

Stigmatisation of people with mental illness

**Report of the research carried out in July 1998 and July 2003
by the Office for National Statistics (ONS) on behalf of the
Royal College of Psychiatrists' Changing Minds Campaign**

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November 2003**

Contents

1.	Introduction	1
2.	Sampling errors and statistical significance	1
3.	Personal knowledge of mental illness in others	1
4.	Attitudes towards those with mental illness	2
5.	Negative attitudes towards mental illness	3
6.	Comparison of attitudes in 1998 and in 2003	3
7.	Attitudes in general towards mental illness	4
8.	The extent to which attitudes are correlated	4
9.	Overall attitudes to each disorder	5
10.	Views about the prognosis for mental disorders	5
11.	Characteristics of those with different attitudes	6
12.	Overall attitudes to the mental disorders covered by the survey	7
	Appendix Sampling error calculations	8

1. Introduction

A module of questions relating to the stigmatisation of people with mental disorders was first included on the ONS Omnibus Survey in July 1998, before the start of a five-year campaign by the Royal College of Psychiatrists to reduce the stigma of mental illness. The questions were included for a second time in July 2003, with the aim of determining whether, and to what extent, public attitudes towards mental illness had changed. It was also envisaged that, provided there had been no major shift in opinions, data from the two surveys could be combined to allow more detailed analysis of the characteristics of those with particular attitudes towards the mentally ill.

Each month in which the Omnibus Survey takes place, interviews are sought in a nationally representative sample of 3,000 private households throughout Great Britain. At multi-household addresses, interviewers use a standard ONS procedure to select one household at random. In households with more than one adult, one person aged 16 and over is randomly selected for interview. This means that people in households containing few adults have a higher probability of selection for interview than those in households with many. Where the unit of analysis is individual adults, as it is for this module, a weighting factor is applied to correct for the unequal probabilities of selection.

Interviews were obtained with 1790 adults aged 16 and over in July 1998, and 1725 in July 2003, response rates of 67% and 65% respectively.

The module consisted of a few introductory questions followed by a series of attitude questions relating to a list of seven mental disorders. The questions are described in the sections that follow.

2. Sampling error and statistical significance

Since the data in this report were obtained from a sample of the population, they are subject to sampling error, and this must be taken into account when considering the results.

In general, attention has only been drawn to differences between estimates when they are significant at the .05 confidence level, thus indicating that there is less than a 5% probability that the observed difference is due to random sampling variation and that no real difference occurred in the population from which the sample was drawn. It should be noted therefore that where large numbers of comparisons are being made, up to one in twenty findings of statistical significance will not, in fact, reflect real differences in the population.

It is also important to remember that sampling error is only one of the factors that affect the results obtained from a survey. Other sources, such as non-response bias, are more difficult to quantify.

See the Appendix for further details of sampling error calculations.

3. Personal knowledge of mental illness in others

To provide a context for their attitudes, respondents were asked if they knew anyone who had had a mental illness. The form of the question was different in the two surveys. In 1998, respondents were asked '*Do you personally know anyone who has had a mental illness?*' with no explanation given of what was meant by the term 'mental illness'. In 2003, respondents were asked separately about each of the seven illnesses covered by the main part of the questionnaire:

- Severe depression
- Panic attacks or phobias
- Schizophrenia
- Dementia (eg Alzheimer's Disease)
- Eating disorder (eg anorexia or bulimia)
- Alcoholism
- Drug addiction

In both surveys, the form of the question was such that respondents were asked about mental illness in people they currently knew, but a positive response did not necessarily mean that the person concerned still had the condition.

Not surprisingly, the more detailed question elicited many more positive responses: in 1998, 52% of respondents said they knew someone with a mental illness, but in 2003, 77% answered 'yes' in relation to at least one of the illnesses specified. Almost half the sample (47%) knew someone who had had severe depression. The next most likely illnesses to have been encountered were alcoholism (37%), dementia (34%) and panic attacks or phobias (33%). Between one fifth and one quarter knew someone who was or had been a drug addict, and a similar proportion knew someone who had had an eating disorder. The least likely mental illness to have been encountered was schizophrenia, but even so, 15% of respondents said they knew someone with this condition.

Respondents were not asked directly if they themselves had ever had any of the specified illnesses, but if they mentioned spontaneously that they had, this was recorded. Only 3% of respondents were forthcoming in this way, far fewer than are likely to have had a mental disorder of some kind, but it is likely that they will have given positive responses to the questions about mental illness in other people.

Women were more likely than men to say they knew someone with each condition specified, except alcoholism and drug addiction, where the reverse was the case.

The pattern according to age was less straightforward. Those aged 16-24 were more likely than those aged 65 and over to know someone who was, or had been, addicted to drugs or alcohol, or who had had an eating disorder. On the other hand, those aged 45 and over were more likely than younger people to know someone with dementia. Severe depression and schizophrenia were more likely to have been encountered by those aged 25-64 than by those in the oldest and youngest age groups.

There were also variations in personal knowledge of someone with mental illness according to socio-economic classification. Overall, those in managerial and professional households were more likely than other respondents to say they knew someone with mental illness (82% compared with 75%). The difference was also apparent for each of the listed mental disorders, but was statistically significant only for dementia, alcoholism and severe depression.

Tables 1-3

4. Attitudes towards those with mental illness

Respondents were asked a series of questions about each of the seven mental illnesses listed at the top of this page.

They were given a card showing five-point scales for eight different types of attribute, and were asked to say which point on each scale they thought best described a person with a

particular mental illness. Six of the scales covered a range of attitudes towards those with a mental illness, and the remaining two sought respondents' views about the likely prognosis for each condition.

The eight scales were as follows, listed in the order in which they were shown to the respondent: the emboldened end of the scale was taken to indicate a negative attitude towards that particular illness.

Dangerous to others/Not dangerous to others
Unpredictable/Predictable
Hard to talk with/Easy to talk with
Have only themselves to blame for their condition/Are not to blame for their condition
Would improve if given treatment/ Would not improve if given treatment
Feel the way we do at times/ Feel different from the way we feel at times
Could pull themselves together if they wanted/Can't do anything to improve the way they feel
Will eventually recover fully/Will never recover fully

Both pairs of extreme codes were combined, and those who could not answer the question were assigned to the central code. Each respondent's view on each attribute in relation to each illness was thus reduced to negative (score 1 or 2), neutral (score 3) or positive (score 4 or 5).

5. Negative attitudes towards mental illness

Responses differed between the seven disorders, differences in attitudes being most marked in relation to dangerousness, blameworthiness, ability to pull themselves together, response to treatment and prospect for recovery.

Drug addiction was viewed more negatively than the other mental disorders: 78% of those interviewed rated drug addicts as unpredictable, 75% thought that they were a danger to other people, and 64% that they were hard to talk to. Alcohol addiction and schizophrenia were viewed only slightly less unsympathetically on these three attributes, but whereas more than half of those interviewed felt that drug and alcohol addicts had only themselves to blame, only 6% felt this about those with schizophrenia.

Dementia was perceived as having the poorest prognosis - 79% of respondents thought that those with dementia would never fully recover, and 50% that it would not improve with treatment. At the other extreme, only 15% thought that people with eating disorders would never fully recover.

Table 4

6. Comparison of attitudes in 1998 and in 2003

Views appear to have changed little between 1998 and 2003, but to the extent that they did, they became somewhat less negative. Table 5 shows that of the 56 items that could be compared, only 11 showed any increase in negative views over the period, and of those, only three increases were statistically significant, and these related to prognosis - the proportions of respondents who thought that those with eating disorders, alcohol addiction, and drug addiction would never fully recover. In contrast, for most mental illnesses there was a reduction in the proportion of respondents saying that people with them were hard to talk to. Interestingly, there was also a fall in the proportions saying that alcoholics and drug addicts were to blame for their condition: the proportion saying this about alcoholics fell from 60% to 54%, and for drug addicts, from 68% to 60%.

For each disorder, the proportion of respondents saying that people who had it 'feel different from the way we feel at times' was markedly lower in 2003 than in 1998. This is difficult to account for, and some interviewers reported that there was some difficulty in understanding what was meant by the statement. The data presented in the remainder of this report are generally for 1998 and 2003 combined.

Table 5

7. Attitudes in general towards mental illness

Looking at only the proportion with negative views takes no account of the extent to which respondents held counterbalancing positive ones. Tables 6 to 13 show the whole range of views, and include a summary line indicating whether respondents were more likely to agree than to disagree with negative statements. These are further summarised in Table 14.

(a) Dangerous to others

More respondents agreed than disagreed for schizophrenia, alcoholism and drug addiction
More respondents disagreed than agreed for each of the other four mental disorders.

(b) Unpredictable

More respondents agreed than disagreed for every mental illness listed except eating disorders

(c) Hard to talk with

More respondents agreed than disagreed for every mental illness listed except panic attacks and eating disorders

(d) They are to blame

More respondents agreed than disagreed for alcoholism and drug addiction
More respondents disagreed than agreed for severe depression, panic attacks, schizophrenia and dementia

(e) Treatment would not help

More respondents agreed than disagreed for dementia
More respondents disagreed than agreed for each of the other six mental disorders.

(g) They could pull themselves together

More respondents agreed than disagreed for alcoholism and drug addiction
More respondents disagreed than agreed for severe depression, panic attacks, schizophrenia and dementia

(h) They will never fully recover

More respondents agreed than disagreed for schizophrenia and dementia
More respondents disagreed than agreed for eating disorders

Tables 6-13

8. The extent to which attitudes are correlated

The level of correlation for a particular pair of attitude statements can be compared for different mental disorders, or alternatively, the extent to which different attitudes are correlated for a particular disorder can be examined.

The seven statements analysed are of two fairly distinct types: statements (a) to (d) and (g) cover general opinions about people with mental disorders, whereas statements (e) and (h)

relate to the likely outcome for those with a particular mental condition. Table 14 shows the extent to which respondents' attitudes were correlated for each of the possible ten pairs of the five attitude variables and for the single pair of prognosis variables.

The pair of variables for which correlations were generally highest were 'they only have themselves to blame for their condition' and 'they could pull themselves together', which is perhaps not surprising, as the concepts underlying the two statements are similar. Other points to note include the relatively high correlation between 'dangerous to others' and 'unpredictable' for schizophrenia, alcoholism and drug addiction.

Table 15

9. Overall attitudes to each disorder

To enable comparison of respondents' overall attitudes to each of the seven mental disorders, it is necessary to combine in some way their scores on each of the five attitude scales. The simplest approach, which has been taken here, is to sum the scores, thus giving each of the scales the same weight. This could be challenged, however: for example, believing that someone with a particular disorder is hard to talk to is not negative to the same degree as thinking them a danger to other people.

The scores that were summed were those on the original five-point scales, where 1 represents a negative view, and 5 a positive one, with those saying 'don't know' re-classified as code 3. Thus the overall score for each respondent lay in the range 5 to 25, with a mid-point of 15. These were then grouped into three categories: 5 to 12 (negative), 13 to 17 (neutral), and 18 to 25 (positive).

As would be expected from the scores on individual attitudes, drug addiction and alcoholism were much more likely to be viewed negatively than any other disorder, and respondents were least likely to have negative attitudes towards dementia, eating disorders and panic attacks.

It might be thought that respondents who knew people with particular mental disorders might view them more sympathetically, but this was only partly the case. Those who knew someone with severe depression and someone who had panic attacks were less likely than those who did not to have negative views about those disorders, but otherwise there were no significant differences in the proportions with negative views overall. However, for two further conditions - schizophrenia and eating disorders - those who had come across people with these conditions were less likely to have neutral views, and more likely to have positive ones.

There was a statistically significant reduction between 1998 and 2003 in the proportion of respondents with negative views about those with severe depression. The reductions for alcoholism and drug addiction were on the borderline of statistical significance.

Tables 16-18

10. Views about the prognosis for mental disorders

Scores on the two scales relating to prognosis were combined in the same way as the five attitude scales discussed in the previous section. Thus respondents' scores could range from 2 to 10, and were grouped into three categories: 2 to 4 (poor), 5 to 7 (neutral), and 8 to 10 (good). Respondents' perceptions of the likely prognosis in terms of recovery and treatment varied widely according to the disorder being considered: 70% thought the

prognosis for dementia was poor, but only 9% thought it was poor for those with eating disorders. People were most likely to have neutral views on the prognosis for schizophrenia.

For four disorders - severe depression, schizophrenia, dementia and alcoholism - those who knew someone with the disorder were more likely than those who did not, to think the outcome was likely to be poor. They were correspondingly less likely to think the prognosis was good (severe depression, dementia) or neutral (schizophrenia, alcoholism).

On the other hand, those who knew someone with panic attacks, an eating disorder or alcoholism, were more likely to think that the likely outcome would be good.

There was a fall between 1998 and 2003 in the proportion of respondents who thought the prognosis was poor for schizophrenia and dementia, but there was an increase for alcoholism and eating disorders.

Tables 19-21

11. Characteristics of those with different attitudes

Men were more likely than women to hold negative attitudes towards every disorder, except alcoholism, drug addiction and dementia, where there was little difference between men and women.

There was a striking association between attitudes and age, in that those aged 16-19 were much more likely than older people to have negative views about every disorder except panic attacks. For example, 36% of those aged 16-19 had negative attitudes towards depression, compared with fewer than 20% in every other age group.

There was no consistent pattern of variation in attitude according to region. Respondents in Scotland were significantly more likely to have negative attitudes towards drug addicts, and those in Wales significantly less likely to have negative attitudes towards those with severe depression and those with dementia. However these apparent differences may not reflect real variation in the population (see Section 1).

Compared with those in routine or manual occupations, those whose current or last job was managerial or professional were less likely to hold negative attitudes towards schizophrenia, and severe depression, dementia and eating disorders, but there were no significant differences for the other three conditions.

Apart from in relation to panic attacks, alcoholism and drug addiction, respondents with a gross personal income of £20,000 a year or more, were less likely to have negative views than respondents in other income groups.

There was also an association for some conditions with "age left full-time education", which is a proxy measure for highest educational level attained. The better-educated respondents were, the less likely they were to hold negative attitudes towards severe depression, schizophrenia and eating disorders. Those still in education at the time of the survey, tended to have more negative views than other respondents, which is consistent with the negative views among 16-19 year olds described earlier.

Adults with at least one child under 16 in the same household were more likely than those with no children to have negative attitudes towards alcoholism and drug addiction, but there were no significant differences according to the age of the youngest child.

Tables 22-29

12. Overall attitudes to the mental disorders covered by the survey

The summary scores relating to each of the seven disorders have been combined to give an overall measure. The grouped summary scores could take any value in the range 1 to 3, so for the combined variable the possible range was 7 to 21. Scores were then grouped into the following categories: 7-10 (negative), 11-12, 13-15, 16-17, and 18-21 (positive).

Fewer than one in ten respondents had a very negative view of all the mental disorders covered in the survey, which is not surprising, given the variation described earlier in the attitudes to the individual disorders. As would be expected from the material presented earlier, there was a small change in a positive direction between 1998 and 2003, but this was less apparent at the extremes than among those with more moderate views.

Associations with classificatory variables are similar to those discussed in the previous section. They are summarised below:

- Men were more likely than women to have negative views (10% compared with 8%);
- Among those aged 16-19, 22% had negative attitudes, compared with 9% or fewer in every other age group;
- There were no significant regional differences;
- Those in routine and manual occupations were twice as likely to have negative views as were those in the other two socio-economic classes (11% compared with 5-6%);
- The proportion with negative views was 10% of those with an income less than £5,000 a year but only 6% of those with an income of £20,000 or more;
- Those still in education were twice as likely to have negative views as were those who had finished their full-time education;
- There were no significant differences according to whether there were children in the household.

Tables 30-38

Appendix Sampling error calculations

Since the data in this report were obtained from a sample of the population, they are subject to sampling error. Any sample is only one of an almost infinite number that might have been selected, all producing slightly different estimates. Sampling error stems from the probability that any selected sample is not completely representative of the population from which it is drawn.

Sampling error shows the amount by which the value of a sample estimate of a variable can be expected to differ from the true value of that variable in the population. With a simple random sample, the formula for calculating the sampling error for a percentage p , is :

$$\sqrt{\frac{p(100 - p)}{n}}$$

where n is the sample size.

The formula for calculating sampling errors of differences in percentages between surveys assuming simple random samples is :

$$\sqrt{\frac{p_1(100 - p_1)}{n_1} + \frac{p_2(100 - p_2)}{n_2}}$$

In general, attention is drawn to differences between estimates only when they are significant at the 0.05 confidence level, thus indicating that there is less than a 5% probability that the observed difference is due to random sampling variation and that no difference occurred in the population from which the sample is drawn.