Effect of aetiological explanations on negative attitudes towards individuals with psychosis.


With special thanks to: Conor Murphy, Mick Jordan, Marina Gorski (Film Department, DBS) & Wayne Byrne.

Why Aetiology?

Experiences of discrimination and negative attitudes, leading to suffering, social isolation, and reduced rates of recovery (Read, Haslam, Sayce, & Davies, 2006).

*Particularly* among individuals who have experienced psychosis (Anglin, Greenspoon, Lighty, Corcoran, & Yang, 2014).

Despite efforts to reduce the stigma and negative attitudes to mental health difficulties / psychosis, negative attitudes have been increasing (Read & Dillon, 2013).

Endorsement of a biomedical paradigm for illness explanation: *‘An illness like any other’*

- Evidence of increased stigma with bio endorsement;
  - Biogenetic → Intolerance
  - Biologically-determined / Brain Disease → dangerousness, actions beyond control, pessimism for recovery (Read, Haslam & Magliano, 2013)

*The way we explain it has implications on how society views it.*
Walker & Read, (2002)

‘Anthony’: Paranoid delusions, self harm voices

Maths Undergrads

“Schizophrenia: a brain disorder with a genetic predisposition”
N = 37

“Schizophrenia: biological and environmental factors”
N = 47

“The long term effects of trauma”
N = 42

Dangerous & Unpredictable medical condition
Bennett, Thirlaway & Murray, (2008)

‘Simon’; paranoid delusions, hearing controlling voices

Social Science Undergrads

- Desire for social distance
- Associative stigma towards close family members
- The perceived potential for recovery*
- Perceived accountability
- Assumption of dangerousness*

→ Higher associated stigma in genetic vignette.

Genetic predisposition within family

Onset following sudden death of wife
Experimental Script

Script
• Integration of previous descriptions from other similar studies (Walker & Read, 2002; Bennet et al., 2008).
• Non-inclusion of labels (“Psychosis”/“Schizophrenia”) – intentional, but considered for future experiments.

Video
• 1 per condition, content changed depending on condition.
• Given by actor, male in white lab coat – impression of being a doctor describing an individual case.
Sequence 1 - *Case presentation*
➢ Description of subject’s background / common symptoms of Psychosis (voice hearing)
  ➢ remained same for each condition

Sequence 2 - *What caused John’s difficulties?*
➢ Explanations – representations of each aetiological explanation.
➢ Biomedical, Psychosocial, Combined –
  Malfunctioning Brain / Growing up in ‘critical environment’ / Combined

Sequence 3 – *Treatment*
➢ Based on aetiological explanation. Attempt not to overload with information, establishing clarity between treatments.
Antipsychotic medication / CBT / Antipsychs + CBT
Attempt not to overload with information, establishing clarity between treatments.
Measures

• Demographics – Gender, Nationality, Highest Level of Education
  • Known someone with Psychosis, Accuracy / Understanding of Video.

• Five attitudes measured using separate likert attitude scales (Bennett and Thirlaway, 2008) with 37 statements in total.
  ➢ Desire for social distance
    I would feel uncomfortable inviting John along to a friend’s party.
  ➢ Associative stigma towards close family members
    If my partner told me that their father had problems just like John, this would not worry me.
  ➢ The perceived potential for recovery
    John will always be ‘mentally ill’. Even if his symptoms disappear they could come back at any time.
  ➢ The perceived accountability of an affected individual
    I don’t think it would be right to hold John entirely responsible if he were to cause somebody offence.
  ➢ Assumption of dangerousness
    I would feel unsafe if I were left alone with John.
Recruitment

• Main recruitment platform: Social media was the main medium used for distribution of the survey link, via platforms such as Instagram, Facebook, Twitter, and LinkedIn. Emails were also sent to any persons or organizations that had association to the target participant population, i.e., student unions/societies.

• Keeping a record: A log of all distribution locations, dates and times was retained. Any responses were recorded in order to obtain an indication of the effectiveness of the varying platforms.

• Effective Medium? As it was students which was required for participation, the approach of social media & emailing organisations was concluded to be valuable and efficient.
Results

Total Participants: N = 230  172 Females / 51 Males

Have you ever known someone with Schizophrenia / form of psychosis?

Yes = 117 / 109 = No

Understanding of content in video (1-10):
Belief that Doctor’s explanation was ‘accurate’ (1-10)

M = 7.63 (1.92)

M = 6.58 (1.83)* → *N = 96

Current field of study:

Psychology related
(Psychology, Counselling, Psychotherapy)  73
Non psych-related  93
Missing / Not currently studying  64

Age (M) = 29.82 (Range: 18 – 65)

Yes = 117 / 109 = No
### Multivariate Analyses

#### Between Conditions

No significant difference in attitudes between conditions (F (10, 418) = 1.45, p = .157, effect size = .033, (1-β) = .73. *LOWER stigmatising attitudes in BIOMEDICAL condition.

#### Known someone with Schizophrenia / Psychosis

Significant difference between those who had known someone with psychosis and those who did not (F (5, 213) = 2.53, p = .030, effect size = .057). (1-β) = .78

→ Significant difference for Perceived Accountability (F (1,214) = 7.95, p = .005, effect size = .04, 1-B = .80)

*LOWER stigmatising attitudes among those who DID KNOW someone w Psychosis, EXCEPT for Perceived Accountability??

#### Field of Study

Significant difference between those in Psych-related fields and non-Psych-related fields (F (5, 154) = 3.49, p = .005, effect size = .102), (1-β) = .91.

→ Significant difference for Perceived Accountability (F (1,213) = 14.42, p <.001, effect size = .08, 1-B = .97)

*LOWER stigma in NON-psych-related fields.

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<table>
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<tr>
<th>Measure</th>
<th>Condition</th>
<th>M</th>
<th>SD</th>
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<tr>
<td>Desire for social distance</td>
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<td></td>
<td>Psychosocial</td>
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<td></td>
<td>Combined</td>
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<tr>
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Overall attitudes less stigmatising across measures compared to original Bennett et al., (2008) study.
Discussion

Results in favour of biomedical paradigm?
• Biological attributions can reduce stereotypes, lower help-seeking stigma, and increase willingness to seek aid in comparison to psychological attributions (Gangi, Yuen, Levine & McNally, 2016).
• Treatability: Decrease sense of essentialism attributed to mentally ill as a result of biomedical paradigms? (Kichuk, Lebowitz & Adams, 2015).
  • Contemporary reviews continue to discount such paradigms (Longdon & Read, 2017).

Knowing someone with Psychosis → reduced stigma?
• History of personal use / knowledge of others’ use of psychiatric services (Walker & Read, 2002).

Higher stigma among psychology students?
• Cases of Schizophrenia: Higher perception of dangerousness and more prognostic pessimism as education progresses (Magliano et al., 2017).
Going forward....

- Aetiology = Red Herring? (Schlier, Schmick & Lincoln, 2014)
- What other factors can be attributed to stigmatising attitudes?
  - Treatability → recovery?
  - Help-seeking behaviour?
  - Illness labels?

- How do we ‘measure’ stigma?
- i.e. perceived accountability?
  - Is the appropriate ‘direction’ of attitudes based on flawed measurement?
References


Thank You

**Any Questions?**

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**Project Link:**