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Awareness of schizophrenia and intellectual disability and stigma across ethnic groups in the UK

Katrina Scior [a,*], Henry W. Potts [b], Adrian F. Furnham [a]

[a] Research Department of Clinical Educational & Health Psychology, University College London, UK
[b] Institute of Epidemiology & Health Care, University College London, UK

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ABSTRACT

Research has examined the public's understanding of mental illness and stigma, but there is scant evidence on intellectual disabilities. This study investigated whether the public from different ethnic groups can recognise symptoms of schizophrenia and intellectual disability depicted in a vignette, and what factors predict recognition and social distance. A survey of lay people of working age was completed in the UK ($N=1002$). The sample was ethnically mixed, with the largest groups consisting of white UK residents, and people from Asian and black African/Caribbean backgrounds. Regression analyses were performed to identify predictors of recognition and social distance. Across the whole sample, 25.7% recognised schizophrenia and 28.0% intellectual disability. Ethnicity, gender, education and prior contact predicted recognition of both vignettes. Social distance was higher for schizophrenia than intellectual disability, but overall participants were ambivalent to mildly negative about social contact with individuals with either symptomatology. Familiarity was associated with lower social distance for both conditions. Symptom recognition predicted reduced social distance for intellectual disability, but not for schizophrenia. The low levels of awareness of symptoms and high levels of stigma among some ethnic groups indicate a need for targeted public education efforts and further research.

1. Introduction

It is now widely recognised that the stigma associated with mental illness and intellectual disability has very negative effects on individuals concerned. Not only do affected individuals have to manage the symptoms of their disorders, but also the negative attitudes and reactions of society at large, which can lead to discrimination and social exclusion (Corrigan et al., 2004; Mencap, 2007), self-stigmatization (Link et al., 2001; Ali et al., 2008) and a reluctance to seek help (Rüsch et al., 2005). Public education campaigns, such as 'Time to Change' in the UK or 'Beyondblue' in Australia, view increasing public awareness and dispelling misconceptions about mental health problems as an essential aspect of efforts to reduce stigma. The few longitudinal studies that have examined public awareness of mental illness indicate that, over time, this has increased (Angermeyer and Matschinger, 2005; Jorm et al., 2006; Reavley and Jorm, 2012a). While awareness is associated with a reduction in the public's desire for social distance from individuals with depression, this is not necessarily the case for schizophrenia (Corrigan et al., 2001; Angermeyer and Matschinger, 2005; Reavley and Jorm, 2012b). That would appear largely due to continuing negative perceptions of individuals with schizophrenia as dangerous and unpredictable, reinforced by sensationalist media reports.

Intellectual disability is defined as a significant impairment in intellectual functioning together with significant impairments in social (adaptive) functioning, which have an onset before adulthood (World Health Organisation, 1990). The large majority of individuals who meet this diagnosis will show *mild* symptoms of intellectual disability and thus are at risk of having their symptoms unrecognised or misattributed to other reasons. Similar to individuals with schizophrenia, people with intellectual disabilities have been marginalised throughout history and face negative public attitudes and social exclusion. In contrast though to the substantial attention that has been paid to stigma and recognition of mental health problems, particularly depression and schizophrenia (Jorm et al., 1997, 2006; Lauber et al., 2003), to date we know very little about lay people's ability to recognise intellectual disability. Nor do we know whether a positive relationship exists between awareness of intellectual disability and stigma. If such a relationship were established, increasing intellectual disability literacy would appear as one important step in countering stigma and aiming towards more inclusion friendly attitudes among the public.

Both awareness of mental illness and social distance have been shown to vary across cultures (Dietrich et al., 2004; Griffiths et al.,

* Correspondence to: Research Department of Clinical Educational & Health Psychology, University College London, Gower Street, London WC1E 6HN, UK. Tel.: +44 20 76791897; fax: +44 20 76791989.
E-mail address: k.scior@ucl.ac.uk (K. Scior).

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2006). The public in Russia and Mongolia showed a higher desire for social distance than in Germany (Dietrich et al., 2004), as did the public in Japan compared to Australians (Griffiths et al., 2006). Mental illness is highly stigmatised in Asian cultures (Ng, 1997) and in sub-Saharan Africa (Adewuja and Makanjuola, 2008; Barke et al., 2011). Such cross-cultural variation may result from different patterns of mental health care, namely institutional versus community care, in the countries concerned (Jorm and Oh, 2009), and extreme scarcity of mental health service resources in many parts of the world (Barke et al., 2011). Cross-cultural differences in attitudes have also been attributed to differences in causal beliefs and the perceived dangerousness of people with mental illness (Angermeyer et al., 2004; Dietrich et al., 2004), which is at least partly due to the levels of media attention and reporting (Angermeyer and Matschinger, 1996). It has also been suggested that stigmatisation is more severe in cultures with a collectivist ethos that discourage open displays of emotions in order to 'save face' and preserve the good reputation of the family (Ng, 1997; Fung and Tsang, 2010). In collectivist cultures, mental illness and disability in a family member are seen to reflect poorly on the family and can influence others' perceptions about the suitability of family members for marriage or employment (Kramer et al., 2002).

Stigma continues to have a detrimental effect on its targets, yet most evidence on public attitudes and awareness originates from Western countries. Hence there is a clear need for more attention to the role of culture in stigmatisation. As noted, to date our knowledge of public attitudes and awareness is largely restricted to prominent mental health problems, while intellectual disability has scarcely been the focus of stigma research (Scior and Furnham, 2011; Werner et al., 2012). This article presents the results of a population survey in the UK aimed at examining recognition and stigma associated with schizophrenia and intellectual disability. Three key cultural communities in the UK are compared, namely white UK residents, people of Asian and Black African/Caribbean backgrounds. Our primary intention was to advance our understanding of public awareness and social distance regarding intellectual disability in the context of multicultural societies. Schizophrenia and intellectual disability were chosen as comparison cases, as both schizophrenia and intellectual disability often have a long lasting and pervasive impact on the person's life and, compared to other mental disorders, both have relatively low lifetime prevalence rates, 1.4% for intellectual disability and 0.4% for schizophrenia (Saha et al., 2005; Allison and Strydom, 2009). Thus one might expect, based on the numbers alone, public awareness of both conditions to be similar.

Based on two diagnostically unlabelled vignettes, one depicting a male with schizophrenia, the other with intellectual disability, our main research questions were: (1) To what extent are lay people able to recognise the respective condition? (2) What factors influence recognition and are these consistent across both conditions? (3) What factors predict stigma and are these the same across both conditions? In particular, is increased recognition of the condition associated with reduced social distance?

2. Methods

2.1. Participants

A cross-sectional survey was conducted in London, involving 1002 UK residents of working age. Of the participants, 29.6% were born outside of the UK, but all had been resident in the UK for at least 3 years. The sample was purposively ethnically mixed, with the largest ethnic groups consisting of white UK residents (41.2%), individuals of Asian (24.7%), and black African/Caribbean backgrounds (20.8%). The mean age across the whole sample was 27 years (S.D.=11); 52.5% were female, 47.2% male (0.3% unspecified). 35.2% had been educated to age 18 or less, and 64.8% were graduates. 46.6% reported prior contact with someone with mental health problems (of these, 13.9% said they knew someone with schizophrenia or symptoms of psychosis, $n=65$). 31.9% reported prior contact with someone with intellectual disabilities, 41.7% reported no prior contact and 26.3% of responses to this question were missing, perhaps because it was at the very end of the survey. In terms of religious affiliation, 34.5% described themselves as Christian, 16.1% as Muslim, 3.5% as Hindu, 1.8% as Jewish, the same proportion as Buddhist, 0.5% as Sikh, and 40.7% as either Agnostic or Atheist. 35% rated religion as important or very important in their lives, and 45% as of little importance.

2.2. Measures

Participants were presented with two unlabelled vignettes of a male in his 20s. The first depicted an individual who met diagnostic criteria for a (mild) intellectual disability, the other for schizophrenia (World Health Organisation, 1990), see Fig. 1. Respondents were asked "what would you say is going on with X?" Participants also rated their views on social contact with someone like the person in the vignette by responding to four statements about social contact in situations of increasing intimacy (live next door, spend an evening socialising, make friends, marry into family), taken from Scior and Furnham (2011). Participants rated their agreement with each item on a 7-point Likert scale. A social distance score is a mean of responses, with higher scores indicating a stronger desire for social distance. The internal reliability of the scale was very good, with

Schizophrenia Vignette

Adam is 24 and lives at home with his parents. He did fine at school, but has only had a few casual jobs since. Over recent months he has spent lots of time alone, locked in his bedroom and frequently refuses to eat with his parents or have a bath. He sometimes gets very agitated for little apparent reason and his parents have heard him talking loudly even when he's alone in his bedroom. At times they find his speech disorganised and hard to follow. When his parents encourage him to make plans for his future he says this is too dangerous. They are certain he is not taking drugs because he never sees anyone or goes anywhere.

Intellectual Disability Vignette

James is 22 and lives at home with his parents and younger brother. He found school a struggle and left without any qualifications. He has had occasional casual jobs since. When his parents try to encourage him to make plans for his future, James has few ideas or expresses ambitions that are well out of his reach. Rather than having him at home doing nothing, his mum has been trying to teach James new skills, such as cooking a meal, but James has struggled to follow her instructions. He opened up a bank account with his parents' help, but has little idea of budgeting and, unless his parents stop him, will spend all his benefits on comics and DVDs as soon as he receives his money.

Fig. 1. Vignettes for schizophrenia and intellectual disability.