Perceptions of schizophrenia in the Australian community: 2005–2017

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ABSTRACT
Background: Community perceptions of schizophrenia potentially influence the wellbeing and quality of life for individuals with the disorder. There is some evidence of improved community knowledge of schizophrenia in recent years; however, misconceptions still remain.

Aims: The aims were to investigate community perceptions of schizophrenia at two points in time.

Method: Two cross-sectional surveys were used to assess perceptions of schizophrenia. Using personal contacts and a snowball approach, members of the Australian community were recruited in 2005 (n = 1214) and in 2017 (n = 985). Participants were asked “What is the first thing that comes to mind when you think about schizophrenia?”

Results: Analyses revealed that community knowledge of schizophrenia was more accurate at the second time point and prosocial tendencies were more evident. Perceptions of dangerousness, aggressiveness and unpredictability did not differ at the two time points. Despite there being fewer responses that confused schizophrenia with dissociative identity disorder, this misconception was still evident.

Conclusions: Although community knowledge about schizophrenia appears to have become more accurate and empathic, the endurance of negative stereotypes and misunderstandings highlights the need for community education programmes to combat stigma and discrimination.

Introduction

Stigma acts as a major barrier to treatment, support and quality of life for individuals and families affected by schizophrenia (Ertugrul & Ulug, 2004; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Defined as “a mark of disgrace or discredit that sets a person aside from others” (Byrne, 2001), stigma was conceptualised by Goffman (1963) as the categorisation, discreditation and consequent devaluation and rejection of a person on the basis of attributes that are viewed by a society as undesirable or deviant. The stigma associated with schizophrenia is more severe than that associated with other mental illnesses (Mann & Himelein, 2004), with some research suggesting that public attitudes are worsening over time (Schomerus et al., 2012; Silton, Fannelli, Milstein, & Vaaler, 2011). These findings are of concern because stigma leads to discrimination that can be experienced across all facets of life.

In the community, mental illness discrimination manifests most commonly through social distancing, and desire for social distance is highest towards individuals with schizophrenia (Mann & Himelein, 2004). Unlike other mental illnesses, improved knowledge about schizophrenia does not appear to reduce the desire for distance. In repeat cross-sectional studies in Australia, Reavley and Jorm (2014) found that the belief that schizophrenia has a genetic basis was stronger in 2011 than in 1995. This belief potentially reduces blame (Kvaale, Gottdiener, & Haslam, 2013) and suggests a recognition of the usefulness of medication (Reavley & Jorm, 2012). However, knowledge about the genetics of schizophrenia is related to more negative stereotyping, such as the perception that individuals are dangerous and unpredictable (Bennett, Thirlaway, & Murray, 2008; Kvaale et al., 2013). This unique trend challenges the premise behind most stigma reduction initiatives that work on the assumption that improved knowledge reduces stigma (for a systematic review, see Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012).

The Australian study also indicated other improvements in knowledge over time. For example, recognition of schizophrenia in case vignettes was significantly higher in 2003/4 at 43%, compared to 27% of participants in 1995 (Jorm, Christensen, & Griffiths, 2006). Respondents at the later time point had higher optimism for treatment suggesting that knowledge about the effectiveness of medication was improving. This is a positive finding because the recognition that schizophrenia can be treated with therapy or medication has been linked to less social distancing (Stuart & Arboleda-Florez, 2001). However, a third study found no change in recognition of the illness from 2003/4 to 2011, and the belief that people with schizophrenia are dangerous was 12% higher in 2011 (Reavley & Jorm, 2012).

People with schizophrenia are often perceived to be more dangerous and unpredictable than those with other mental illnesses (Reavley & Jorm, 2014). This perception can elicit a
fearful response (Graves, Cassisi, & Penn, 2005; Thonon & Laroi, 2017) which increases desire for social distance and worsens discrimination (Angermeyer, Matschinger, & Corrigan, 2004; Lauber, Nordt, Falcato, & Rossler, 2004). The limited research to date has produced conflicting results and few studies have investigated how perceptions of dangerousness have changed over time. By contrast with the Australian study, research from the UK (N = 1725) found perceptions of dangerousness were 5% lower in 2005 compared to 1998 (Crisp, Gelder, Goddard, & Meltzer, 2005), whereas a smaller study in the USA (N = 650) revealed that public perceptions of dangerousness between 1996 and 2006 remained the same (Pescosolido et al., 2010). There are several possible factors influencing these contrasting results including differences in methodology, public exposure to misrepresentations in the media which often link schizophrenia with violence and instability (Owen, 2012), and sometimes portray characters with multiple personalities as schizophrenic (Smith & Cooper, 2006; Wedding & Niemiec, 2003). It is not surprising then, that the misconception of schizophrenia as a split personality is widespread (Economou, Richardson, Gramandani, Stalikas, & Stefanis, 2009; Stuart & Arboleda-Florez, 2001) and associated with perceptions of dangerousness, unpredictability and social distancing (Schlier & Lincoln, 2013).

The focus on knowledge and stereotypes has tended to dominate schizophrenia research. However, several studies have investigated positive attitudes and how they are related to behavioural intention. A large study in France reported that the majority of participants felt the desire to help or expressed pity for a person with schizophrenia, although less than half indicated sympathy (Angermeyer, Millier, Rémuzat, Refai, & Toumi, 2013). Similarly, Thonon and Laroi (2017) found that 65% of participants reported positive behavioural tendencies such as helping and protecting. A small study with American psychology students showed that those who indicated stronger values of benevolence and universalism held more positive attitudes towards schizophrenia; however, social distancing was not lower (Norman et al., 2010). To our knowledge, no research has reported changes in positive attitudes over time.

Angermeyer and Schomerus (2017) called for more innovative research methods in their review of population studies of attitudes towards mental illness. Approximately half of the reviewed studies used vignettes with specific case descriptions that limited their generalisability. In the current study we sought to capture perceptions of schizophrenia through people’s spontaneously generated comments in response to a single broad question, rather than specific questions with limited response options. The use of open questioning is likely to produce more detailed responses and to allow participants to explain their answers (Singer & Couper, 2017). Open questioning has been used in research on mental illness more generally (Phelan, Link, Stueve, & Pescosolido, 2000) but, to our knowledge, only one small study from China (N = 68) has used this method to explore community attitudes towards individuals with schizophrenia (Lam & Sun, 2014).

In summary, the limited previous research looking at changes in attitudes towards schizophrenia over time has produced mixed results. In some respects, knowledge appears to have improved, although this has not necessarily reduced negative stereotyping. It is unclear whether prosocial behaviours such as empathy have changed along with knowledge, but certain stereotypes seem to have endured. Given the critical importance of developing a better understanding of attitudes in order to inform the development of community education programmes, the current study aimed to investigate perceptions of schizophrenia in the Australian community and changes across time. The research also considered relationships of perceptions with age, education and personal contact.

Method

Participants

The participants were 2199 adults (1325 female), currently living in Australia, with the majority residing in or near the city of Brisbane. The remainder lived in other parts of Australia. Data were collected with two separate samples from the general community at two time points 12 years apart: Time 1 in 2004/5 (n = 1214) and Time 2 in 2016/17 (n = 985).

There were more females in the Time 2 sample (67%) compared to the earlier sample (52%) but at both time-points the proportions of males and females were similar across age and education. Participant age ranged from 20 to more than 60 years. At both time points, one third of the respondents were aged between 20 and 29 years, and there were fewest aged over 60 years. Although there was considerable spread across levels of education, participants were more highly educated than the Australian population (see Table 1). In addition, participants at the most recent time point reported higher levels of education than those at Time 1.

Measures

Two separate surveys were undertaken as part of a larger study examining attitudes towards disability in the Australian community. For the current study about schizophrenia, participants at both time points were asked: “What is the first thing that comes to mind when you think about schizophrenia?” Along with sociodemographic items, participants were also asked to indicate whether or not they knew someone with schizophrenia (response options: yes or no) and, if so, to describe their relationship with that person (e.g. family, friend).

Study design and data analytic plan

The research used a qualitative and repeated cross-sectional design with year of survey completion as the independent variable in comparisons of attitudes at the two time points. The dependent variables were perceptions of schizophrenia based on coded responses to the open-ended question.
Although attempts were made to match the two samples (2005 and 2017) on all demographic characteristics, they differed on gender, education and contact with a person with schizophrenia. Consequently, when comparing attitudes at the two time points, we used a one-way analysis of covariance (ANCOVA) to control statistically for the influence of these variables. Age was not used as a covariate as this variable was matched across the two time points. In the combined sample, t tests were used to explore relationships of gender, age, education and contact with perceptions of schizophrenia.

### Procedure
Ethical approval was granted by Queensland University of Technology’s Human Research Ethics Committee prior to data collection at both time points (approval numbers 3396 H and 1600000752, respectively). At Time 1, participants completed surveys in hard copy format and returned them personally to the researchers or via reply-paid envelopes. Time 2 participants had the option of completing the survey online or in hard copy. Participation was voluntary and anonymous.

Time 1 data were collected by undergraduate students as part of the fieldwork requirements of a psychology unit. The students were told to approach people who were known to them (e.g. friends, neighbours, acquaintances) and invite them to complete the questionnaire. At Time 2, data were collected using a snowball approach. The researchers invited persons known to them to participate and to pass on the invitation to others. They also posted the study via personal social media.

### Results

#### Preliminary analysis
Thematic analysis of the question “What is the first thing that comes to mind when you think about schizophrenia?” was used to investigate participants’ knowledge and perceptions. Following Braun and Clarke’s (2006) recommended phases (familiarisation, code generation, theme emergence, theme review), one researcher read the responses several times before identifying as many categories as possible and then combining similar themes to best represent the data (Walker & Myrick, 2006). When respondents provided a response that fitted into more than one category, multiple codes were given. Approximately 75% of the responses were independently coded by a second experienced researcher. Both coders identified similar themes with few disagreements. Discrepancies were resolved through discussion.

Respondents who did not provide a response or stated that they had no knowledge were combined into a single category. Responses that did not fit a common theme or lacked sufficient detail were excluded from analysis (7.4%, n = 164).

#### Main analysis
Eleven separate themes emerged from the analysis. From the most to least commonly mentioned they were: (1) correct fact (e.g. a specific symptom); (2) split/multiple personality; (3) no knowledge/no response; (4) unpredictability; (5) crazy, dangerous or aggressive behaviour; (6) brain-based condition, medication, treatable; (7) emotional instability, (8) consequences (e.g. social difficulties); (9) sympathy, support, awareness of stigma/misconceptions; (10) media (e.g. movie or news story); (11) incorrect fact (e.g. a different psychological disorder such as bipolar).

Many participants mentioned accurate facts about schizophrenia (e.g. that it is a mental illness) or described causes (31% at Time 1 and 50% at Time 2). However, some respondents confused schizophrenia with other mental illnesses (30% at Time 1 and 16% at Time 2). The most common misconception, mentioned by 28% of participants at Time 1 and 14% at Time 2, was that schizophrenia involves split or multiple personalities when in fact this is the main feature of Dissociative Identity Disorder. Fewer respondents failed to respond or stated that they did not know anything about schizophrenia at the second time point (6%, compared with 18% at Time 1).

Perceptions of unpredictability (10% at Time 1 and 12% at Time 2) were evident in comments about lack of control and sudden changes in behaviour. Those who mentioned unpredictability sometimes associated it with danger and recognised the need for medication (e.g. “can be dangerous/unpredictable if they stop taking medication”). Perceptions of danger or aggressiveness reflected a common theme (9% at both time points), expressed in responses such as “mad and dangerous people” and “frenzied panic or attack.” Some participants appeared to be aware that their response was socially unacceptable (e.g. “they’re crazy… sorry”). Several responses included under this theme reflected a desire for social distance expressed in comments such as “cannot trust them,” “stay away if possible” and “call the cops.”

The idea that schizophrenia is related to a chemical imbalance in the brain and that it can be managed with treatment was expressed by 8% of participants at both time points. Their comments ranged from more negative ones (e.g. “person who can snap at any time if they don’t keep up their medication”) to more optimistic ones (e.g. “they

### Table 1. Descriptive characteristics of the sample: age and education.

| Year    | N   | 20–29 | 30–39 | 40–49 | 50–59 | 60+ | Total |
|---------|-----|-------|-------|-------|-------|-----|-------|
| 2004/5  | 1214| 33%   | 22%   | 19%   | 18%   | 9%  | 100%  |
| 2016/17 | 985 | 33%   | 23%   | 18%   | 13%   | 13% | 100%  |

*ABS (2005) figures for the Australian population for comparison.
*ABS (2016) figures for the Australian population for comparison.
can be like everyone else with medication”). Although participants who commented on the brain or treatment were more likely to mention unpredictability, they were twice as likely to express sympathy for the person with schizophrenia.

The responses also portrayed some prosocial tendencies (3% at Time 1 and 9% at Time 2) such as sympathy and recognition of support needs (“I feel sorry for (them),” “(they) would benefit from love and support,” “it is a horrible thing to have”) and an awareness of potential stigma (“it is misunderstood,” “misrepresnt(ed) in popular culture”). A small proportion of participants made references to the media (3% at Time 1 and 2% at Time 2), with 22% of responses referring to “split personality.” Specific films such as Jekyll and Hyde and A Beautiful Mind were mentioned, along with more general comments. Some participants acknowledged that their perceptions had been influenced by the media: “Even though I know it’s wrong, my first thought is ‘multiple personality’ … Hollywood did a good job brainwashing me.”

**Relationships between personal characteristics and perceptions of schizophrenia**

**Gender, age and education.** Relationships of perceptions with gender, age and education were investigated using t tests (see Table 2). Compared with men, women were significantly more likely to provide a response, to state a correct fact about schizophrenia or to make a comment relating to the brain and medication. Prosocial views were also more likely amongst women. They were significantly more likely to respond with sympathy, to note the need for support, to express an awareness of stigma and to recognize the potential impact of schizophrenia on an individual’s life. Females were less likely to respond with the split personality misconception.

Younger people were significantly more likely to mention a correct fact about schizophrenia and less likely to give no response. There were no significant age differences across negative attitudes, prosocial comments or misconceptions.

As shown in Table 2, tertiary educated participants provided correct factual responses significantly more often than those with lower levels of education. They also made more references to the brain-based model of schizophrenia and the need for treatment. In addition, those with tertiary education were significantly less likely to mention split personalities and more likely to indicate sympathy and need for support. Participants with lower levels of education were more likely to leave the question unanswered.

**Personal contact with someone with schizophrenia.**

Participants with no personal contact with a person with schizophrenia (n = 1417) were significantly more likely to mention the split personality misconception (see Table 3). Those who reported personal contact (n = 632) were significantly more sympathetic, more aware of the need for support, more understanding of the difficulties, and more aware of the stigma and misconceptions associated with schizophrenia. They recognised the impact that schizophrenia has on a person’s life, and those who had closer contact (family or partner; n = 215) showed even greater recognition than those with more distant contact (acquaintance or work colleague; n = 173) (M = 11.6, SD = 3.2 and M = 5.2, SD = 2.2, respectively; t(378) = −2.03, p = 0.02). Respondents with closer contact gave fewer responses related to unpredictability (M = 7.0, SD = 2.6) than those with more distant contact (M = 13.0, SD = 3.4; t(312) = −2.03, p = 0.04).

**Attitudes across time**

One-way ANCOVAs were conducted to compare attitudes from Time 1 and Time 2 while controlling for gender, education and personal contact (see Table 4). This analysis was required because the Time 1 and Time 2 data were not matched on these demographic variables.

The proportion of respondents who did not answer the question or who indicated no knowledge of schizophrenia was significantly lower in 2017 (6%) than in 2005 (17%). At the second time point, significantly higher proportions of participants mentioned a correct fact about schizophrenia. Although the media continued to be mentioned, there were significantly fewer references to split or multiple personalities at Time 2.

The proportion of participants who responded with sympathy or awareness of the need for support was higher at Time 2, as were the proportions that mentioned the impact of schizophrenia on individuals and families. Some responses did not differ significantly at the two time points, including the perception that people with schizophrenia are dangerous or unpredictable.

### Table 2. Responses according to gender, education and age (Time 1 and Time 2 data combined).

| Response                                | Gender (n = 2029) | Highest education (n = 2030) | Age (n = 2037) |
|-----------------------------------------|-------------------|-------------------------------|----------------|
|                                         | Female | Male | r values | Female | Male | r values | t-test | 20–49 | 50+ | r values |
| Correct fact                            | 43%    | 35%  | 3.62*** | 33%    | 47%  | −6.27*** | 43%    | 35%  | 3.44*** |
| Incorrect fact (another disorder)       | 2%     | 2%   | 0.19    | 2%     | 2%   | 0.31     | 1%     | 2%   | −1.45   |
| Split/multiple personality              | 18%    | 28%  | −5.32*** | 25%    | 18%  | 4.35***  | 21%    | 22%  | −0.55   |
| Brain-based, medication, treatable       | 9%     | 6%   | 3.03*** | 7%     | 9%   | −2.26*   | 7%     | 9%   | −1.09   |
| Emotional instability                   | 7%     | 6%   | 1.28    | 7%     | 6%   | 0.95     | 7%     | 7%   | −0.12   |
| Crazy, dangerous, aggressive            | 9%     | 10%  | −0.77   | 10%    | 8%   | 1.41     | 10%    | 8%   | 1.46    |
| Unpredictability                        | 11%    | 10%  | 1.12    | 11%    | 10%  | 1.31     | 11%    | 10%  | 0.30    |
| Sympathy, support                       | 7%     | 3%   | 3.72*** | 5%     | 7%   | −2.18*   | 6%     | 6%   | 0.07    |
| Consequences                            | 7%     | 5%   | 2.46    | 5%     | 7%   | −1.88    | 6%     | 7%   | −1.29   |
| Media                                   | 3%     | 3%   | −0.33   | 2%     | 3%   | −0.73    | 3%     | 2%   | 1.25    |
| No knowledge, no response               | 11%    | 15%  | −2.08*  | 15%    | 10%  | 3.28***  | 11%    | 15%  | −3.13** |

*p < 0.05, **p < 0.01, ***p < 0.00.
The aim of this study was to explore perceptions of schizophrenia in the Australian community and to investigate differences in perceptions at two points in time. Although there were no differences in perceptions of dangerousness or unpredictability, participants at the most recent time point appeared to have more knowledge about schizophrenia, and were more sympathetic, recognising the need for support and the impact that schizophrenia is likely to have. The finding that more people were able to provide specific responses in the second survey suggests a growing awareness of schizophrenia in the Australian community. Consistent with other research (Jorm et al., 2006; Reavley & Jorm, 2011), we found that significantly more people can now spontaneously identify schizophrenia as a mental illness or mention common symptoms associated with the disorder; however, there is still some confusion about the nature of schizophrenia. Despite fewer descriptions of schizophrenia as a split personality, this misconception is still evident. Participants who mentioned split personality were less likely to indicate sympathy or need for support, a finding in line with previous research (Tanaka, Inadomi, Kikuchi, & Ohta, 2005) that may act as a barrier to social support and treatment. Those who mentioned split personality were likely to reference the media, often naming specific films, reinforcing previous suggestions that the media may be fuelling discrimination through inaccurate and negative portrayals of schizophrenia (Smith & Cooper, 2006).

Despite better knowledge and understanding, common stereotypes of dangerousness and unpredictability appear to remain. This finding is consistent with research conducted in the USA from 1996 to 2006 (Pescosolido et al., 2010) but contrary to findings from two other studies. In the UK, beliefs about dangerousness and unpredictability were lower in 2003 compared to 1998 (Crisp et al., 2005) and in a previous Australian sample, such beliefs were considerably higher in 2011 compared to 2004 (Reavley & Jorm, 2011). Reconciling the different findings is difficult because of varying methodologies and the potential for social desirability response biases. Interestingly, we found that some participants became aware in their subsequent comments that their initial response about dangerousness was socially inappropriate or discriminatory. Such instances demonstrate the value of eliciting spontaneous perceptions that may be less contaminated by political correctness, as well as the automaticity of stereotypes that drive stigma.

### Table 3. Responses according to personal contact with schizophrenia (Time 1 and Time 2 data combined).

| Response                                      | Contact     | Mean | SD | No contact | Mean | SD | t-test | df  |
|-----------------------------------------------|-------------|------|----|------------|------|----|--------|-----|
| Correct fact                                  | 25.4 (4.4)  |      |    | 23.3 (4.2) | 1.06 |    | 1419   |     |
| Incorrect fact (another disorder)             | 1.0 (1.1)   |      |    | 2.0 (1.3)  | -0.98|    | 2175   |     |
| Split/multiple personality                    | 16.0 (3.6)  |      |    | 22.0 (4.2) | -3.94***|   | 1647   |     |
| Brain-based, medication, treatable            | 8.0 (2.7)   |      |    | 7.0 (2.5)  | 0.90 |    | 2175   |     |
| Emotional instability                         | 7.0 (2.5)   |      |    | 6.0 (2.4)  | 0.60 |    | 2175   |     |
| Crazy, dangerous, aggressive                  | 8.2 (2.8)   |      |    | 8.4 (2.8)  | -0.49|    | 2175   |     |
| Unpredictability                              | 9.0 (2.9)   |      |    | 10.0 (2.0) | -1.40|    | 2030   |     |
| Sympathy, support                             | 7.7 (2.7)   |      |    | 3.9 (1.9)  | 3.38***|  | 1127   |     |
| Consequences                                  | 9.1 (2.9)   |      |    | 4.1 (2.0)  | 4.15***|  | 1089   |     |
| Media                                         | 2.3 (1.5)   |      |    | 2.6 (1.6)  | -0.31|    | 2175   |     |
| No knowledge, no response                     | 9.8 (3.0)   |      |    | 12.2 (3.8) | -1.76|    | 1590   |     |

SD: Standard Deviation; df: degrees of freedom. Responses on each item range from 0 (did not respond to this item) to 1 (responded to this item).

### Table 4. ANCOVA results and descriptive statistics of responses by year controlling for gender, education and personal contact.

| Response                                      | Time 1 % | Std. error | Time 2 % | Std. error | F ratio |
|-----------------------------------------------|----------|------------|----------|------------|---------|
| Correct fact                                  | 28.7 (1.4)|           | 46.6 (1.5)|           | 76.27***|
| Incorrect fact (another disorder)             | 1.7 (0.4)|           | 1.5 (0.4)|           | 0.22    |
| Split/multiple personality                    | 26.1 (1.1)|           | 12.7 (1.3)|           | 61.80** |
| Brain-based, medication, treatable            | 76.0 (0.7)|           | 70.0 (0.8)|           | 0.27    |
| Emotional instability                         | 64.0 (0.7)|           | 63.0 (0.8)|           | 0.01    |
| Crazy, dangerous, aggressive                  | 8.2 (0.8)|           | 8.6 (0.9)|           | 0.15    |
| Unpredictability                              | 9.1 (0.9)|           | 11.0 (1.0)|           | 2.06    |
| Sympathy, support                             | 3.0 (0.6)|           | 7.9 (0.7)|           | 25.48***|
| Consequences                                  | 4.8 (0.7)|           | 7.1 (0.8)|           | 5.19*   |
| Media                                         | 3.0 (0.4)|           | 1.9 (0.5)|           | 2.63    |
| No knowledge, no response                     | 15.9 (0.9)|           | 5.5 (1.0)|           | 58.44***|

Between subjects degrees of freedom = 4, within subjects degrees of freedom = 2161.

\[ p < 0.05. \]

\[ p < 0.001. \]
positive behavioural tendencies that may be useful in combating discrimination. Many participants in the current study mentioned the impact that schizophrenia can have on an individual’s life, with those in the second survey significantly more aware. Not surprisingly, this recognition was more common among those who had personal contact with a person with schizophrenia. They reported consequences such as isolation, discrimination and suicidality.

Expressions of sympathy and understanding of the need for support were evident in many responses, especially from women and those with personal contact. Prosocial comments were more common in the second survey, with many participants using highly emotive language such as “tormented,” “sorrow” and “mental anguish.” These findings suggest a growing sense of empathy within the community which has not been explored in other research. Some comments revealed a sense of pity, a commonly evoked emotion towards schizophrenia (Angermeyer et al., 2013; Thonon, Pletinx, Grandjean, Billieux, & Larøi, 2016) that may partly drive positive behaviours such as helping and associating with individuals with schizophrenia (Thonon & Larøi, 2017). However, as Cuddy, Fiske, and Glick (2007) highlighted, pity can lead to avoidance, demeaning attitudes or overprotection that may indirectly reinforce the low status of an individual with schizophrenia. Further exploration of emotional reactions towards schizophrenia and their impact on behaviour may help to direct future efforts to reduce stigma and discrimination.

Many Australians, particularly women, those with tertiary education, and younger participants, identified schizophrenia as a chemical imbalance in the brain or mentioned that treatment or medication is required, confirming a general endorsement of the biogenetic illness model of schizophrenia (Angermeyer & Matschinger, 2005; Pescosolido et al., 2010). References to medication were often paired with comments around sympathy and need for support, adding a new layer to the research on how endorsement of a biogenetic illness model of schizophrenia affects perceptions. Although this perspective is linked to higher stigmatising beliefs (Bennett et al., 2008; Read, Haslam, Sayce, & Davies, 2006), it has also been associated with less blame (Kvaale et al., 2013) and now with more sympathy and understanding that may facilitate access to treatment and social support.

The research presented here has several limitations. Although we were able to recruit two relatively large samples, the participants were generally more highly educated than the general community, and previous research would suggest that their views are likely to be somewhat more positive (Reavley & Jorm, 2014; von dem Knesebeck et al., 2013). In addition, our samples were drawn largely from a single capital city so do not necessarily reflect the perceptions of people in other regions of Australia or in other countries. Although our use of an open-ended question was valuable in eliciting spontaneous comments, we cannot assume that people’s responses to a single question accurately reflect their perceptions. Any methodology that relies on self-report depends on participants being both willing and able to report honestly and openly, especially if their deeply-held views conflict with socially acceptable and politically correct ones. Study designs that employ multiple methods of measurement are likely to provide a more accurate and complete picture. Another limitation that must be kept in mind is that we used convenience samples. A more rigorous sampling method may have produced a more representative sample from the country’s population. The fact that the two samples were recruited in different ways and were not perfectly matched on all demographic characteristics is also a shortcoming of the research.

Despite these limitations, the current study contributes to existing knowledge about community perceptions of schizophrenia and differences in perceptions across the 12 years from 2005 to 2017. Our method of assessing attitudes through their spontaneous expression in response to a single open question makes a methodological contribution to the field. Most previous studies have employed specific case vignettes or provided prompts based on particular features or known stereotypes (Angermeyer & Schomerus, 2017).

Conclusions

This study found that alongside more accurate knowledge about schizophrenia, the community appears now to be more sympathetic and more aware of the need for support of individuals with schizophrenia. Given that negative stereotypes of dangerousness and unpredictability appear to be stable across time, future research could focus more on positive perceptions and prosocial behaviours and explore how these relate to stereotypes and social distancing. Understanding both negative and positive perceptions of schizophrenia is likely to assist with developing targeted campaigns aimed at increasing community support that will ultimately improve the well-being and quality of life of individuals with schizophrenia.

Disclosure statement

No potential conflict of interest was reported by the authors.

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