

Staff attitudes towards patients with schizophrenia

Per Vendsborg¹, Johanne Bratbo², Anders Dannevang², Julie Hagedorn-Møller², Kristen Kistrup⁴, Anne Lindhardt³ & Merete Nordentoft³

ABSTRACT

INTRODUCTION: Stigmatizing attitudes have been reported in international studies among staff in psychiatry. The authors wanted to investigate if this was the case in Denmark.

MATERIAL AND METHODS: A survey of attitudes among staff at two psychiatric units in Copenhagen was performed using the Mental Illness: Clinicians' Attitudes scales. The scales have 16 questions to which another four questions were added by the authors.

RESULTS: A total of 548 staff members answered the questions (61 doctors and 487 other professionals). The majority of the respondents believed in the possibility of recovery for patients and only a minority associated a high degree of dangerousness with schizophrenia. The cause of the illness was mainly regarded as being biological, but all agreed to a bio-psycho-social aetiological approach. The majority of the respondents believed that the illness was chronic and agreed on the need for staff to also be aware of patients' somatic illness. The doctors did not question their role as "real doctors" or the scientific basis for psychiatry. The majority would not mind working with a colleague with schizophrenia, but about half would hesitate to disclose if they themselves were diagnosed with the illness. Being a woman working in community psychiatry with long experience and participation in a recovery educational programme were associated with less stigmatizing attitudes.

CONCLUSION: The survey showed a relatively low level of stigmatizing attitudes. This runs counter to the results from international investigation. This trend could be interpreted both as a result of a shift towards a more recovery-oriented approach to treatment as well as a reflection of political correctness.

FUNDING: not relevant.

TRIAL REGISTRATION: not relevant.

Stigmatization, i.e. prejudices and discrimination, is a serious additional problem for people with mental illness. For many people, this is a greater problem than the illness itself. Stigma reduces wellbeing, increases shame, pain, exclusion and financial problems. Stigma is perceived as a main obstacle to recovery.

The tendency to stigmatise can be seen as a general human trait explained in theories from psychology, anthropology and sociology [1-5].

Psychiatry is one area in which patients with mental illness experience stigma, but this also occurs in the

health sector in general. This poses a great professional challenge for management as well as staff who need to implement a cultural change towards that instils greater respect for the patients' opinions and autonomy. Psychiatry should stimulate empowerment and recovery without increasing stigma [6-11].

For the time being, several initiatives attempt to increase knowledge and challenge prejudice in Denmark, and one focus area is psychiatric staff. For ten years, The Danish Mental Health Fund has provided information about depression and anxiety and recently also schizophrenia. The national anti-stigma campaign ONE OF US was launched in 2011 as a joint effort counting The Danish Health and Medicines Authority, Danish Regions, The Danish Foundation TrygFonden, service users' and relatives' organizations and also The Ministry of Social Affairs and Integration and Local Government Denmark.

Similar national anti-stigma campaigns have run for years in several other countries, e.g. in Australia (National Community Awareness Program), New Zealand (Like minds, like mine) [12] and Scotland. One of the more recent national initiatives was the English Time to Change campaign. The latter is the largest initiative so far with a budget of GBP 20 million over a three-year period. Both activities and evaluation are rooted in a solid scientific basis. The aim is to demonstrate the most effective way to reduce stigma as well as to increase knowledge in this field. As part of the campaign, Professor Graham Thornicroft and his team at the Institute of Psychiatry in London [13] have constructed the Mental Illness: Clinicians' Attitudes (MICA) scales used in this paper.

The purpose of the present study was to measure attitudes among psychiatric staff and to test the usefulness of the scales in a Danish context. In addition, the survey was supplemented by four focus groups to which the results of the survey were presented for debate. The quantitative as well as the qualitative results were presented to the psychiatric staff who contributed to the survey in order to motivate reflection and discussion.

MATERIAL AND METHODS

The Attitudes Among Psychiatric Staff survey described herein was a collaborative initiative counting The Danish Mental Health Fund, the National anti-stigma project ONE OF US and The Danish Association of Community

ORIGINAL ARTICLE

- 1) The Danish Mental Health Fund, Copenhagen
- 2) ONE OF US, Copenhagen
- 3) Psychiatric Centre Copenhagen
- 4) Psychiatric Centre Frederiksberg

Dan Med J
2013;60(10):A4710

 TABLE 1

Percentages of respondents agreeing (summarized: strongly agree + agree + partly agree) with the question.

	Doctors (n = 61)	Other staff (n = 487)
People with schizophrenia can never reach a good quality of life	7	4
People with schizophrenia are dangerous more often than not	2	3
The public does not need to be protected from people with schizophrenia	81	82
I think schizophrenia is a chronic illness ^a	75	68
Schizophrenia is set off primarily by a disease in the brain ^a	100	96
Schizophrenia is set off primarily by relations in the family ^a	44	68
Schizophrenia is primarily set off by serious traumas ^a	63	77
Schizophrenia is primarily set off by genetic predisposition ^a	100	98
Schizophrenia is primarily set off by a combination of the mentioned factors ^a	100	99
Psychiatry is just as scientific as other fields of medicine	95	
Being a psychiatrist is not like being a real doctor	3	–
Working in the mental health field is just as respectable as other fields of health	–	57
Being a health-care professional in the area of mental health is not like being a real health-care professional	–	55
General practitioners should not be expected to complete a thorough assessment of people with psychiatric symptoms because they can be referred to a psychiatrist	48	55
Psychiatrists know more about the lives of people treated for a mental illness than do family members or friends	24	–
Health/social care staff knows more about the lives of people treated for a mental illness than do family members or friends.	–	44
Staff who themselves have had schizophrenia, can have special competencies in their work ^a	59	79
The way we speak about the patients in the ward influences our opinion about the possibility for recovery ^a	100	89
It is important that any doctor supporting a person with schizophrenia also assesses their physical health	100	–
It is important that any health/social care professional supporting a person with schizophrenia also ensures that their physical health is assessed	–	99
If a person with schizophrenia complained of physical symptoms (such as chest pain), I would attribute it to their mental illness	0	3
I just learn about mental health when I have to, and would not bother reading additional material on it	3	15
If a consultant psychiatrist instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions	9	8
I feel as comfortable talking to a person with schizophrenia as I do talking to a person with a physical illness	81	83
I would use the terms "crazy", "nutter", "mad" etc. to describe people with schizophrenia who I have seen in my work	12	15
If a colleague told me he or she had schizophrenia, I would still want to work with him or her	88	92
If I had schizophrenia, I would never admit this to any of my friends because I would fear being treated differently	25	24
If I had schizophrenia, I would never admit this to my colleagues for fear of being treated differently	53	45

a) Question added to the Danish survey.

Psychiatry. The survey was carried out at two psychiatric units in Copenhagen within The Mental Health Services of The Capital Region of Denmark.

There is one scale for doctors (MICA 2) and one slightly different scale for other professional groups of psychiatric staff (MICA 4) [13]. The Danish translation of the scales was validated before use. Questions about personal data were added.

Furthermore, the scales were extended by four additional questions (one of which had five answer options) with special relevance to schizophrenia. These eight answers are marked with a star in the table. Graphically, these questions were kept apart from the original 16 questions from the English version of the scales. All questions have six multiple-choice answer op-

tions ranging from "strongly agree" to "strongly disagree". In this paper, the results are divided into two main categories: "Strongly agree/agree/partly agree" and "partly disagree/disagree/strongly disagree" (Table 1).

Furthermore, the MICA scores of doctors and other professionals were calculated [13]. A higher MICA score indicates a more stigmatising attitude. The MICA score was used in independent sample t-tests and correlation analysis. In addition, a multiple regression analysis (n = 446) was conducted on the eight questions we had added to the survey (see Table 1) in order to find variables that significantly correlated with the MICA score.

Trial registration: not relevant.

RESULTS

The number of respondents totaled 548 persons: 61 doctors and 487 other staff professionals (35% nurses, 24% nurse's aides, 14% administrative staff, 11% occupational therapists, 6% psychologists and 6% social workers). Women accounted for 60% of the doctors and 80% of the other staff. 52% worked in hospital units and 23% in community psychiatry. 76% worked with patients with schizophrenia, 65% reported family or friends with a mental health problem and 7% reported a mental health problem of their own. The response rate was 79% from Centre Frederiksberg and 41% from Centre Copenhagen. No statistically significant difference $t(492) = -0.9$, $p > 0.05$ in the MICA score was found between Centre Frederiksberg (mean = 37.18; standard error = 0.55) and Centre Copenhagen (mean = 37.61; standard error = 0.43).

The data are shown in Table 1. Doctors and other staff agreed that recovery is possible for patients with schizophrenia and that they pose a low risk to the public. The majority regarded schizophrenia as a chronic disorder caused by biological factors or a combination of biological and social factors.

The majority of the respondents agreed that they would treat patients with respect, would be aware of their physical health and would continue to work with a colleague who disclosed schizophrenia (Figure 1). The high level of tolerance may be questioned as the survey also showed that respondents would be rather reluctant to disclose this if they themselves had suffered from the same diagnosis (Figure 2).

Some of the questions focused on the perceived status of psychiatry. Whereas doctors did not doubt their professions' scientific basis and their status as "real doctors", other groups of staff showed a greater variation in opinion about the perceived status of their profession.

Almost all respondents agreed that the tone and the way they talk about their work and patients have an impact on their view of the possibility for recovery. When it comes to working with a colleague with personal first-hand experience of schizophrenia, the groups are split, however, with a tendency towards acceptance.

Doctors (mean = 32.00; standard error = 0.83) achieved a significantly lower MICA score $t(503) = -6.03$, $p < 0.001$ than other groups of staff (mean = 38.13; standard error = 0.35). In general, the MICA score was negatively correlated with the belief of schizophrenia being a chronic illness $\rho(491) = -0.208$, $p < 0.001$. That is, a higher MICA score meant that respondents were more convinced that schizophrenia was a chronic illness.

The multiple regression analysis showed that six of our eight questions correlated significantly with the

FIGURE 1

If a colleague told me he or she had schizophrenia, I would still want to work with him or her.

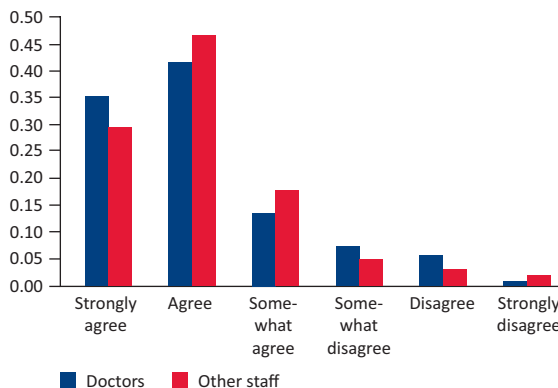
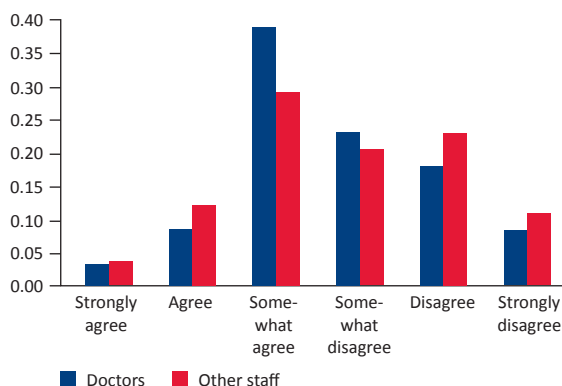


FIGURE 2

If I had schizophrenia, I would never admit this to my colleagues for fear of being treated differently.



MICA score ($R^2 = 0.201$; $p < 0.001$). The opinion that: 1) schizophrenia is primarily set off by a disease in the brain ($\beta = 0.118$; $t(437) = 2.44$; $p < 0.05$), 2) schizophrenia is primarily set off by multiple factors (in agreement with the bio-psycho-social model) ($\beta = 0.210$; $t(437) = 4.41$; $p < 0.001$) 3) professionals having had schizophrenia themselves have special competences in treating this group of patients ($\beta = 0.162$; $t(437) = 3.60$; $p < 0.001$), and 4) the understanding that the tone of the workplace and the way the professionals speak about the patients can affect their own view of the patients' ability to recover ($\beta = 0.169$; $t(437) = 3.68$; $p < 0.001$), all correlated positively with the MICA score. In this multiple regression model, the negative correlation between the MICA score and 5) the opinion that schizophrenia is a chronic illness was found as well ($\beta = -0.107$; $t(437) = -3.36$;

A total of 548 staff members answered the questions.



$p < 0.01$). Furthermore, a negative correlation with 6) the view that schizophrenia is primarily set off by circumstances in the family ($\beta = -0.121$; $t(437) = -2.35$; $p < 0.05$) appeared.

DISCUSSION

People who have schizophrenia are often portrayed as dangerous and violent in the media which is also reflected in the public's attitudes both in Denmark [14] and England [15]. The fact that that this prejudice is not shared by psychiatric staff is therefore a positive finding of the present survey.

The question about dangerousness is a challenging one since a small, but grossly overestimated increase in risk of aggression is observed in connection with people with schizophrenia [16]. Therefore, it is important to ask if there is an overestimation of risk and not just a risk increase (which there is). It is also worth noting that respondents were asked specifically about schizophrenia and not mental illness in general. In population surveys, schizophrenia combined with abuse is perceived as being associated with a high degree of danger [15].

The perception of dangerousness rose in the second half of the 20th century during which period deinstitutionalisation also occurred. Phelan & Link [17] suggested that this is caused by the widely known expression "dangerous to oneself and others" used in conjunction with forced hospitalisation of people with schizophrenia now living in the community. It can be concluded that psychiatric staff hold a very low degree of prejudicial beliefs of dangerousness although the majority work in units where people with a high degree of aggressiveness are hospitalised.

Surveys have shown that the public is more optimistic about recovery than professionals working within

psychiatry [18]. For example, studies have shown that about 60% of the public believe that people with serious mental illness can recover. Questions about perception of recovery are worded differently in the various surveys and results are therefore difficult to compare. Nevertheless, it should be regarded as a positive finding that more than 90% of the respondents in the actual survey believe that even people with schizophrenia can recover to a level allowing them to enjoy a good quality of life.

This finding is contrasted by the fact that the majority views schizophrenia as a chronic illness. This approach is normally regarded as stigmatizing, but in this case it could reflect an uncertainty that could be ascribed to the wording of the question. Does the question mean: "Is it always a chronic illness?" or "Can it be chronic?" Even if the respondents have adopted a recovery-oriented approach, it is true that not everybody is cured. This question does not form part of the original English scale. Another additional question to the scale concerned triggering factors. Most mental health professionals have scientific training. Therefore, it is expected that many agree on a biological and genetic approach. However, also environmental factors have support and all respondents agree on a combination which is in accordance with the official bio-psycho-social model of psychiatry.

In addition to the questions on respondents' attitudes towards people with schizophrenia, there are six questions in the scale and two additional questions all about opinions on psychiatry and professionally correct behaviour. Three questions differ between MICA 2 (doctors) and MICA 4 (other staff).

Doctor respondents have a strong professional identity as medical doctors and find the scientific basis of psychiatry to be just as solid as that of somatic disorders. They do not regard their profession as being different from other medical specialities. Other psychiatric staff respondents answered quite differently worded questions in respect to this topic and their answers were characterised by a greater difference in opinion about status and respect.

The authors behind the English scale find it stigmatizing if the respondent is not of the opinion that general practitioners should assess people with psychiatric symptoms thoroughly. Only half of the respondents share this point of view. This might partly be explained by the fact that it is unclear whether the question concerns somatic or psychiatric illness. Furthermore, there are structural differences between the mental health systems and services of England and Denmark.

Doctors and other psychiatric staff agree with the importance of showing attention to somatic symptoms and not write them off as symptoms of the psychiatric illness (diagnostic overshadowing). The high degree of

attention to somatic symptoms can be linked to newly published data showing that people with schizophrenia live 20 years less than the general population [19].

The final section of the scale concerns staff behaviour towards people with schizophrenia, specifically if they themselves or a colleague was affected.

About 80% say that they feel comfortable speaking to a person with schizophrenia. In the public, this figure is approx. 50% [15]. This discrepancy is not surprising as mental health staff receive training in this area.

Almost 90% of the respondents say that they would still want to work with a colleague if he or she suffered from schizophrenia. This is not in accordance with the known difficulties experienced when people with former mental illness apply for a job in psychiatry – so-called professionals with user experience or peers.

A common question in questionnaires aimed at the general public is whether they would be open and disclose this if they themselves were to get a mental illness. Usually, about 25% would not disclose this information to their friends and family, and about half would disclose the information to their colleagues [14]. The same seems to be the case in this survey. It is somewhat surprising that so many answer that they would disclose their diagnosis considering the serious consequences this could have.

CONCLUSION

The overall conclusion was that the respondents were not very stigmatized. This is not in accordance with international surveys [6, 7, 9, 10]. It may be that the attitudes among psychiatric staff in Denmark are different or have changed, e.g. following the shift to a more recovery-oriented treatment. On a less positive note, the answers may also be interpreted as a sign of political correctness. During the focus group discussions, some of the participants did agree with this explanation.

The fact that the findings are not in accordance with reports of patients' experiences [5] could be ascribed to the above-mentioned explanations. However, the fact that the questionnaire neither included nor measured factors which patients found to be stigmatizing is also a contributing and likely explanation. A fundamental claim from service users is that they should be approached as human beings rather than be perceived as having a diagnosis; to be met as unique, self-supporting and competent individuals with the right to take part and to be included in all decisions concerning their personal life and recovery. These factors are not included or measured by the MICA scale.

CORRESPONDENCE: Per Vendsborg, Psykiatrifonden – Innovation, Hejrevej 43, 2400 Copenhagen NV, Denmark. E-mail: pbv@psyknet.dk

ACCEPTED: 19 July 2013

CONFLICTS OF INTEREST: Disclosure forms provided by the authors are available with the full text of this article at www.danmedj.dk

LITERATURE

1. Arboleda-Flórez J. The rights of a powerless legion. In: Arboleda-Flórez J, Sartorius N, eds. *Understanding the stigma of mental illness*. Chichester: Wiley, 2008:1-17,67.
2. Thornicroft G. *Shunned: discrimination against people with mental illness*. Oxford: Oxford University Press, 2007.
3. Thornicroft G, Rose D, Kassam A et al. Stigma: ignorance, prejudice or discrimination? *Br J Psychiatr* 2007;190:192-3.
4. Vendsborg P, Nordentoft M, Lindhardt A. Stigmatising of persons with a mental illness. *Ugeskr Læger* 2011;173:1194-8.
5. Vendsborg P, Blinkenberg S, Kistrup K et al, eds. *Dømt på forhånd – om stigmatisering af mennesker med psykisk sygdom*. Copenhagen: Psykiatri-Fondens Forlag, 2011.
6. Lauber C, Anthony M, Ajdacic-Gross V et al. What about psychiatrists' attitude to mentally ill people. *Eur Psychiatry* 2004;19:423-7.
7. Lauber C, Nordt C, Braunschweig C et al. Do mental health professionals stigmatize their patients? *Acta Psychiatr Scand* 2006;113:51-9.
8. Lauber C, Nordt C, Falcató L et al. Factors influencing social distance toward people with mental illness. *Commun Ment Health J* 2004;40:265-74.
9. Rao H, Mahadevappa H, Pillay P et al. A study of stigmatized attitudes towards people with mental health problems among health professionals. *J Psychiatric Ment Health Nursing* 2009;16:279-84.
10. Ross CA, Goldner EM. Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *J Psychiatric Ment Health Nursing* 2009;16:558-67.
11. Schulze B. Stigma and mental health professionals. *Int Rev Psychiatry* 2007;19:137-55.
12. Vaughan G, Hansen C. Like minds, like mine: a New Zealand project to counter the stigma and discrimination associated with mental illness. *Aust Psychiatry* 2004;12:113-7.
13. Kassam A, Glozier N, Leese M et al. Development and responsiveness of a scale to measure clinicians' attitudes to people with mental illness (medical student version). *Acta Psychiatr Scand* 2010;122:153-61.
14. *Stigma og psykiske lidelser – som det opleves og opfattes af mennesker med psykiske lidelser og borgere i Danmark*. Copenhagen: Dansk Sundhedsinstitut DSI og Det Nationale Forskningsinstitut for Velfærd SFI, 2010.
15. Crisp A, Gelder MG, Rix S et al. Stigmatization of people with mental illness. *Br J Psychiatr* 2000;177:4-7.
16. Fazel S, Gulati G, Linsell L et al. Schizophrenia and violence. *PLoS Med* 2009;6(8):e1000120.
17. Phelan JC, Link BG. The growing belief that people with mental illnesses are violent: the role of the dangerousness criterion for civil commitment. *Soc Psychiatry Psychiatr Epidemiol* 1998;33(suppl 1):7-12.
18. Hugo M. Mental health professionals' attitudes towards people who have experienced a mental health disorder. *J Psych Ment health nurs* 2001;8: 419-25.
19. Wahlbeck K, Westman J, Nordentoft M et al. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *Br J Psychiatr* 2011;199:453-8.