Attitudes and Beliefs Towards Mental Disorders

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2016

BSc in Psychology

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Foreword

Submitted in partial fulfillment of the requirements of the BSc Psychology degree, Reykjavik University, this thesis is presented in the style of an article for submission to a peer-reviewed journal.

Abstract

The aim of this study was to get a better understanding of which variables affect attitude towards mental disorders. Of special interest was to explore how familiarity with mental disorders affected attitude. Participants were 218 students at Reykjavík University. Prejudice towards mental disorders was rather low among participants. Results revealed that there is a significant inverse relationship between familiarity and prejudice, both having a family member diagnosed with a mental disorder (β = -.150, p < 0,05) and a friend diagnosed with a mental disorder (β = -.174, p < 0,01), when all other variables had been accounted for. These findings further address the issue individuals with mental disorders are facing, stigmatization and social distancing. This study data could add further realization for the need for campaigns being created that increase proximity with individuals with mental disorders.

Keywords: mental disorder, familiarity, prejudice, human rights, perceived inequality.

Útdráttur

Tilgangur rannsóknarinnar var að ná betri skilning á hvaða breytur hefðu áhrif á viðhorf til geðraskana. Sérstakur áhugi var að athuga hvernig nánd við einhvern með geðröskun hefði áhrif á viðhorfið. Þátttakendur voru 218 nemendur við Háskólann í Reykjavík. Fordómar gagnvart geðröskunum var almennt lágt meðal þátttakenda. Niðurstöður sýndu fram á marktækt gagnstætt samband milli nándar og fordóma, bæði það að eiga fjölskyldumeðlim greindan með geðröskun (β = -.150, p < 0,05) og vin greindan með geðröskun (β = -.174, p < 0,01). Þessar niðurstöður varpa enn frekara ljósi á þá fordóma sem einstaklingar með geðraskanir glíma við. Rannsóknin gæti leitt huga fólks að því hve mikilvæg nánd við geðraskanir raunverulega er. Helst er þessi vitneskja mikilvæg herferðum þar sem megin tilgangur er að uppræta fordóma gagnvart geðröskunum.

Attitudes and Beliefs Towards Mental Disorders

Attitudes and beliefs towards people with mental disorders have varied greatly since it was first studied in the late 1940s, up until now. In early studies, mental health professionals found that the public had little knowledge about mental illnesses (Rabkin, 1974). Now however, bewilderment among the mental health professionals is being caused by their newly raised alertness that stigma still goes side by side with mental illnesses (Angermeyer & Dietrich, 2006). Many factors are at play which lead to different attitudes, beliefs and stigma toward mental disorders; for example, the public's knowledge about mental disorders, stereotypes and how the news portrays the mentally ill (Corrigan, 2012).

The lifetime prevalence rate of getting a mental disorder is around fifty percent and in a recent study done in the United States, it was reported that only twenty percent of adults diagnosed with a mental disorder seek help from a mental health professional (Wang et al., 2005; Kessler, McGonagle, Zhao, & et al, 1994). This low percentage of help-seeking behavior is partly caused by stigma towards mental disorders that is induced by negative beliefs and attitudes towards people with mental disorders. A German study which focused on mental help-seeking behavior found out that 80% of the lay public thought that help was needed if you had depression and 86% if you had schizophrenia (Angermeyer, Matschinger, & Heller, 2001). It is a popular notion amongst the general public that if you have a mental disorder, help is needed. However only a small portion actually seeks help. Embarrassment caused by the public's stigma is one of the main reasons, which leads individuals to rather hide their symptoms than seeking needed treatment (Greene-Shortridge, Britt, & Castro, 2007; Nadeem et al., 2007). For psychiatry to improve and people with mental disorders to seek assistance, battling stigma has to be a priority since it seems to be one of the biggest obstacle for its progress (Jj, 2002; Sartorius, 2002; Wang PS et al., 2005).

Studies in the early 1990s reported many interesting facts about public's attitude

towards people diagnosed with depression (Angermeyer & Matschinger, 2004). Around one third of the German general population reported that they would not rent a room to someone with depression, almost fifty percent said they would not recommend someone with depression for a job and only one out of five expressed they wanted to talk to someone about a family member who had depression. Looking at these statistics, it is clear that people with mental disorders are facing discrimination, but has the attitude improved? Population surveys constructed in the years 1990 and 2011 in Germany showed that attitude towards individuals with depression and alcohol abuse had not changed and had worsened towards schizophrenia (Angermeyer, Matschinger, & Schomerus, 2013). Another study done between 2009 and 2012 in England showed the same results, where no significant improvements were in attitudes towards mental disorders during that three year period (Lacko, Henderson, & Thornicroft, 2013).

In a literature review which gathered data from 62 studies, between the years 1990 and 2004 concerning attitudes and beliefs towards mental disorders, sociodemographic variables such as gender, age and education revealed rather inconsistent results (Angermeyer & Dietrich, 2006). More studies revealed males having a more negative attitude towards mental disorders than females but in most cases there was no significant difference. Age is positively related to poorer attitude in all studies except one and education is positively related to better attitude in 20 studies.18 studies showed no significant relationships. There seem to be no studies which explore the effect parents educational level and financial status have on attitude towards mental disorders.

A vast amount of studies have shown association between familiarity and stigmatization towards mental disorders, such as social distancing (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Link & Cullen, 1986). In a study about how to eliminate stigma towards schizophrenia, results

showed that participants with less familiarity to the mentally ill opted for more social distance (Penn et al., 1994). Same results were found in a more recent study where participants were students in a community college, but with more precise definition of the familiarity they had had with the mentally ill (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). Examples of familiarity were everything from having never observed a person with a mental disorder or watching a movie about mental disorders to having a family member, friend, work colleague or themselves been diagnosed with a mental disorder. Results revealed a significant inverse connection between familiarity and social distance. The more familiarity with individuals who have mental disorders the less social distance. In a study by Crisp et al. (2000) where fifty percent of participants reported personal knowledge of someone with a mental disorder, did not show more significant difference in stigma towards mental disorders than others. According to Alexander and Link (2003), they call in to question the generalizability of these studies on the ground of ambiguous definitions of stigma and familiarity, which might have led to the non significant difference in the study done by Crisp et al.. When studies have different examples of familiarity, such as some of them only mention a friend or a family member diagnosed with a mental disorder while others go to the lengths of mentioning class mates and work partners as well, which makes it hard to evaluate the effect familiarity has on attitudes towards mental disorders.

One proposed definition of human rights is that they are norms which protect the public from social, political and legal injustice (Nickel, 2014). According to Donnelly (2013), only when human rights are not met, they are openly discussed in the public. A vast improvement has been made in human rights since the eighteenth and nineteenth centuries where slavery, genocide and autocracy were the norm (Pogge, 2008). Even though laws have been made in regards to improving human rights and the public is more capable of recognizing injustice, equality is far from being reached. For instance there are 830 million

humans that are undernourished and 774 million adults are illiterate on earth. Lately, there has been a climactic increase in research related to human rights (Amon, Baral, Beyrer, & Kass, 2012), but few to no studies seem to be directly linking human rights attitude with attitude towards mental disorders. It is reasonable to assume that a positive view towards human rights in general, generalizes to attitudes regarding mental illness.

Familiarity with mental disorders is one of the key prejudice causes. The less close you are or have been to a person(s) with mental disorder(s), predicts more prejudice. Social distance is one prejudiced attitude caused by little familiarity with mental disorders, where individuals tend to stay away or avoid people with mental disorders. The aim of this study was to investigate which variables do affect attitude towards mental disorders. It was of special interest to explore how familiarity with mental disorders affect attitude, and if human rights attitude were connected to attitude towards mental disorders. From the writings above, these are the hypotheses proposed: 1) An inverse relationship is between familiarity and prejudice; 2) Demographic variables like gender, age, parental education and finances predict prejudiced attitude toward mental disorders; 3) Individuals with positive attitudes towards human rights have less prejudice against mental disorders.

Method

Participants

Students at Reykjavík University participated in the survey. A convenience sampling method was used to select participants for the survey. This method was chosen because of good accessibility to participants and closeness to the researcher. No course credit or reward of any kind was offered to participants for completing the survey. To recruit participants an e-mail was sent out to all students within Reykjavík University. The survey contained relevant information about the researcher, approximate time it took to complete, the surveys agenda and a direct web link to the survey itself. As well as sending out an e-mail, a message

with the direct web link to the survey including the surveys agenda was posted in the student unions Facebook pages to encourage more students to participate in the survey.

Out of roughly 3500 students in Reykjavík University, 218 of them participated. Significantly more women filled out the survey, or 131 versus 83 males, and four values were missing. By far the most frequent age among the participants was 21 to 25 years old (n = 106) and the least common age was 18 to 20 years old (n = 7). Before participants filled out the survey they were given a non-disclosure agreement, which stated that all of the answers would be untraceable to them personally and any question they did not feel like answering, could be skipped (Appendix A).

Instruments and Measures

Background information. Participants background information was gained by questions regarding age and gender (1 = "males", 2 = "females") (Appendix B). Further data was gathered with questions regarding the participants' parents, their financial status and education (both ranging from 1-8, with financial status being worse with higher scores but education being better with higher scores).

Diagnostic information. Participants were asked whether a family member, a friend/acquaintance or the participant himself/herself had been diagnosed with a mental disorder(s) (Appendix B). Yes or no questions were asked about family members and friends and if they had been diagnosed with any mental disorder (0 = "no", 1 = "yes"). In regards to the participants themselves, there were ten options, first option was that they had not gotten any diagnosis, the next eight options listed the most common mental disorders (social anxiety disorder, schizophrenia, depression, attention deficit disorder, hyperactivity, obsessive-compulsive disorder, bipolar disorder and general anxiety disorder) and in the last option they could type in "other". This question was not limited to one answer but rather the participants could select as many mental disorders (or none) as they had been diagnosed with.

The Prejudice scale. The scale consisted of 14 questions related to participants' attitudes and beliefs towards individuals with mental disorders (i.e. "individuals with mental disorders are more likely to be violent") (Appendix B). Participants answered on a five point Likert scale from 1, strongly disagree to 5, strongly agree. Questions were chosen from other similar studies (Chong et al., 2007; Siu et al., 2012). The internal consistency was good, as resolved by a Cronbach's alpha of 0,739.

Perceived inequality. Was measured by asking participants if they felt some groups were facing injustice (i.e. "Do women and men in Iceland have the same opportunities in life") (Appendix B). Questions were on a five point Likert scale, 1, strongly disagree to 5, strongly agree. The same was asked about disabled individuals and non-disabled, also gay and heterosexual. The questions were put under one construct, having high Cronbach´s alpha of 0,766.

Human rights scale. Was made directly from the ATHRI Guide, which has a total number of 40 questions regarding human rights (Appendix B) (Narvaez, Getz, Rest, & Thoma, 1999). Out of these 40 questions, 14 were chosen (i.e. "Freedom of speech should be a basic human right", "People should not be discriminated against because of their race, sex, religion or handicap in a democratic country like ours" and "Abortion is any woman's right"). Questions chosen were picked by the researcher in the disposition of being related to the country's relevant topics. The questions were on a five point Likert scale from 1 being strongly disagree to 5 being strongly agree. Cronbach´s alpha (0,678) showed decent internal consistency.

Believes about the causes of mental disorders. Was assessed with a question containing examples of causal beliefs (Appendix B). Participants could select multiple beliefs they thought were the causes of getting a mental disorder (i.e. "stress, alcohol abuse, genetics and more").

Political view. Was measured with one question put on a Likert ratio scale from 0-10, zero being furthest to the left in political view and 10 being furthest to the right in political view ("Where on the scale from one to ten, where zero is to the left and ten to the right, would you put your political view?") (Appendix B).

Procedure/Design/Data Analysis

The survey was sent out to all students at Reykjavík University on the 10th of March 2016, and was active for roughly two weeks or until the 25th of March.

To test hypothesis 1-3 a multiple linear regression was used with five different models. First model employed the demographic variables predicting for prejudice, having been diagnosed with a mental disorder joined in the second model, third model added having a family member and/or a friend diagnosed with a mental disorder, fourth model added human rights attitudes and in the fifth and last one, perceived inequality was added. Correlation matrix was also run to see how the variables related to one another, which in turn could help interpret the regression model.

Prejudice scale was loaded negatively, with higher score indicating more prejudice. Out of the fourteen questions, six of them were loaded positively and had to be recoded. The human rights attitude scale was on the other hand loaded positively, with higher score indicating better human rights attitude. Human rights attitude scale had four questions that were loaded negatively and had to be recoded. A reliability analysis was performed for the prejudice scale, human rights attitude scale and perceived inequality scale. All three scales had good Cronbach's alpha scores.

Results

The aim of this study was to see how variables such as familiarity with mental disorders, gender, age and human rights attitude would predict prejudice towards mental disorders. Prejudice was used as the criterion variable while predictor variables were gender,

age, parents education, parents financial status, participant having been diagnosed with a mental disorder (MD), family member having been diagnosed with a MD, friend having been diagnosed with a MD, attitude toward human rights and perceived inequality. Correlation matrix was first run to find relations between all the variables, in continuation, a multiple linear regression models were made to see which variables predicted for prejudice towards MD.

The distribution of the prejudice participants had towards mental disorders was negatively skewed, meaning more participants had little prejudice. Minimum score was 1,21, maximum was 3,93 with a mean value of 2,35 (*SD* = 0,473). Out of the 218 participants, 98 of them or 45,2% had been diagnosed with some kind of a mental disorder, which is almost half of the participants. The most common mental disorders among participants were depression (19,8%) and general anxiety disorder (17,1%), least common was schizophrenia with only 1 diagnosed.

Table 1 shows a correlation matrix, which reveals that having a family member diagnosed with a mental disorder significantly relates to all the other variables except age. Prejudice is most strongly negatively related human rights attitude ($r = -.5$, $p < 0,01$) and least related to parents financial status ($r = -.06$, $p > 0,05$). Additionally having a better human rights attitude results in a less prejudiced attitude towards mental disorders ($r = -.5$, $p < 0,01$).

Table 1

Pearson r bivariate correlations for the variables in the study

	1	2	3	4	5	6	7	8	9
1. Age	1.0								
2. Parents education	-.33**	1.0							
3. Parents	.12	-.37**	1.0						

finances									
4. Participant diagnosed	.01	-.09	.05	1.0					
5. Family m. diagnosed	.08	-.15*	.17*	.28**	1.0				
6. Friend diagn.	-.02	-.10	.03	.21**	.38**	1.0			
7. Human rights attitude	.08	-.00	.07	.01	.20**	.21**	1.0		
8. Perceiv. ineq.	-.16*	.16*	-.11	-.02	-.15*	-.17*	-.27**	1.0	
9. Prejudice	-.08	-.08	-.06	-.21**	-.34**	-.37**	-.5**	.20**	1.0

* $p < 0,05$ (two-tailed test).

** $p < 0,01$ (two-tailed test).

The multiple linear regression models in Table 2 predict prejudice. Model 5 reveals that main effects are to be found from gender, family member diagnosed with a mental disorder, friend diagnosed with a mental disorder and human rights attitude when all the other variables have been included. All the significant main effects were negative with the most significant one being human rights attitude (β = -.403, $p < 0,001$). Following up came gender (β = -.181, $p < 0,001$), then having a friend diagnosed with a mental disorder (β = -.174 $p < 0,001$) and lastly with less significance having a family member diagnosed with a mental disorder (β = -.150, $p < 0,05$). In model 2, having been diagnosed with a mental disorder is significant (β = -.159, $p < 0,05$), but when having a family member and a friend diagnosed with mental disorder were added to the regression in model 3, then having been diagnosed lost its significance. Human rights attitude in model 4 increases the prediction value for having been diagnosed with mental disorder but not enough to make it significant again. Having a family member and a friend diagnosed with a mental disorder was also affected by

human rights attitude by loosing a bit of its prediction value. Of special interest, perceived inequality, which showed relation to many variables in the correlation matrix, had no main effect and little to none effect on the other variables when other variables were included.

Table 2

Multiple linear regression models, predicting prejudice

	Model 1	Model 2	Model 3	Model 4	Model 5
	β	*β*	*β*	*β*	*β*
Demographic variables	Prejudice	Prejudice	Prejudice	Prejudice	Prejudice
Gender	-.327**	-.310**	-.251**	-.171**	-.181**
Age	-.060	-.064	-.062	.002	-.001
Parents education	.067	.051	.018	.055	.057
Parents financial status	.014	.014	.029	.041	.040
Particip. diagnosed					
Particip. diagnosed		-.159*	-.066	-.093	-.092
Family/friends diagnosed					
Family member diagnosed			-.197**	-.148*	-.150*
Friend diagnosed			-.226**	-.174**	-.174**
Human rights					
Human rights attitude				-.399**	-.403**
Perceived inequality					
Perceived inequality					-.027
Adj. *R* square (%)	10	12	22	36	36
F	6.252**	6.238**	9.039**	15.201**	13.474**

β = Beta, standardized coefficient

* p < 0,05 (two-tailed test).

** p < 0,01 (two-tailed test).

Discussion

The study's main hypothesis stated that there is a significant inverse relationship between familiarity and prejudice, both having a family member diagnosed with mental disorder (*β* = -.150, p < 0,05) and a friend diagnosed with mental disorder (*β* = -.174, p <

0,01) significantly explained prejudice, when all other variables had been accounted for. Of particular interest, participants whom had been diagnosed with some kind of mental disorder(s) showed significant inverse relationship as well with animosity. However when having a family member and a friend diagnosed with a mental disorder was also accounted for in the regression model, the relationship between having been diagnosed and prejudice was no longer significant. So in a sense, the main hypothesis can only be partially supported when all variables have been accounted for. These results are in trend with the latest research where little familiarity has been associated with stigmatization towards mental disorders (Corrigan, Edwards, et al., 2001; Holmes et al., 1999; Link & Cullen, 1986). Very few studies seem to expand the familiarity to the degree of having been diagnosed yourself with a mental disorder and how that affects your attitude. One study was found which implemented a definition to their familiarity scale, but in the study, only two percent out of 208 participants admitted having been diagnosed with mental disorder (Corrigan, Green, et al., 2001). The study in question showed significant inverse relationship between attitude and familiarity, but with only two percent having been diagnosed, it is impossible to infer which part of the familiarity scale affected the attitude. In the current study with almost the same number of participants, 45% said they had been diagnosed with some mental disorder. Operational definitions of mental disorder might be the main cause, where in the Corrigan study, mental disorder was defined as limited to only having bipolar or schizophrenia, while in the current research more common mental disorders were available in the definition. In the current study, one had been diagnosed with schizophrenia (0,5%) and two with bipolar (0,9%), so in that sense, the statistics are almost the same as the ones in the Corrigan study, further adding the need for more precise definition of mental illness in attitude studies.

Hypothesis 2 implied that the demographic variables, gender, age, parents' education and financial status could predict prejudiced attitude towards mental disorders. The current

study found only gender to be a significant predictor, but as more models and variables were added to the multiple regression the Beta value got lower, but still kept it's significance nonetheless (Model 1: β = -.327; Model 5: β = -181). There are more studies which show males having poorer attitudes towards mental disorders than females but in most cases there is no significant difference between gender (Angermeyer & Dietrich, 2006). Contrary to previous studies (Angermeyer & Dietrich, 2006) which reveal that age positively relates to poorer attitudes towards mental disorders, the current study found no significant difference. Since the current study was conducted in a university, almost fifty percent of the participants were between the age of 21 and 25 years old, making it hard to impossible to make any assumptions from the age variable.

Finally, human rights had significant prediction value for prejudice towards mental disorders (β = -.403, p < 0,01), better human rights attitude resulted in less prejudice. No previous studies have examined the direct link between these two variables so no comparison could be made. Of certain interest was how perceived inequality, a variable that portrays the view participants had on other people´s human rights attitude, had no prediction value when all other variables had been accounted for.

The main limitation of the study is the sample size and little age distribution making it have low generalizability. The strength of the study, and also possibly a weakness, was the wide definition of mental disorders. While many studies isolate themselves to two or three mental disorders, the current study took examples of eight mental disorders. The main strength was finding relationship between human rights attitude and mental disorder attitude that previously had not been accounted for in such a clear-cut manner. Another strength was that only one other study has been done in Iceland about this matter, which was a qualitative study and limited itself to only attitudes towards depression.

These findings further address the issue individuals with mental disorders are facing, stigmatization and social distancing. Results reveal the high importance of familiarity to mental disorders. The data from this study could add further realization for the need for campaigns created to increase proximity with individuals with mental disorders. Since there seems to be a direct link between human rights attitude and attitude towards mental disorders, governments could try to implement some ways to add improvements in both or the other. In continuation of this study, a finer line has to be made in this kind of research, descriptions of both mental disorders and familiarity must have a better definition, so studies become more comparable and valid than before. Same study but with better age cohort, more distinctive social economic status and bigger sample size could provide superior results and help define the issue.

References

Alexander, L., & Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, *12*(3), 271–289. http://doi.org/10.1080/0963823031000118267

Amon, J. J., Baral, S. D., Beyrer, C., & Kass, N. (2012). Human rights research and ethics review: protecting individuals or protecting the state? *PLOS Med*, *9*(10), e1001325. http://doi.org/10.1371/journal.pmed.1001325

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163–179. http://doi.org/10.1111/j.1600-0447.2005.00699.x

Angermeyer, M. C., & Matschinger, H. (2004). Public attitudes to people with depression: have there been any changes over the last decade? *Journal of Affective Disorders*, *83*(2–3), 177–182. http://doi.org/10.1016/j.jad.2004.08.001

Angermeyer, M. C., Matschinger, H., & Riedel-Heller, S. G. (2001). What to do about mental disorder—help-seeking recommendations of the lay public. *Acta Psychiatrica Scandinavica*, *103*(3), 220–225.

Angermeyer, M. C., Matschinger, H., & Schomerus, G. (2013). Attitudes towards psychiatric treatment and people with mental illness: changes over two decades. *The British Journal of Psychiatry*, bjp.bp.112.122978. http://doi.org/10.1192/bjp.bp.112.122978

Chong, S. A., Verma, S., Vaingankar, J. A., Chan, Y. H., Wong, L. Y., & Heng, B. H. (2007). Perception of the public towards the mentally ill in developed Asian country. *Social Psychiatry and Psychiatric Epidemiology*, *42*(9), 734–739. http://doi.org/10.1007/s00127-007-0213-0

Corrigan, P. W. (2012). Where Is the evidence supporting public service announcements to eliminate mental illness stigma? *Psychiatric Services, 63*(1), 79–82. http://doi.org/10.1176/appi.ps.201100460

Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin, 27*(2), 219–225.

Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services, 52*(7), 953–958. http://doi.org/10.1176/appi.ps.52.7.953

Corrigan, P. W., Watson, A. C., Byrne, P., & Davis, K. E. (2005). Mental illness stigma: problem of public health or social justice? *Social Work, 50*(4), 363–368.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry, 177*(1), 4–7. http://doi.org/10.1192/bjp.177.1.4

Donnelly, J. (2013). *Universal Human Rights in Theory and Practice*. Cornell University Press.

Evans-Lacko, S., Henderson, C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009-2012. *The British Journal of Psychiatry, 202*(s55), s51–s57. http://doi.org/10.1192/bjp.bp.112.112979

Greene-Shortridge, T. M., Britt, T. W., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172*(2), 157–161. http://doi.org/10.7205/MILMED.172.2.157

Holmes, E. P., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. A. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin, 25*(3), 447–456.

Jj, L.-I. (2002). The WPA and the fight against stigma because of mental diseases. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *1*(1), 30–31.

Link, B. G., & Cullen, F. T. (1986). Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior*, *27*(4), 289–302. http://doi.org/10.2307/2136945

Nadeem, E., Lange, J. M., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and U.S.-born black and latina women from seeking mental health care? *Psychiatric Services*, *58*(12), 1547–1554. http://doi.org/10.1176/ps.2007.58.12.1547

Narvaez, D., Getz, I., Rest, J. R., & Thoma, S. J. (1999). Individual moral judgment and cultural ideologies. *Developmental Psychology*, *35*(2), 478–488. http://doi.org/10.1037/0012-1649.35.2.478

Nickel, J. (2014). Human rights. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Winter 2014). Retrieved from http://plato.stanford.edu/archives/win2014/entries/rights-human/

Penn, D. L., Guynan, K., Daily, T., Spaulding, W. D., Garbin, C. P., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, *20*(3), 567–578. http://doi.org/10.1093/schbul/20.3.567

Pogge, T. W. (2008). *World Poverty and Human Rights*. Polity.

Rabkin, J. (1974). Public attitudes toward mental illness: A review of the literature. *Schizophrenia Bulletin*, *1*(10), 9–33.

Sartorius, N. (2002). Fighting stigma: theory and practice. *World Psychiatry*, *1*(1), 26–27.

Siu, B. W. M., Chow, K. K. W., Lam, L. C. W., Chan, W. C., Tang, V. W. K., & Chui, W. W. H. (2012). A questionnaire survey on attitudes and understanding towards mental disorders. *East Asian Archives of Psychiatry*, *22*(1), 18.

Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, & Kessler RC. (2005). Twelve-month use of mental health services in the united states: Results from the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 629–640. http://doi.org/10.1001/archpsyc.62.6.629

Appendix A

Kæri þátttakandi,

Ég bið þig um að taka frá tíma til að svara þessum viðhorfslista, þessi könnun snýr að BSc verkefni mínu við sálfræðideild Háskólans í Reykjavík.

Öll svör eru ónafngreinanleg, ef þú treystir þér ekki til að svara einstaka spurningum þá getur þú slept því að svara þeim.

Þátttaka í rannsókninni ætti ekki að taka lengri tíma en 10 mínútur.

Rannsakandi: Sturla Brynjólfsson, sálfræðinemi við Háskólann í Reykjavík, sturlab13@ru.is
Leiðbeinandi: Kamilla Rún Jóhannsdóttir, lektor við sálfræðisvið Háskólans í Reykjavík

HÁSKÓLINN Í REYKJAVÍK
REYKJAVIK UNIVERSITY

Appendix B

Questionnaire

Ert þú karl eða kona?

- ◯ Karl
- ◯ Kona

Hvað ert þú gamall/gömul?

- ◯ 18 til 20 ára
- ◯ 21 til 25 ára
- ◯ 26 til 30 ára
- ◯ 31 til 35 ára
- ◯ 36 ára eða eldri

Hver er menntun móður þinnar?

- ◯ Lauk grunnskólaprófi eða minna
- ◯ Hóf framhaldsskólanám í menntaskóla eða iðnskóla
- ◯ Lauk framhaldsskóla í menntaskóla eða iðnskóla
- ◯ Hóf háskólanám
- ◯ Lauk grunngráðu í háskóla
- ◯ Lauk mastersgráðu í háskóla
- ◯ Lauk doktorsgráðu í háskóla
- ◯ Veit ekki, eða á ekki við

Hver er menntun föður þíns?

- ◯ Lauk grunnskólaprófi eða minna
- ◯ Hóf framhaldsskólanám í menntaskóla eða iðnskóla
- ◯ Lauk framhaldsskóla í menntaskóla eða iðnskóla
- ◯ Hóf háskólanám
- ◯ Lauk grunngráðu í háskóla
- ◯ Lauk mastersgráðu í háskóla
- ◯ Lauk doktorsgráðu í háskóla
- ◯ Veit ekki, eða á ekki við

Ef þú hugsar um fjárhagsstöðu foreldra þinna, hversu vel fjárhagslega stæð telurðu að þau séu miðað við aðrar fjölskyldur á Íslandi?

- ○ Miklu betur stæð
- ○ Töluvert betur stæð
- ○ Svolítið betur stæð
- ○ Álíka vel stæð
- ○ Svolítið verr stæð
- ○ Töluvert verr stæð
- ○ Miklu verr stæð
- ○ Veit ekki, eða á ekki við

Hversu sammála eða ósammála ert þú eftirfarandi staðhæfingum?

	Mjög ósammála	Frekar ósammála	Hvorki né	Frekar sammála	Mjög sammála
Fatlaðir og ófatlaðir njóta sömu tækifæra á Íslandi	○	○	○	○	○
Konur og karlar njóta sömu tækifæra á Íslandi	○	○	○	○	○
Samkynhneigir og gagnkynhneigðir njóta sömu tækifæra á Íslandi	○	○	○	○	○

Hefur þú verið greind/ur með eitthverja af eftirtöldum röskunum? Hægt er að haka í fleiri en einn valmöguleika.

- ☐ Ekkert að neðantöldu á við um mig
- ☐ Félagsfælni
- ☐ Geðklofi
- ☐ Þunglyndi
- ☐ Athyglisbrestur
- ☐ Ofvirkni
- ☐ Þráhyggju- og árátturöskun
- ☐ Geðhvörf
- ☐ Almenn kvíðaröskun
- ☐ Other: _____

Hefur einhver í þinni nánustu fjölskyldu verið greindur með geðröskun?

- ○ Já
- ○ Nei

Hefur einhver úr þínum vinahóp/kunningjahóp verið greindur með geðröskun?

- ○ Já
- ○ Nei

Hverja/r telur þú vera líklegustu orsakir geðraskanna? Hakaðu við alla þá valmöguleika sem eiga við.

- ☐ Lítill viljastyrkur
- ☐ Streita
- ☐ Skaði í heila og/eða taugakerfinu
- ☐ Félagslegir þættir
- ☐ Misnotkun eiturlyfja
- ☐ Misnotkun áfengis
- ☐ Erfðir

Hér fyrir neðan eru nokkrar staðhæfingar, merktu í þann kassa sem lýsir best hversu sammála/ósammála hverri staðhæfingu þú ert.

	Mjög ósammála	Frekar ósammála	Hvorki né	Frekar sammála	Mjög sammála
Það er erfitt að eiga í samskiptum við fólk með geðraskanir	○	○	○	○	○
Fólk með geðraskanir er líklegra til þess að vera ofbeldishneigt	○	○	○	○	○
Meirihluta fólks með geðraskanir getur batnað	○	○	○	○	○
Fólk með geðraskanir á að hafa sömu réttindi og allir aðrir	○	○	○	○	○
Það er mögulegt fyrir alla að þróa með sér geðröskun	○	○	○	○	○

Hér fyrir neðan eru nokkrar staðhæfingar, merktu í þann kassa sem lýsir best hversu sammála/ósammála hverri staðhæfingu þú ert.

	Mjög ósammála	Frekar Ósammála	Hvorki né	Frekar Sammála	Mjög sammála
Ef ég væri með geðröskun myndi ég ekki segja frá því	○	○	○	○	○
Ég finn fyrir hræðslu þegar ég er nálægt einhverjum með geðröskun	○	○	○	○	○
Mér finnst að heimili fyrir fólk með geðraskanir eigi ekki að vera nálægt öðrum íbúðakjörnum	○	○	○	○	○
Það ætti að eyða meiri pening í útgjöld fyrir fólk með geðraskanir	○	○	○	○	○
Almenningur er almennt skilningsríkur og umburðarlyndur gagnvart fólki með geðraskanir	○	○	○	○	○

Hér fyrir neðan eru nokkrar staðhæfingar, merktu í þann kassa sem lýsir best hversu sammála/ósammála hverri staðhæfingu þú ert.

	Mjög ósammála	Frekar ósammála	Hvorki né	Frekar sammála	Mjög sammála
Ef ég væri með geðröskun myndi ég vilja að fólk vissi af því	○	○	○	○	○
Það er erfitt að spá fyrir um hegðun fólks með geðraskanir og skap þeirra	○	○	○	○	○
Mér finnst erfitt að vera nálægt einhverjum með geðröskun	○	○	○	○	○
Almenningur ætti að vera betur varinn fyrir fólki með geðraskanir	○	○	○	○	○

Hér fyrir neðan eru nokkrar staðhæfingar, merktu í þann kassa sem lýsir best hversu sammála/ósammála hverri staðhæfingu þú ert.

	Mjög ósammála	Frekar ósammála	Hvorki né	Frekar sammála	Mjög sammála
Almenningur á að geta tjáð skoðanir sínar ef hann er ósammála stjórnvöldum	○	○	○	○	○
Framfærslustyrkir ættu einungis að vera veittir þeim sem eru raunverulega bágstaddir en ekki vinnufærum iðjuleysingjum	○	○	○	○	○
Tjáningafrelsi er grundvallarmannréttindi	○	○	○	○	○
Ef lítill hluti nemenda í skóla hvorki skilur né talar íslensku, ætti skólinn að ráða inn kennara sem skildu þá og gætu kennt þeim þó það væri kostnaðarsamt	○	○	○	○	○
Allir eiga rétt á fæði, fatnaði og heimili	○	○	○	○	○

	Mjög ósammála	Frekar ósammála	Hvorki né	Frekar sammála	Mjög sammála
Það er réttlætanlegt að dæma manneskju til dauða sem hefur framið morð af ásettu ráði	○	○	○	○	○
Í lýðræðisríki er nauðsynlegt að fjölmiðlar séu ekki ritskoðaðir og njóti sjálfstæðis frá stjórnvöldum	○	○	○	○	○
Ef atvinnulausir geta ekki fundið sér vinnu þýðir það að þeir eru ekki að leita nógu vel, þar af leiðandi ætti ríkið ekki að styrkja þá	○	○	○	○	○
Samkynhneigðir kennarar geta verið góðar fyrirmyndir fyrir börnin okkar, alveg eins og hver annar	○	○	○	○	○
Einstaklingar eiga rétt á trúfrelsi	○	○	○	○	○

Hér fyrir neðan eru nokkrar staðhæfingar, merktu í þann kassa sem lýsir best hversu sammála/ósammála hverri staðhæfingu þú ert.

	Mjög ósammála	Frekar ósammála	Hvorki né	Frekar sammála	Mjög sammála
Það ætti ekki að að eyða tíma né peningum í réttarhöld yfir fólki sem við vitum fyrir víst að séu sek	○	○	○	○	○
Einstaklingum á ekki að vera mismunað eftir kynþætti, kyni, trúarbrögðum eða fötlun	○	○	○	○	○
Sjúklingur sem kvelst og er með banvænan sjúkdóm á rétt á líknardrápi	○	○	○	○	○
Fóstureyðing er réttur allra kvenna	○	○	○	○	○

Hvar á skalanum 0 til 10, þar sem 0 er til vinstri og 10 til hægri, myndir þú staðsetja stjórnmálaskoðanir þínar?

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○