Review article

Public beliefs about and attitudes towards people with mental illness: a review of population studies


Objective: To provide a review of population-based attitude research in psychiatry during the past 15 years.

Method: An electronic search using PubMed, Medline, and Academic Search Premier plus a hand search of the literature was carried out for studies on public beliefs about mental illness and attitudes towards the mentally ill published between 1990 and 2004.

Results: Thirty-three national studies and 29 local and regional studies were identified, mostly from Europe. Although the majority are of descriptive nature, more recent publications include studies testing theory-based models of the stigmatization of mentally ill people, analyses of time trends and cross-cultural comparisons, and evaluations of antistigma interventions.

Conclusion: Attitude research in psychiatry made considerable progress over the past 15 years. However, there is still much to be done to provide an empirical basis for evidence-based interventions to reduce misconceptions about mental illness and improve attitudes towards persons with mental illness.

Summations

- In the time period since 1990, misconceptions about mental disorders still prevailed among the general public.
- There are indications of inter-cultural variations of beliefs and attitudes as well as of changes over time.
- There are marked differences between the various mental disorders with regard to beliefs and attitudes.

Considerations

- Up until now, population-based attitude research in psychiatry has mainly been descriptive in nature. Other approaches, e.g. the testing of theory-based models, are still under-represented.
- So far, attitude research was mainly focused on schizophrenia and depression, other mental disorders have been neglected.
- There is only little known about the relation between attitudes towards people with mental disorders and the actual behaviour towards them.
Introduction

In 1989, a review article was published in this journal by Dinesh Bhugra on ‘Attitudes towards mental illness’ focusing on studies of public attitudes towards mental illness, mentally ill people and their treatment environs (1). Ever since then, in many countries reforms of mental health care have been initiated or have made further progress (2, 3). One aim of these reforms was to better integrate mentally ill people into society. However, in recent years there has been a growing awareness among mental health professionals that mental illness is still surrounded by stigma. According to Sartorius it is the most important obstacle to the provision of mental health care for people with mental disorders (4). Moreover, as Jorm (5) was able to show, the public’s mental health literacy is still unsatisfactory and needs to be improved. Otherwise, this may hinder public acceptance of evidence-based mental health care. In the 1990s, several programs have been launched around the globe, aimed at either improving public knowledge about mental disorders or reducing the stigmatization and discrimination of those suffering from these disorders (e.g. 6–9). In view of these developments we thought that it is time to carry out a new literature review on public beliefs and attitudes, covering the time period between 1990 and 2004.

Aims of the Study

In particular, the following questions are addressed:

i) To what extent are mental disorders recognized as such and what beliefs about the origin, treatment and course of mental disorders prevail among the general public?

ii) What attitudes towards mentally ill people are prevalent among the general public?

iii) How are beliefs and attitudes related to people’s socio-demographic characteristics and how are they influenced by familiarity with mental illness?

iv) What are the results of studies testing hypotheses derived from modern stigma theory?

v) Have there been any changes in attitudes and beliefs over the years?

vi) Which results yield cross-cultural comparisons of beliefs about mental disorders and attitudes towards people with mental disorder?

vii) What are the results of studies evaluating the effect of interventions aimed at improving the public’s knowledge and at reducing the stigma attached to mental disorders?

The answers to these questions may give an impression of the magnitude of the problem, give some insights into how stigma operates and provide some clues as to what strategies may be best suited to modify existing misconceptions about mental disorders.

Material and methods

We electronically searched PubMed, Medline and Academic Search Premier for studies covering the time period from January 1990 to December 2004. The search was conducted by entering each of the following keywords (attitudes*), (public attitudes*), (general public*), (beliefs*), (lay beliefs*), (stigma*), and (social distance*) in combination with (mental illness*), (mental disorder*), (schizophrenia*), (depression*), (Alzheimer’s disease*), (anxiety disorder*), (OCD*), (alcoholism*), (drug addiction*), (dementia*), (eating disorder*) and (bipolar disorder*) into each of these databases. Following the electronic search, hand searches of the literature identified were undertaken in the form of citation chasing. From these primary and secondary references, those reports were included in our review that met the following criteria: first, the paper was written in English. Second, the focus of the study was on the general public. Studies investigating attitudes and beliefs of particular subgroups (e.g. consumers, carers, health professionals, university students, etc.) were excluded. Third, studies were based on random or quota samples drawn from the general population or from primary care services. Studies using convenience samples were not taken into consideration. Searches for articles in October, November and December issues (2004) of the main journals publishing relevant articles were performed to identify any research that had not yet been entered into any of the above databases. The following journals were searched: Social Psychiatry and Psychiatric Epidemiology, Acta Psychiatrica Scandinavica, British Journal of Psychiatry, Psychological Medicine, European Psychiatry, International Journal of Social Psychiatry, American Journal of Public Health, Social Science and Medicine, European Archives of Psychiatry and Clinical Neurosciences, Canadian Journal of Psychiatry, and Schizophrenia Bulletin. All articles included into our review were systematically screened by both authors for information relevant to the questions posed in the Introduction.

Results

The above search strategy yielded an output of 3651 articles. However, this output constitutes a gross
total since a number of studies appeared more than once after the different keyword combinations were entered into each of the databases. Of the articles identified, 110 met the inclusion criteria. While between 1990 and 1992 only two relevant articles had been published in the following years, a steep linear increase can be observed (1993–1995: 11 articles, 1996–1998: 23 articles, 1999–2001: 32 articles), resulting in a maximum of 41 articles between 2002 and 2004. The articles referred to 62 studies. Differentiating between surveys on a national level and those on a regional or local level, the characteristics of the studies included are reported in Tables 1 and 2. The tables show that a total of 33 national surveys have been conducted in 14 different countries, with 23 of these having been carried out in Europe, six in America, and two each in Asia and Oceania. An additional stock of 29 local or regional surveys can be added to the collection, with 14 of them having been conducted in Europe, five each in America and in Asia, four in Oceania and one in Africa. The majority of the surveys (44) are based on random samples of the general population. The number one interview technique used was personal interviewing (38), followed by telephone interviews (13). Only five of the surveys were conducted by mail. Response rates for the personal interview surveys varied between 64.0 and 98.3%, between 44.0 and 75.4% for the telephone surveys and between 34.5 and 60.0% for the mail surveys. Sample sizes ranged from a minimum of 90 to a maximum of 7278 individuals. While depression (31 surveys) and schizophrenia (29 surveys) were in the lead of the illnesses addressed in these studies, alcoholism (8), anxiety disorders (7), dementia (6) and drug addiction (4) were studied comparatively rarely. One survey each paid attention to mania, obsessive-compulsive disorder, prescription drug dependency, eating disorders, mental retardation and childhood hyperactivity. Twenty-six studies dealt with mental illness in general. Thirty surveys used vignettes as a stimulus. The majority of surveys were focused on public beliefs about mental illnesses (51 surveys) and attitudes towards persons with mental illnesses (45 surveys). Only 11 surveys investigated attitudes towards psychiatric facilities.

Articles reporting descriptive data on public beliefs about mental illness and attitudes towards people with mental illness made up the lion’s share (10–19, 21, 22, 26–32, 34, 36, 40–45, 47–55, 58–65, 67, 69, 73–86, 89–95, 98–109, 111–113). In contrast, articles devoted to testing of theory-based models of the stigmatization of mentally ill people (33, 35, 37–39, 72, 109) were rare. The same applies to the analysis of time trends (20, 24, 25, 58, 68, 87), cross-cultural comparisons of beliefs and attitudes (23, 40, 42, 44, 46, 47, 49, 51, 53, 54, 66, 70, 71, 83, 105, 111) and the evaluation of interventions aimed at improving knowledge of mental disorders and reducing stigmatization of mentally ill people (56, 57, 83, 87, 96, 97, 114–116). In the following, the major findings of these various approaches of attitude research are presented.

Descriptive studies on public beliefs about mental disorders

Studies on beliefs about mental disorders take an interest in the question as to what extent they are recognized as such and what beliefs about the causes, the course and the treatment of these illnesses are prevalent among the public. Several studies using case vignettes agree that many members of the lay public cannot correctly recognize mental disorders. Schizophrenic symptoms are more often seen as an expression of a mental illness (range 69–88%) than are depressive symptoms (26–69%) or symptoms of alcoholism (16–49%) (23, 24, 34, 41, 50, 65, 66, 74, 80, 109).

All studies using vignettes conclude that lay beliefs about the causes of mental disorders clearly differ from the results of psychiatric research in that psychosocial factors, particularly psychosocial stress, are predominating in comparison with biological factors. This holds even truer for depression than for schizophrenia (22, 23, 32, 34, 40, 41, 47, 65, 81, 93). If one concentrates on the studies using the same instrument for the assessment of causal beliefs (22, 23, 32, 34, 40) the following picture emerges: acute stress in the form of life events is the most frequently endorsed cause (schizophrenia: 72.5–87%, depression: 81–85.5%), followed by (chronic) stress in partnership and family (schizophrenia: 59–64%, depression: 70–74%), brain disease (schizophrenia: 48.5–71%, depression: 19–59%) and heredity (schizophrenia: 39–67.5%, depression: 21–58%). Studies using diagnostic labels as stimulus come up with somewhat mixed results: while in the case of depression, psychosocial stress is again favored over biological causes as explanation (57, 60, 87), in the case of schizophrenia the situation is different, with biological factors being as frequently endorsed as a cause (86) or even more frequently than psychosocial stress (22, 101–103). The results of studies assessing causal beliefs about mental illness in general are rather inconsistent in this regard (46, 62, 91, 95, 107, 119).

As far as help-seeking beliefs are concerned, the results are inconsistent. This may, in part, have to do with the diversity of the care systems in the various countries. However, some general tendencies emerge. In the case of depression, the general practitioner is most frequently recommended as a
<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Sampling procedure</th>
<th>Age</th>
<th>Interview</th>
<th>Response rate (%)</th>
<th>Sample size</th>
<th>Disorder</th>
<th>Stimulus</th>
<th>Beliefs about mental illness</th>
<th>Attitudes towards mentally ill people</th>
<th>Attitudes towards psychiatric services</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>1991</td>
<td>Quota sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>–</td>
<td>1443</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>Quota sample</td>
<td>14+</td>
<td>Personal interview</td>
<td>–</td>
<td>1042</td>
<td>Depression</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>(11)</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>1990</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>68.9*</td>
<td>2045*</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(12–17)</td>
</tr>
<tr>
<td></td>
<td>1990</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
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<td>2118*</td>
<td>Depression</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(12–15, 18–20)</td>
</tr>
<tr>
<td></td>
<td>1990</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>72.3* /67.4*</td>
<td>1022*/800*</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(12–15, 17–19, 21–27)</td>
</tr>
<tr>
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<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>70.9*</td>
<td>1912*</td>
<td>Depression</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>(12–15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1992</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>67.8*</td>
<td>2030*</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(12–15)</td>
</tr>
<tr>
<td></td>
<td>1992</td>
<td>Quota sample</td>
<td>16+</td>
<td>Personal interview</td>
<td>–</td>
<td>2176*</td>
<td>Depression</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(20, 29)</td>
</tr>
<tr>
<td>Italy</td>
<td>2000</td>
<td>Cluster sample§</td>
<td>18–70</td>
<td>Self-report questionnaire</td>
<td>98.5</td>
<td>714</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(12–15, 16, 26, 30, 32)</td>
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<tr>
<td>Luxembourg</td>
<td>Quota sample</td>
<td>15+</td>
<td>Telephone interview</td>
<td>–</td>
<td>501</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(12, 14)</td>
<td></td>
</tr>
<tr>
<td>Norway</td>
<td>1992</td>
<td>Stratified random sample</td>
<td>15+</td>
<td>Telephone interview</td>
<td>–</td>
<td>1063</td>
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<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>(40)</td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>Random sample</td>
<td>1994</td>
<td>18–84</td>
<td>Personal interview</td>
<td>?</td>
<td>689**</td>
<td>Mental illness</td>
<td>Vignette</td>
<td>X</td>
<td>X</td>
<td>(46)</td>
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### Table 1. (Continued)

<table>
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<tr>
<th>Country</th>
<th>Year</th>
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<th>Age</th>
<th>Interview</th>
<th>Response rate (%)</th>
<th>Disorder</th>
<th>Stimulus/Concepts</th>
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<tbody>
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<td>UK</td>
<td>1991</td>
<td>Quota sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>–</td>
<td>1500</td>
<td>Depression, Label X (56, 57)</td>
</tr>
<tr>
<td></td>
<td>1995</td>
<td>Quota sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>–</td>
<td>1500</td>
<td>Depression, Label X (56, 57)</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Quota sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>–</td>
<td>1500</td>
<td>Depression, Label X (56, 57)</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Quota sample</td>
<td>15+</td>
<td>Personal review</td>
<td>–</td>
<td>1500</td>
<td>Schizophrenia, Label X (58)</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>Random sample</td>
<td>16+</td>
<td>Personal interview</td>
<td>67</td>
<td>1737</td>
<td>Schizophrenia, Depression, X (58)</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Random sample</td>
<td>16+</td>
<td>Telephone interview</td>
<td>44</td>
<td>1326</td>
<td>Mental illness, Depression, Alcohol addiction, Drug addiction, Panic disorder, Eating disorder, X (62)</td>
</tr>
<tr>
<td>Ireland</td>
<td>1989</td>
<td>Quota sample</td>
<td>16+</td>
<td>Personal interview</td>
<td>–</td>
<td>1403</td>
<td>Depression, Label X (60)</td>
</tr>
<tr>
<td>Canada</td>
<td>2002</td>
<td>Random sample</td>
<td>21+</td>
<td>Telephone interview</td>
<td>44</td>
<td>1000</td>
<td>Depression, Label X (61)</td>
</tr>
<tr>
<td>US</td>
<td>1998</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>76.1</td>
<td>1444</td>
<td>Depression, Schizophrenia, Drug dependence, Alcohol dependence, Mental illness, Depression, X (58)</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>Random sample</td>
<td>21+</td>
<td>Personal interview</td>
<td>–</td>
<td>1387</td>
<td>Mental illness – X (73)</td>
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<td>Dominica</td>
<td>1995</td>
<td>Random sample</td>
<td>–</td>
<td>Telephone interview</td>
<td>64</td>
<td>135</td>
<td>Depression, Label X (74)</td>
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<tr>
<td>Australia</td>
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<td>Random sample</td>
<td>18–74</td>
<td>Telephone interview</td>
<td>76.4</td>
<td>1326</td>
<td>Mental illness – X (62)</td>
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<td>New Zealand</td>
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<td>Random sample</td>
<td>16–44</td>
<td>Telephone interview</td>
<td>76.4</td>
<td>1326</td>
<td>Mental illness – X (62)</td>
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</table>

**Public beliefs about and attitudes towards mentally ill**
Table 2. Overview of regional and local surveys published since 1990

<table>
<thead>
<tr>
<th>Region</th>
<th>Year</th>
<th>Sampling procedure</th>
<th>Age</th>
<th>Interview</th>
<th>Response rate (%)</th>
<th>Sample size</th>
<th>Disorder</th>
<th>Stimulus</th>
<th>Beliefs about mental illness</th>
<th>Attitudes towards mentally ill people</th>
<th>Attitudes towards psychiatric services</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helsinki, Seinäjoki, Joensuu, Pieksämäki, Tampere, Finland</td>
<td>1985</td>
<td>Random sample</td>
<td>?</td>
<td>Self-administered questionnaire</td>
<td>69</td>
<td>514</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(84)</td>
</tr>
<tr>
<td>Mannheim/Germany</td>
<td>?</td>
<td>Random sample</td>
<td>16+</td>
<td>Telephone interview</td>
<td>75.4</td>
<td>7278</td>
<td>Schizophrenia</td>
<td>Label</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(44)</td>
</tr>
<tr>
<td>Berlin, Bonn, Düsseldorf, Essen, Cologne, Munich/Germany</td>
<td>2001</td>
<td>Random sample</td>
<td>16+</td>
<td>Telephone interview</td>
<td>51.9</td>
<td>1426</td>
<td>Depression</td>
<td>Label</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(65, 66)</td>
</tr>
<tr>
<td>Nuremberg, Würzburg/Germany</td>
<td>2000</td>
<td>Random sample</td>
<td>18+</td>
<td>Telephone interview</td>
<td>68.5</td>
<td>1508</td>
<td>Depression</td>
<td>Label</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(67)</td>
</tr>
<tr>
<td>Two boroughs in greater Athens/Greece</td>
<td>1994</td>
<td>Random sample</td>
<td>19–64</td>
<td>Personal interview</td>
<td>360</td>
<td>324</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(88)</td>
</tr>
<tr>
<td>Vizcaya/Spain</td>
<td>?</td>
<td>Stratified random sample</td>
<td>16–65</td>
<td>Personal interview</td>
<td>400</td>
<td>1426</td>
<td>Depression</td>
<td>–</td>
<td>X</td>
<td>X (89)</td>
<td>–</td>
<td>(90)</td>
</tr>
<tr>
<td>Northtown/UK</td>
<td>?</td>
<td>Quota sample</td>
<td>?</td>
<td>Personal interview</td>
<td>–</td>
<td>154</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(91)</td>
</tr>
<tr>
<td>Malvern and Bromsgrove/UK</td>
<td>1989</td>
<td>Quota sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>–</td>
<td>1887</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(92, 93)</td>
</tr>
<tr>
<td>Herne Hilland and Streatham Hill/UK</td>
<td>1993</td>
<td>Random sample</td>
<td>?</td>
<td>Personal interview</td>
<td>70</td>
<td>215</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(94–97)</td>
</tr>
<tr>
<td>Two urban areas/UK</td>
<td>?</td>
<td>Random sample</td>
<td>18+</td>
<td>Postal survey</td>
<td>42.6</td>
<td>208</td>
<td>Mental illness</td>
<td>Vignette</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(98)</td>
</tr>
<tr>
<td>Scotland/UK</td>
<td>2001</td>
<td>Random sample</td>
<td>16+</td>
<td>Personal interview</td>
<td>981</td>
<td>1061</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(99)</td>
</tr>
<tr>
<td>Co. Louth and Co. Meath/Ireland</td>
<td>?</td>
<td>Random sample</td>
<td>17–66</td>
<td>Personal interview</td>
<td>77.5</td>
<td>155</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(100)</td>
</tr>
<tr>
<td>Calgary, Drumheller, Edmonton/Canada</td>
<td>1998/1999</td>
<td>Random sample</td>
<td>15+</td>
<td>Telephone interview</td>
<td>71.9</td>
<td>1508</td>
<td>Schizophrenia</td>
<td>Label</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>(101, 102)</td>
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<td>Québec/Canada</td>
<td>?</td>
<td>Stratified random sample</td>
<td>18+</td>
<td>?</td>
<td>60.7</td>
<td>1001</td>
<td>Schizophrenia</td>
<td>Label</td>
<td>X</td>
<td>X (103)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Delaware County/US</td>
<td>1988</td>
<td>Stratified random sample</td>
<td>?</td>
<td>Postal survey</td>
<td>34.5</td>
<td>206</td>
<td>Schizophrenia</td>
<td>Vignette*</td>
<td>X</td>
<td>X (104)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>San Francisco/US</td>
<td>?</td>
<td>Random sample†</td>
<td>55+</td>
<td>Personal interview</td>
<td>?</td>
<td>209</td>
<td>Dementia</td>
<td>Label</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>(105)</td>
</tr>
<tr>
<td>Mexico City/Mexico</td>
<td>?</td>
<td>Quota sample</td>
<td>18–60</td>
<td>Personal interview</td>
<td>–</td>
<td>800</td>
<td>Mental illness</td>
<td>–</td>
<td>X</td>
<td>X (106)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2 Kibbutzim/Israel</td>
<td>?</td>
<td>A) Random sample</td>
<td>20+</td>
<td>Self-administered questionnaire</td>
<td>96.4</td>
<td>108</td>
<td>Mental disorders</td>
<td>–</td>
<td>X</td>
<td>X (107)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B) Total population</td>
<td>20+</td>
<td>Self-administered questionnaire</td>
<td>97.8</td>
<td>90</td>
<td>Psychosis</td>
<td>Vignette</td>
<td>X</td>
<td>– (107)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Istanbul/Turkey</td>
<td>?</td>
<td>Random sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>98.3</td>
<td>707</td>
<td>Depression</td>
<td>–</td>
<td>X</td>
<td>– (108)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Sanakali/Turkey</td>
<td>2000</td>
<td>Total population</td>
<td>18+</td>
<td>Personal interview</td>
<td>84.9</td>
<td>207</td>
<td>Schizophrenia</td>
<td>Vignette*</td>
<td>X</td>
<td>X (109)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Novosibirsk/Russia</td>
<td>2002</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>74.5</td>
<td>745</td>
<td>Schizophrenia</td>
<td>Vignette*</td>
<td>X</td>
<td>X (40, 110)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Ulaanbaatar/Mongolia</td>
<td>2002</td>
<td>Random sample</td>
<td>18+</td>
<td>Personal interview</td>
<td>95.2</td>
<td>952</td>
<td>Schizophrenia</td>
<td>Vignette*</td>
<td>X</td>
<td>X (40, 110)</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
helping source (28–30, 52, 74, 78, 89, 118). In the case of schizophrenia, the public is more ready to recommend seeking help from a psychiatrist than in case of depression (28–30, 52, 58, 74). If mental disorders are recognized as such, the willingness to address a psychiatrist increases (52).

All studies using case vignettes agree in that the public’s beliefs about psychological interventions (e.g. psychotherapy or counselling) are predominantly favourable, while very negative views prevail about pharmacological treatments (10, 19, 23, 24, 27–29, 41, 52, 78, 80, 82, 118). Surprisingly, with one exception (10), the particular liking of psychotherapy is more developed for schizophrenia than for depression (19, 27–29, 52, 78, 80, 82). For example, in a study from Australia (80) psychotherapy was considered by 55% of the respondents as being helpful for the treatment of schizophrenia and by 34% as being helpful for the treatment of depression while only 23% recommended antipsychotic medication and 29% antidepressants. Similar findings have been reported from a study in Switzerland using the same instrument (52). Similarly to causal beliefs, the results are somewhat different when explicit diagnostic labels are used. In the case of depression, again, psychosocial interventions are favoured over medication (57, 87), while in the case of schizophrenia, medication is more frequently considered as the appropriate form of treatment (58, 86, 101). In a survey in the US, most respondents agreed that psychiatric medications are effective, and fewer than half had concerns regarding potential problems. However, the majority of the respondents would not be willing to take them (72).

In general, in the absence of a treatment, the course of mental disorders is seen rather pessimistically. The deterioration of the mentally ill person’s state is expected to be severer for schizophrenia than for depression. Conversely, on condition that an appropriate treatment is provided, the prognosis for both disorders is assessed quite optimistically (10, 23, 34, 58, 67, 78).

No consistent relationships were found between gender and age of respondents on the one hand, and their illness beliefs on the other. Respondents with a higher educational level less frequently tended to make the person afflicted responsible for his or her illness and were more willing to recommend psychosocial interventions for treatment (23, 47, 69, 81, 111).

Table 2. (Continued)

<table>
<thead>
<tr>
<th>Region</th>
<th>Year</th>
<th>Sampling procedure</th>
<th>Age</th>
<th>Interview</th>
<th>Response rate (%)</th>
<th>Sample size</th>
<th>Disorder</th>
<th>Stimulus</th>
<th>Beliefs about mental illness</th>
<th>Attitudes towards psychiatric services</th>
<th>Attitudes towards mentally ill people</th>
<th>Attitudes towards psychiatric services references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahir Dar/Ethiopia</td>
<td>?</td>
<td>Random sample</td>
<td>17–70</td>
<td>Personal interview</td>
<td>?</td>
<td>450</td>
<td>Schizophrenia</td>
<td>Vignette</td>
<td>X</td>
<td>(111)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albury and surrounding rural area in New South Wales,Australia</td>
<td>?</td>
<td>Random sample</td>
<td>20–59</td>
<td>Postal survey</td>
<td>39</td>
<td>3109</td>
<td>Depression</td>
<td>Vignette</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canberra and south-east New South Wales,Australia</td>
<td>1988</td>
<td>Random sample</td>
<td>18–52</td>
<td>Postal survey</td>
<td>~60</td>
<td>1094</td>
<td>Depression</td>
<td>Vignette</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Australia 1998</td>
<td>Random sample</td>
<td>15+</td>
<td>Personal interview</td>
<td>70.2</td>
<td>3010</td>
<td>Depression</td>
<td>Label</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dunedin/New Zealand 1993</td>
<td>Random sample</td>
<td>?</td>
<td>Postal survey</td>
<td>55</td>
<td>194</td>
<td>Mental illness</td>
<td>Vignette</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*DSM III-R.
*DSM IV.
Participants were recruited from four public sector primary care clinics and were randomly selected from clinic logs.

Descriptive studies on attitudes towards people with mental disorders

People with mental disorders are experienced by the majority of the public to be in need of help and...
dependent on others (20, 34, 36). Among the negative attributes attached to people with mental disorders the most prevalent one appears to be that they are unpredictable. This holds true more for people with schizophrenia (54–85%) or alcoholism (71%) than for people with depression (28–56%) or anxiety disorders (50%) (13, 34, 35, 41, 59, 104). Less frequently, persons with mental disorders are considered as violent and dangerous. Here, a similar picture emerges as with unpredictability. In particular, people with schizophrenia (18–71%) and alcoholism (65–71%) are seen as dangerous. To a lesser extent, this also applies to people with depression (14–33%) and anxiety disorders (26%) (13, 34, 35, 59, 62, 65, 66, 85, 101). The majority of the public show pro-social reactions, i.e. they feel sorry for persons with mental illnesses and they also feel the need to help them. This is particularly true for depression. Next come feelings of uneasiness, uncertainty and fear, reactions which are mostly set off by persons with schizophrenia. Infrequently, aggressive reactions occur (20, 34). There is an observable tendency towards distancing from persons with mental illness. With increasing intimacy of social relationships increases the desire for social distance. Rejection is most pronounced towards persons with drug abuse and alcoholism, followed by those with schizophrenia and is less pronounced towards people with depression and anxiety disorders (10, 15, 34, 51, 65, 67, 104, 111). All vignette studies examining the effect of subject-generated mental illness labels on public attitudes show that labelling leads to more rejection and other adverse reactions (20, 33, 41, 51, 66, 98, 109).

Attitudes towards people with mental illness vary to a small extent only depending on sociodemographic characteristics. For example, in a German study, gender, age, education and residency accounted for only 1.4% of the variance (36). As concerns gender, the results are quite inconsistent. In the majority of cases (18 times) where the influence of gender on attitudes was examined no association between the two was observed (12, 15, 20, 40, 53, 54, 60, 66, 69, 88, 107, 109, 119). In 11 instances men expressed more negative attitudes than women (17, 34, 51, 54, 88, 119), in six instances the opposite was found (17, 34, 75, 76, 86). In most instances (32 times), negative attitudes were positively associated with age (12, 15, 20, 40, 41, 51, 54, 60, 66, 67, 69, 84, 88, 92, 93, 107, 109, 119), while the reverse relationship was reported only once (53). To what extent this may be due to either ageing or cohort effects remains an open question. In 10 instances, age did not matter (34, 66, 67, 88, 94, 100, 109, 119). In 20 of 38 observations a positive relationship showed between educational level and attitudes: persons with a higher educational level tended to distance themselves less from the mentally ill and expressed more liberal views (20, 34, 41, 53, 54, 67, 75, 76, 84, 88, 92–94, 107, 111, 119). In 18 cases, no relationship with education was reported (12, 15, 34, 40, 66, 88, 94, 100, 109, 119). The few studies dealing with urban–rural differences come up with quite contradictory results. While two studies found a stronger desire for social distance among rural residents (101), another study found the opposite (66). While in one study the perception of mentally ill people as being unpredictable was more pronounced among rural residents (42), in two other studies no urban–rural differences were found with regard to perceived dangerousness (63, 67).

In 61 cases the relationship between familiarity with mental illness, i.e. having personally experienced a mental illness or having personal contact with people suffering from mental illness, and attitudes was examined. Thirty times it was reported that people had more positive attitudes if they were familiar with mental illness (15, 51, 54, 58, 59, 60, 64, 68, 71, 72, 76, 77, 84, 92, 93, 98, 119). The opposite was found in only one instance (59). In 30 cases no association between familiarity and attitudes was reported (16, 48, 54, 71, 77, 94, 98, 100, 101, 107, 119).

Studies testing theory-based models of the stigmatization of mentally ill people

Two recently developed conceptualizations of stigma served as the main theoretical framework for empirical studies, namely Link and Phelan’s (120) sociological concept of the ‘stigma process’ and Corrigan and Watson’s (121) social–psychological concept of the ‘public stigma’.

According to Link and Phelan (120), the stigma process sets off by recognizing and labelling a difference between a person and other people. The next step involves the linking of the labelled person with the negative stereotypes that predominate in society about this group of people. This way, the person now belongs to a distinct category of people from whom the beholder dissociates. The stigma process culminates in that the person concerned is exposed to different forms of discrimination and the negative social consequences resulting from this. The authors differentiate between individual and structural discrimination as well as self-stigmatization. The first refers to the behaviour of individuals that is directed straight against the members of a stigmatized group. The most frequently applied measure of individual
discrimination is the desire for social distance (122). Structural discrimination describes the negative consequences that result from the imbalances and injustice inherent in social structures, political decisions and legal regulations for the members of a stigmatized group. The third form of discrimination (self-stigmatization) comes from within the mentally ill persons themselves in that they adopt the stereotypes prevailing in society about people with mental illness.

The link between the two components of the stigma process, stereotype and discrimination, has been investigated in the meantime, with the interest lying on the impact of the different aspects of the stereotype of the mentally ill on individual discrimination and on the acceptance of structural discrimination of people with schizophrenia. Of the different stereotype components, the idea of unpredictability and dangerousness had the strongest impact on the social distance desired towards a person with schizophrenia: the more this view was adopted, the higher was the desire for social distance. The converse applies to the idea that people with schizophrenia were particularly intelligent and gifted. The acceptance of structural discrimination, on the contrary, was mainly influenced by the belief that those affected are to blame for their own illness: the more distinct the inclination to blame the ill, the higher the tendency towards approving of structural discriminations (35). Of particular interest for the structural discrimination of mentally ill persons is the result of a survey in Germany, which investigated the public’s preferences when it comes to the allocation of financial resources to health care and medical research. While somatic illnesses like cancer or cardiovascular diseases ranked first, depression, schizophrenia and alcoholism were the taillights (38, 39). Findings similar to what has been found in Germany are reported from the US: respondents who labelled persons with mental disorders as suffering from mental illness expressed a preference for greater social distance; and the degree of dangerousness that the public ascribed to these persons appeared to mediate the influence of the labelling effect (66).

According to Corrigan and Watson (121), public stigma denotes the reaction of the general public to a certain group of individuals based on the stigma that is attached to this group. It comprises three components: stereotype, prejudice and discrimination. Stereotypes are collectively shared beliefs about a group of individuals. Most of the people are familiar with these stereotypes, however, not everybody adopts them. If they are adopted, prejudices develop, which result in negative emo-

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Using data from a study conducted in Germany, this model was applied to investigate the effect of labelling of schizophrenia and depression as mental illnesses. In the case of schizophrenia, this kind of labelling elicited the belief that those affected with this illness are dangerous and unpredictable. Consequences were negative emotional reactions, like increasing fear and aggression. These resulted in an increasing desire for social distance. No such associations could be demonstrated for depressive disorders (33). Furthermore, the model was used to study the effect of familiarity with mental illness on the attitudes towards people with schizophrenia and depression. It could be shown that with growing familiarity, the tendency towards considering the ill person to be dangerous and unpredictable was decreasing, and people had less fear and social distance was desired less frequently (37).

Analysis of time trends in beliefs about mental illnesses and attitudes towards people with mental illness

For identifying developmental trends in patterns of beliefs and attitudes over time, results of cross-sectional surveys, which were conducted at different points in time, were compared with each other. Unfortunately, there are only a few of these studies and they came up with rather contradictory results. The study covering the longest period of time was undertaken in the US. Phelan et al. (68) compared the data of a survey dating from 1996 and those taken from a study conducted by Star back in 1950. They found that while today, the image of mental disorders is somewhat more differentiated among the American public, mentally ill individuals are nowadays more frequently considered to be dangerous as compared to the 1950s. Covering a much shorter time period (only 2 years), a study from Hong Kong came up with similar results: while the public’s knowledge of mental illness had slightly improved, their attitudes towards mental patients had become slightly more negative (76). In contrast, Madianos et al. (88) reported that the residents of two boroughs in greater Athens expressed more positive attitudes towards the mentally ill in 1994 than back in 1979/1980. According to the authors, the results could be explained in the context of a positive and tolerant social climate in the Athens area, strengthened by the implementation of local community mental health intervention programmes. Finally, a comparison of data from two surveys conducted in West German states in 1990 and 2001 revealed that the public’s emotional reactions and their desire for
social distance towards persons with major depression had by and large remained unchanged (20). Psychotropic drugs were assessed more favourably by the German public in 2001 than 11 years ago (25). Based on a series of surveys conducted in the years 1990–1992, it could be shown that there was a marked increase of the preference for social distance from people with schizophrenia immediately following violent attacks by two individuals suffering from schizophrenia against prominent German politicians (12–14).

Cross-cultural comparisons of beliefs and attitudes

A distinction can be made here between surveys which investigate variations in the pattern of beliefs and attitudes within a single country and others, which investigate variations between different countries. Differences in beliefs and attitudes have been studied in five countries. A comparison between the old West German states and the New Laender (former German Democratic Republic, GDR) in 1990, i.e. shortly after the German reunification, showed that lay beliefs about schizophrenia were almost identical. However, the tendency to define depressive symptoms as an illness and to recommend psychiatric treatment was less pronounced in the former GDR (23). Eleven years later these differences had diminished and the beliefs of the East German population had become similar to those of the West German population (24).

Surveys from Switzerland show that, as compared with French-speaking Swiss, there was a marked reluctance of the German-speaking Swiss to resort to specialist help, particularly to mental health professionals, in case of mental illness (46). Another comparison of the three language regions in Switzerland revealed that people living in the Italian-speaking part expressed a stronger desire for social distance than people living in the German- and French-speaking parts (51). People from the French- and Italian-speaking parts were more willing to accept restrictive measures against persons with mental illness than those from the German-speaking part of Switzerland (54). People living in the French-speaking part were also more in favour of compulsory admissions (53). Non-Swiss residents held more positive attitudes towards volunteering in psychiatry, i.e. they were more willing to regularly visit a long-term patient in a psychiatric institution, to help in a club for ex-patients, or to look after a mentally ill person not belonging to the household (49).

A study from Italy reported that people living in southern Italy were less ready to acknowledge patients’ social competence and civil rights than those from other parts of the country (42).

A survey in the US yielded that people from the South of the US tended to endorse more frequently that the person’s bad character or stresses in life are responsible for the occurrence of mental disorders (70). Their preferences for social distance from persons with mental disorders were the same as in the rest of the US (66). Asian and Hispanic respondents perceived mental patients as significantly more dangerous than did white respondents (71). African Americans were more likely than whites to reject the idea that mental illnesses are caused by either genetics or an unhealthy family upbringing. They also tended to have more negative attitudes than whites towards professional mental health treatment (70). The results of a study among older adults recruited from primary-care clinics in San Francisco indicated that Anglo older adults are significantly more knowledgable about Alzheimer’s disease than African American, Asian, and Latino older adults (105).

In New Zealand, as compared to the general population the awareness of mental illnesses and the number of mental illnesses recalled was lower among Maori and much lower among pacific people. While among Maori the acceptance of people with mental illness in general or schizophrenia in particular was similar to the general population it was lower among pacific people (83).

International comparisons are made possible by surveys conducted in different countries using the same methodology. Unfortunately, up until now results from only two representative studies among the general population addressing the question of inter-country differences with regard to beliefs and attitudes have been published. A comparison between Novosibirsk (Russia), Ulaanbaatar (Mongolia) and Germany revealed that people from the former two cities show a stronger tendency towards attributing the cause of mental illness to the afflicted individual (40). The same tendency has been reported from another non-western culture (109). As already outlined earlier, there was a close association for schizophrenia between labelling as mental illness and the stereotype of dangerousness in Germany. This association was neither found in Novosibirsk nor in Ulaanbaatar (110).

In another study the attitudes towards the mentally ill among the residents of two Central European regions which were at considerably different stages of development in moving towards community-based care were compared. People living in the community care area (a district of the city of Mannheim in Germany) showed slightly more rejection. However, they also took a more
rational and sophisticated position towards the mentally ill. People living in the custodially orientated catchment area (Grand Duchy of Luxembourg), on the contrary, showed a more vague pattern in their attitudes (44).

Evaluation of interventions aimed at improving knowledge of mental illnesses and reducing stigmatization of mentally ill people

Six studies are available in which population surveys have been used to evaluate interventions aimed at transferring knowledge or reducing stigma. Four studies were focused on depression.

Paykel et al. (57) evaluated the ‘Defeat Depression Campaign’, an activity of the Royal College of Psychiatrists in association with the Royal College of General Practitioners between 1992 and 1996 in the UK (56). Surveys of public attitudes and knowledge were conducted in late 1991, early 1995 and mid-1997. The share of those subjects who saw depression as a medical illness increased significantly. In addition, the acceptance of antidepressants increased, with more respondents regarding them as effective in 1997. In contrast, the proportion of those regarding antidepressants as addictive remained almost unchanged: three-fourth of respondents agreed to this view.

Hegerl et al. (87) evaluated the effect of the ‘Nuremberg Alliance Against Depression’, a campaign aimed at informing the public about the causes and treatment of depression. Prior to the beginning of the campaign and 1 year later, telephone surveys were conducted with a random sample in the cities of Nuremberg and Wurzburg, the latter functioning as the control region. As concerns illness beliefs, the result was rather sobering. Although the share of respondents making a lack of self-control responsible for the disorder had decreased in Nuremberg more clearly than it had in Wurzburg, fewer respondents from both cities agreed to the view that a dysfunction of the brain was the cause. Respondents’ opinion in terms of using antidepressants for the treatment remained almost unchanged, the same applies to respondents’ opinion as to the negative effects of antidepressants.

Jorm et al. (114) evaluated the effect of a consumer guide called ‘Help for Depression: What Works (and What Doesn’t)’, containing evidence-based information about treatments for depression. A pretest, which included a scale assessing depression, was mailed as a screening test for depression to a random sample of Canberra citizens and citizens from the area of south-east New South Wales. The mail package also contained questions asking about attitudes to different health professionals and treatments. The consumer guide was sent to half of a subsample that scored above a set cut-off point on the depression scale and indicated interest in participating in the study. The remaining half of the sample received a brochure providing basic information about depression. Six months later, a second postal survey was conducted. Those who had received the consumer guide more often rated cognitive-behaviour therapy to be helpful. The same was true for electroconvulsive therapy and St John’s wort. However, respondents’ views on antidepressants or interpersonal psychotherapy remained unchanged.

In another study conducted in the same area, the effect of two internet depression sites on stigma have been investigated. A total of 525 individuals with elevated scores on the depression assessment scale were randomly allocated to a depression information website, a cognitive-behavioural skills training website or an attention control condition. Personal stigmatizing attitudes to depression and the perception of what most people believe about people with mental illness were assessed before and after the intervention. Relative to the control, the internet sites significantly reduced personal stigmatizing attributes, although the effects were small. While informing the individuals had no effect on the perceptions of stigma; the cognitive-behavioural component was associated with an increase in perceived stigma relative to the control (115, 116).

In order to evaluate a national media campaign to counter stigma and discrimination associated with mental illness that has been launched in New Zealand, a series of four surveys had been conducted. It could be shown that advertising has a significant impact on the public’s attitudes and knowledge. There was a significant increase in reported acceptance of people with experience of mental illness while the attitude towards people with schizophrenia remained virtually unchanged. As compared with the general population, Maori and pacific people did not show the same level of improvement in attitudes (83).

Prior to the opening of two staffed group homes for severely mentally ill people, situated in the London borough of Lambeth, immediate neighbours living on the same street as these facilities were interviewed. In one area, an educational campaign was conducted comprising a primarily didactic component (an information pack containing a video and information sheets), a primarily social component (social events and social overtures from staff) and a mixed component (a formal reception and informal discussion sessions). One
year after the start of the educational campaign the survey was repeated in both areas. There was no significant difference between increase in knowledge in the two areas over time. However, there was an overall decrease in the fear and exclusion dimension of the CAMI in the experimental area at follow-up compared to the control area. The acceptance of patients increased in the experimental area (96, 97).

Discussion

The main findings of the last 15 years of attitude research in psychiatry may be summarized as follows:

i) A substantial part of the public cannot recognize specific mental disorders. When confronted with pathological behaviour, as depicted in a vignette, people most frequently tend to adopt psychosocial stress as a causal explanation and to recommend psychological interventions for treatment. If diagnostic labels are being used in case of depression the same is found while in case of schizophrenia biological explanations are as frequently or even more frequently endorsed and psychotropic medication recommended.

ii) The majority of the public consider people with mental disorders as in need of help and show pro-social reactions. However, a substantial part perceives them as unpredictable and dangerous and reacts with fear. There is an observable tendency to distance oneself from people with mental disorders.

iii) Although there are various similarities between mental disorders as concerns public beliefs and attitudes, there are also marked differences. For instance, people with schizophrenia or alcoholism are more frequently considered as unpredictable and violent than people with depression and anxiety disorders. Rejection is most pronounced towards people with drug abuse and alcoholism, followed by those with schizophrenia, and is less pronounced towards people with depression and anxiety disorders.

iv) While the association between gender and attitudes is inconsistent, there exists strong evidence that negative attitudes are positively associated with age and negatively with educational attainment. However, the explanatory power of socio-demographic characteristics is only poor.

v) If there is any relationship there is a positive association between familiarity with mental illness and the acceptance of people with mental disorders. Consequently, to facilitate the contact with people with mental disorders may prove effective in reducing negative attitudes.

vi) Models derived from modern stigma theories allow to systematically investigate the relations between the various stigma components as, for instance, the effect of labeling on attitudes or that of the different aspects of the stereotype of the mentally ill on social distance or on the acceptance of structural discrimination.

vii) Up until now, too few trend analyses have been carried out to allow firm conclusions to be drawn as concerns the development of beliefs and attitudes over time. While there are some indications that the gap between public beliefs and scientific evidence has become narrower, attitudes do not show a consistent trend in one direction or the other.

viii) Comparisons between various regions or ethnic groups within countries as well as comparisons between countries reveal considerable differences in beliefs about mental disorders and in attitudes towards people with mental illness. There are some indications that people from non-western ethnic groups are less aware of and knowledgeable about mental illness and tend to attribute the cause of the illness more frequently to the afflicted individual.

ix) The evaluation of interventions aimed at improving the public’s knowledge of depression, using population surveys, suggests that this may be achieved in some areas while others, particularly people’s views on medication, may prove more resistant to change. Some findings suggest that informing people may not necessarily affect their attitudes.

From our review the following conclusions for future research may be drawn:

i) In recent years, attitude research in psychiatry has made considerable progress. However, the vast majority of studies are still dedicated to the descriptive recording of public beliefs about mental illness and public attitudes towards persons with mental illnesses. There is a pressing need for more studies using more sophisticated approaches, like the testing of theory-based models, cross-cultural comparisons and trend analyses. They only may provide us with insights into the mechanisms of and contextual influences on stigma that are needed for successful antistigma interventions.
ii) The vast majority of surveys covered by this review have been conducted in Western countries and only nine out of 61 originate from the rest of the world. There is a need for more transcultural studies using representative samples [instead of convenience samples as have been used in a number of previous studies (e.g. 123, 124)].

iii) Current attitude research mainly took an interest in schizophrenia and depression. Only a few studies have looked into alcoholism, drug abuse, anxiety disorders and dementia. Other disorders such as bipolar disorder have not been the focus of population studies yet. Strictly speaking, the titles of the majority of papers alluding to ‘mental disorders’ or ‘mental illness’ in general (e.g. 10, 15, 16, 23, 26) are somewhat misleading.

iv) Moreover, population surveys have thus far focused almost exclusively on attitudes towards mentally ill persons. With the exception of a few studies only (65, 67, 98), comparisons with people affected with somatic illnesses or mentally healthy people (‘normal persons’) have not been carried out. Thus, it remains largely unknown to what extent the public’s beliefs about and attitudes towards mental disorders differ from the beliefs about and attitudes towards other social groups.

v) In order to avoid the overgeneralization of research findings, a clear distinction between beliefs and attitudes related to pathological behaviour (as assessed by means of vignettes) and those related to diagnostic labels (for instance ‘schizophrenia’ or ‘depression’) seems necessary.

vi) The assessment of beliefs and attitudes about mentally ill people in general appears of limited value in view of the marked differences between the various mental disorders.

vii) An important limitation of the research reviewed in this paper, with very few exceptions (96, 97, 112, 113), is that the relationship between attitudes and behaviour has not yet been examined. Thus, it remains an open question as to what extent beliefs about mental illnesses and attitudes towards mentally ill people are in fact related to actual behaviour. More research is needed to shed light on this relationship; however, it must be acknowledged that this is a very difficult area of research.

viii) Although some of the mechanisms which form the basis of discrimination against persons with mental illnesses have been subjected to a closer analysis, and with evaluations of educational programmes having yielded some useful suggestions for the planning of interventions aimed at reducing the stigma attached to mental illness, we are still far from evidence-based antistigma programmes. This is not the least due to the fact that popular strategies for combating mental illness stigma have received contradictory evaluations, resulting in deep disagreement as to their effectiveness in actually reducing stigma and discrimination (125). For instance, while some studies (66, 101) are supportive of the mental illness is a brain disease strategy, other studies (36, 40, 51) found evidence that promoting biological concepts among the public might not contribute to a desired reduction in social distance towards people with mental disorders.

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