffer from mental illness (Al-Naggar, 2013). This might be due to different levels of education, or with interaction with different people from different background, such as students from other countries and different culture. Future research should take this into account and try to assess participant's contact and understanding of mental illness as a way to best assess their stigma.

CONCLUSION

Results from the current study on personal and perceived stigma between psychology and non-psychology participants have found that psychology participants diagnosed correctly the person depicted in vignettes more often than non-psychology participants, and that psychology students have less stigmatising attitudes towards people who suffer from mental

health. This findings suggests that programs aimed at reducing stigma in the general population should focus on contact between the population and those who suffer from mental illness in order to decrease their levels of stigma. Those interventions should focus on perceptions of dangerousness and social distance, as well as personal stigma, which are based on a persons' beliefs.

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Appendix

My name is Penelope and I am conducting research in the Department of Psychology that explores views and attitudes regarding mental health. This research is being conducted as part of my studies and will be submitted for examination.

You are invited to take part in this study and participation involves completing and returning the attached anonymous survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services are included on the sheet handed with this questionnaire.

Participation is completely voluntary and so you are not obliged to take part. You can withdraw from the study at any time.

Participation is anonymous and confidential. Thus responses cannot be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been collected.

The questionnaires will be securely stored and data from the questionnaires will be transferred from the paper record to electronic format and stored on a password protected computer.
It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.

Should you require any further information about the research, please contact
Penelope Di Palma,

supervisor can be contacted at

Thank you for taking the time to complete this survey.

Are you a:

Male ☐
Female ☐

How old are you? [ ]

What is your background?
Psychology ☐
Non-Psychology ☐

Vignettes

Troubled Person:
John is 30 years old. Up until a year ago, life was pretty okay for him. While nothing much was going wrong in his life he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and that when things go wrong, he sometimes gets nervous or annoyed. Otherwise he is getting along pretty well. He enjoys being with other people and although he sometimes argues with his family, he has been getting along pretty well with them.

Depression:
John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.

Early Schizophrenia:
John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night when they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realize he is not taking drugs because he never sees anyone or goes anywhere.

Questionnaire Questions - Please read everything carefully

What would you say, if anything, is wrong with John?

How do you think John could best be helped?

Rate the likely helpfulness of the interventions below as helpful, harmful or neither

Typical GP or family doctor	Helpful	Harmful	Neither
Typical Chemist (pharmacist)	Helpful	Harmful	Neither
A Counsellor	Helpful	Harmful	Neither
A social worker	Helpful	Harmful	Neither
A telephone counselling service	Helpful	Harmful	Neither
A psychiatrist	Helpful	Harmful	Neither
A psychologist	Helpful	Harmful	Neither
Help from close family	Helpful	Harmful	Neither
Help from close friends	Helpful	Harmful	Neither
A naturopath or a herbalist	Helpful	Harmful	Neither
The clergy, a minister or priest	Helpful	Harmful	Neither
John trying to deal with his problems on his own	Helpful	Harmful	Neither
Vitamins and minerals	Helpful	Harmful	Neither
Tonics or herbal medicines	Helpful	Harmful	Neither
Pain relievers, such as aspirin, codeine or Panadol	Helpful	Harmful	Neither
Antidepressants	Helpful	Harmful	Neither
Antibiotics	Helpful	Harmful	Neither
Sleeping pills	Helpful	Harmful	Neither
Anti-psychotics	Helpful	Harmful	Neither
Tranquilizers such as Valium	Helpful	Harmful	Neither

Becoming physically more active, such as playing more sport, or doing a lot more walking or gardening	Helpful	Harmful	Neither
Reading about people with similar problems and how they have dealt with them	Helpful	Harmful	Neither
Getting out and about more	Helpful	Harmful	Neither
Attending courses of relaxation, stress management, meditation or yoga	Helpful	Harmful	Neither
Cutting out alcohol altogether	Helpful	Harmful	Neither
Psychotherapy	Helpful	Harmful	Neither
Hypnosis	Helpful	Harmful	Neither
Being admitted to a psychiatric ward of a hospital	Helpful	Harmful	Neither
Undergo electro-convulsive therapy (ECT)	Helpful	Harmful	Neither
Having an occasional drink to relax	Helpful	Harmful	Neither
Going on a special diet or avoiding certain foods	Helpful	Harmful	Neither

<u>With</u> the sort of professional help you think is most appropriate, what is the likely result for the person in the vignette?

Full recovery with no further problems
Full recovery, but problems would probably re-occur
Partial recovery
Partial recovery, but problems would probably re-occur
No improvement
Get worse.

<u>Without</u> the sort of professional help you think is most appropriate, what is the likely result for the person in the vignette?

Full recovery with no further problems
Full recovery, but problems would probably re-occur
Partial recovery
Partial recovery, but problems would probably re-occur
No improvement
Get worse.

In your opinion, how likely it is that John would do something violent toward other people?

Very likely somewhat likely somewhat unlikely very unlikely

How willing would you be to:

(1) move next door to the person depicted in the vignette

definitely willing probably willing probably unwilling definitely unwilling

(2) spend an evening socializing with the person

definitely willing probably willing probably unwilling definitely unwilling

(3) make friends with the person

definitely willing probably willing probably unwilling definitely unwilling

(4) start working closely with the person

definitely willing probably willing probably unwilling definitely unwilling

(5) have the person marry into the family

definitely willing probably willing probably unwilling definitely unwilling

Do you believe that:

(1) People with a problem like John's could snap out of it if they wanted

Strongly Disagree Disagree Don't know Agree Strongly agree

(2) A problem like John's is a sign of personal weakness

Strongly Disagree Disagree Don't know Agree Strongly agree

(3) John's problem is not a real medical illness

Strongly Disagree Disagree Don't know Agree Strongly agree

(4) People with a problem like John's are dangerous

Strongly Disagree Disagree Don't know Agree Strongly agree

(5) It is best to avoid people with a problem like John's so that you don't develop this problem

Strongly Disagree Disagree Don't know Agree Strongly agree

(6) People with a problem like John's are unpredictable

Strongly Disagree Disagree Don't know Agree Strongly agree

(7) If I had a problem like John's I would not tell anyone

Strongly Disagree Disagree Don't know Agree Strongly agree

(8) I would not employ someone if I knew they had a problem like John's

Strongly Disagree Disagree Don't know Agree Strongly agree

(9) I would not vote for a politician if I knew they had suffered a problem like John's

Strongly Disagree Disagree Don't know Agree Strongly agree

Is the person in the vignette likely to be discriminated against by others in the community?

Yes No I don't know

Please read the following statements and underline the answer that you think most relates to you over the last few weeks.
Have you recently:

1	Been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7	Been able to enjoy your normal day to day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8	Been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9	Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	Been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

Thank you very much for your co-operation.

Support Services

If you find that any of the questions affected you in any way, you can contact the helplines below:
Samaritans
Tel: +353 1 6710071

Pieta House Tel: +353 01-6010000

AWARE Tel: 1890 303 302

Shine Tel: 021 4377 052