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Attitudes towards severe mental illness and social distance: A survey of volunteer befrienders in Austria

Sarah Toner[1], Karin Fabisch[2], Stefan Priebe[1] and Günter Klug[3]

Abstract

Background: Research suggests there is a propensity for people in the general population to distance themselves from people with severe mental illness (SMI), which reportedly decreases with increased contact with individuals with SMI. Volunteer befrienders in the mental health sector have ongoing contact with this population, yet little data exist to reflect their attitudes towards people with SMI.

Method: A questionnaire was distributed to all volunteer befrienders for people with SMI within volunteering programmes organised in five Austrian regions. A vignette described an individual with SMI and was followed by questions assessing willingness to interact with this person in personal or professional contexts. Social distance scores, calculated based on responses to attitude items, were used as the dependent variable in regression analyses. Independent variables included participant characteristics, experience of family/friends with mental illness, time spent befriending and satisfaction with the relationship.

Results: Questionnaires were completed and returned by 360 volunteers (54.0%). A minority would allow someone with SMI to look after their children (6.2%), while most volunteers positively endorsed other personal interactions such as having the individual marry into their family (67.8%) or become a neighbour (99.7%). Social distance ($M = 2.5$, standard deviation [SD] = 1.16) was not associated with any independent variables.

Conclusions: Volunteers had a lower desire for social distance from individuals with SMI as compared to findings from the general population. Future research may establish whether lower social distance is part of the motivation to volunteer as a befriender to people with severe mental illness or develops over time in that role or both.

Keywords

Volunteer, befriend, social distance, attitudes, severe mental illness

Background

A tendency to socially distance oneself from people with mental illness has been reported in a systematic review of public attitudes (Angermeyer & Dietrich, 2006). Social distance is considered a reflection of negative attitudes towards people with mental illness and denotes relative willingness to engage in relationships with this population in scenarios of varying intimacy (Bowman, 1987). Greater social distance has implications for increased discrimination and prejudice regarding mental illness (Baumann, 2007). This has received substantial attention from the World Psychiatric Association (Sartorius, 2005), particularly in relation to severe mental illness (SMI) and represents the basis of numerous interventions developed to target negative attitudes towards mental illness worldwide (e.g. Angermeyer, Matschinger, & Schomerus, 2013; Henderson & Thornicroft, 2009).

Several factors have been associated with lower social distance from people with SMI in the general population. These include low symptom severity as perceived by members of the general population (Gaebel, Zäske, & Baumann, 2006), what the general population believe to be the cause of the illness (e.g., a stressful life event or biological causes) (Dietrich et al., 2004), lower perceived dangerousness of the person with SMI (Corrigan, Green,

[1]Unit for Social and Community Psychiatry (WHO Collaborating Centre for Mental Health Service Development), Newham Centre for Mental Health, Queen Mary University of London, London, UK
[2]University Hospital for Psychiatry and Psychotherapeutic Medicine, Medical University Graz, Graz, Austria
[3]Psychosocial Services, Society for Mental Health Promotion, Graz, Austria

Corresponding author:
Stefan Priebe, Unit for Social and Community Psychiatry, Newham Centre for Mental Health, Glen Road, London E13 8SP, UK.
Email: s.priebe@qmul.ac.uk

Lundin, Kubiak & Penn, 2001), help-seeking behaviours of the person with SMI (Angermeyer, Breier, Dietrich, Kenzine, & Matschinger, 2005; Jorm, Angermeyer & Katschnig, 2000) and greater familiarity with SMI in the general population, typically through increased contact with people with SMI (Angermeyer, Matschinger, & Corrigan, 2004). As such, some initiatives have been developed to educate the general population about SMI (Angermeyer et al., 2013), while other initiatives primarily aim to facilitate social contact with the general population and social inclusion of people with SMI (Henderson & Thornicroft, 2009). Results in Germany, which incorporated an educational approach using a biomedically derived explanation of illness causation, showed poorer attitudes towards SMI (Angermeyer et al., 2013). In contrast, longitudinal studies of attitudes in the United Kingdom, following an educational initiative with emphasis on social inclusion and increased contact between the general population and those with mental illness, reported a decrease in desire for social distance, despite no change in overall knowledge of SMI (Evans-Lacko, Henderson, & Thornicroft, 2013). It would therefore appear that increased familiarity with people with SMI may constitute a promising approach to reducing the desire for social distance in the general population compared with educational approaches alone. However, it remains unclear how different forms of contact or the nature of the relationship with people with SMI may influence social distance.

In contrast to suggestions that the general population tends to avoid contact with people with SMI, volunteers in mental health services actively seek contact with people with SMI. Unlike other investigated populations such as psychiatric staff or relatives of people with SMI, volunteers seek relationships, unpaid and without familial responsibility. While attitudes and social distance of the general population, relatives and staff have been reported previously (Grausgruber, Meise, Katschnig, Schöny, & Fleischhacker, 2007), no such information is available on volunteers. In fact, volunteers remain an under researched group; a systematic review of volunteers found that data from only 540 volunteers in mental health care is available worldwide, across 14 publications (Hallett, Klug, Lauber, & Priebe, 2012), none of which relates to their attitudes towards people with SMI or desire for social distance.

One specific type of volunteering used to improve social inclusion for people with SMI is befriending. This involves a one-to-one relationship between a volunteer and patient, typically with the aim of reducing social isolation and loneliness in the patient (Thompson, Valenti, Siette, & Priebe, 2016). As a result, this group represents a valuable source of information as to how social contact may impact upon desired social distance or negative attitudes towards SMI. It is therefore surprising that the attitudes of volunteer befrienders have been given little attention to date (Hallett et al., 2012). Addressing this gap in the literature may contribute to our understanding of the association between familiarity and desired social distance, and thus inform future initiatives to foster positive attitudes towards people with SMI.

Method

This was a cross-sectional survey in five volunteering organisations ('gemeinnützige Vereine') in Austria that run volunteering programmes with befriending. Data collected included socio-demographic characteristics and self-reported responses to different hypothetical scenarios featuring an individual with SMI. Ethics approval was granted by the Medical University of Graz (ref: 26-319 ex 13/14).

Eligibility criteria

All current volunteers from the five participating organisations were included ($N = 663$).

Recruitment

Five major volunteering organisations in Austria were approached to participate in the survey. They were the 'Gesellschaft zur Förderung seelischer Gesundheit' (society for mental health promotion), the 'Verein pro humanis' (both covering the region of Styria), 'pro mente Kärnten' (covering Carinthia) 'pro mente Ober-Österreich' (covering Upper-Austria) and 'pro mente Wien' (covering Vienna). All are constituents of 'pro mente Austria', an umbrella organisation responsible for the majority of non-profit organisations for mental health in Austria. Together, the selected organisations cover half of the eight Austrian regions and the capital Vienna, and share similar operating procedures.

Organisations were contacted by the senior author (G.K.) who explained the aims of the project, obtained consent and provided practical support. Each organisation subsequently distributed questionnaires, information sheets and consent forms to all current volunteers. Data collection began in May 2014 and concluded in August of 2015.

Materials

The questionnaire was developed through a collaborative and iterative process between the research teams in Austria and London. The English items were translated into German by bi-lingual researchers for the purpose of data collection and back-translated for the analysis stage. The final questionnaire included the following vignette describing an individual with SMI, which has been commonly used in existing literature on social distance (e.g.,

Table 1. Responses to attitude questions from volunteer befrienders and the general population.

Attitude items	Volunteers (% yes)	Public (% yes)
Would you accept this person as a neighbour?	99.7	70.4
Would you accept this person marrying somebody in your family?	68	31.5
If you were an employer, would you employ this person?	39	35.1
Would you accept this person as your employer?	27	19.6
Would you let this person look after your children?	6.2	10.5

Grausgruber et al., 2007): *'Imagine a 25 year old woman who was living a normal life but all of a sudden she starts to hear voices and feels persecuted without any obvious reason'*. The vignette was followed by five scenarios involving personal and professional interactions with the individual. Volunteers were required to indicate whether they would willingly accept the interaction using yes/no responses.

Procedure

The five volunteering organisations facilitated distribution of the information sheet, questionnaire, consent form, and return envelopes. The data collection items were marked by the relevant organisation with identification codes unique to each volunteer. Over a 12-month period, documents were then returned by volunteers to the volunteering organisation to be anonymised and transferred to the research team. Data were entered into SPSS (version 24) (IBM Corp, 2016) for analysis. Double entry of the data and subsequent comparison was conducted to ensure reliability.

Analysis

Descriptive results for sociodemographic characteristics and responses to attitudinal questions are presented, excluding missing data. Consistent with previous literature (Link, Cullen, Frank, & Wozniak, 1987), yes (1) and no (0) responses to attitudinal questions were summed to give a social distance. This yielded social distance scores which could range from 0 (*unwilling to engage in any proposed interactions/higher social distance*) to 5 (*willing to engage in all social interactions/lower social distance*). Internal consistency of the scale was then tested using the Kuder-Richardson formula (Guttman, 1974; Mokken, 1971; Mokken, Lewis, & Sijtsma, 1986). Social distance scores were used as the dependent variable in a univariable linear regression model with the following independent variables: age, gender, having a close friend with SMI, having a family member with SMI, past psychiatric treatment, current psychiatric treatment, length of experience as a befriender and satisfaction with befriending relationship. Significant predictors ($p<.10$) were considered suitable for subsequent multivariable analysis.

Results

Sample

The final sample comprised of 360 participants (response rate of 54.3%), with a mean age of 54.5 years (standard deviation [*SD*] = 12.99) and most of whom were female (78.8%). Participants were asked if they had a close friend or family member with SMI (56.0% and 42.0% respectively) or if they had personal experience of psychiatric treatment either in the past or at the time of assessment (34.9% and 7.6% respectively). On average, participants had spent 44.0 months in a befriending relationship (*SD* = 54.65) and typically rated their satisfaction with the relationship as either very satisfied (51.7%) or mostly satisfied (43.7%) as opposed to indifferent (3.7%), mostly dissatisfied (0.9%) or very dissatisfied (0.0%).

Attitudes

Responses to the five attitude items relating to the vignette are presented in Table 1, including data from the general population in Austria (Grausgruber et al., 2007).

Social distance

Volunteers had a mean social distance score of 2.5 (*SD* = 1.16). While no participants had a score of zero, which would indicate the greatest desire for social distance, 22.9% had a score of one, 33.6% had a score of two, 23.7% had a score of three, 12.8% had a score of four and the remaining 5.9% had no/lower social distance. The internal consistency reliability coefficient (Cronbach's alpha) for the scale was .56.

Univariable linear regression analysis was used to determine associations between social distance and volunteer characteristics and experiences (Table 2). While age met the criterion for inclusion in further multivariable analysis, no other measures did. Furthermore, age alone did not reach significance at the 5% level.

Discussion

Main findings

Volunteers exhibited highly variable responses to hypothetical interactions with people with SMI. The majority

Table 2. Univariable linear regression analysis for volunteers' social distance scores.

Variables	Univariable analysis		
	B	(95% CI)	*p*-value
Age	−.011	(−.022 to .000)	.059
Male vs. female	−.182	(−.516 to .152)	.284
Friend with mental illness (yes vs. no)	.000	(−.295 to .295)	.999
Relative with mental illness (yes vs. no)	−.054	(−.350 to .241)	.717
Experience of psychiatric treatment in the past (yes vs. no)	.181	(−.122 to .485)	.241
Experience of current psychiatric treatment (yes vs. no)	.124	(−.423 to .671)	.655
Months spent befriending	.001	(−.002 to .003)	.664
Satisfaction with befriending relationship	−.183	(−.419 to .052)	.126

CI: confidence interval.

would accept an individual with SMI becoming their neighbour and marrying into their family, whereas only a small minority would allow the individual to look after their children. Overall social distance scores were not associated with sociodemographic variables measured or experience of befriending. The findings therefore reflect complexity of the relationship between social distance and social contact with individuals with SMI, beyond frequency of or satisfaction with this social contact.

Strengths and limitations

To the authors' knowledge, this study is the largest available of volunteer befrienders for individuals with SMI. This not only reflects an atypically high response rate relative to most surveys using postal returns of questionnaires (Shih & Fan, 2008), but also allowed statistical power sufficient to examine relationships between volunteer characteristics and social distance scores, further increasing applicability of the findings.

Methodological approaches implemented constitute a major strength of the study. For instance, the breadth of regions covered by the selected Austrian organisations serve to reduce the likelihood of location-specific confounding effects on the findings and increase scope for comparison with previous studies conducted in Austria. Although Grausgruber et al. (2007) included all nine Austrian regions, those covered in the present study comprise approximately half of Austria's inhabitants and include both rural and urban regions. The authors therefore feel the present findings may be appropriately compared with earlier findings. This being said, applicability in other contexts remains uncertain without replication in other regions. This is particularly relevant as befriending appears to be globally applied; a systematic review found schemes in Germany, the United Kingdom, and United States (Hallett et al., 2012) with other schemes researched in Nigeria (Abayomi, Adelufosi, & Olajide, 2013).

Furthermore, the vignette and subsequent scenarios used here mirror those used in previous investigations of other groups such as the general population, mental health staff and relatives of individuals with SMI (Grausgruber et al., 2007). The means of measurement therefore allow direct comparison with and contribution towards existing literature. Although the data presented were collected 7–8 years after the earlier investigation, there had been no substantial changes to the social context or health care system between the two data collections that would have been likely to influence the responses of the volunteers. Thus, one may consider the samples and their respective contexts comparable.

The study also has some limitations. The decision to replicate the methodology used in an earlier investigation (Grausgruber et al., 2007) was linked with a low internal consistency of the attitudinal items. The five items used deviate from the original 7-item scale developed by Link and colleagues (1987). However, the deviation from the original tool was required to compare our findings directly with the existing data.

A further limitation is the response rate of 54%. Although this is a rather positive rate for the type of survey used, 46% of the target sample did not respond. The impact of the selection on the results cannot be determined.

Finally, while the sociodemographic characteristics measured in this study did not show significant associations with social distance in the sample, they were not exhaustive. In their investigation, Grausgruber and colleagues (2007) found social distance to be associated with education level, built environment (large town) and age. As such, characteristics not included here could potentially yield a better understanding of factors associated with social distance in volunteer befrienders.

Comparison with existing literature

Relative to findings from a large sample of the general population in Austria, the present results demonstrate volunteers' greater likelihood to accept all five proposed interactions with an individual with SMI. Consequently, volunteers had lesser social distance ($M=2.5$) than the

general population ($M = 1.7$) (Grausgruber et al., 2007), in keeping with existing evidence of increased familiarity lowering social distances (Angermeyer, Matschinger & Corrigan, 2004). Volunteers also had a lower desire for social distance than both relatives ($M = 2.0$) and staff ($M = 2.3$). Differences between groups may point to an influential effect of motivations underpinning contact with individuals with mental health, as volunteers seek this without familial ties or payment.

Volunteers' responses to individual attitude items, compared to other population subgroups reflect greater complexity in the relationship between social contact and attitudes towards people with SMI, beyond that of familiarity or interpretation illness-related factors (e.g., illness severity or perceived dangerousness). Generally, response patterns to hypothetical professional and personal interactions were similar between volunteers, relatives and staff, when compared to the general population. However, the volunteer befriender sample exhibited relatively extreme response rates on two of the five attitude items. 'Willing to have this person as your neighbour' was endorsed by almost the entire volunteer population, a much higher rate than that of other groups. Conversely, volunteers were least likely to allow the individual with SMI to look after their children relative to other groups, including the general population. Although methodological differences between studies could contribute to a systematic trend towards more positive or negative responses in volunteers as the other groups were sampled within the same study, it is unlikely to produce such a divergence in response patterns.

The extreme responses in comparison to other groups appears confined to personal interactions rather than professional (i.e., being an employer or employee). As such, one could posit that some aspect of becoming or being a volunteer befriender impacts attitudes towards professional interactions in a similar way as would being a family member or staff. However, attitudes towards personal interactions indicate greater complexity, beyond the scope of the present findings, which would necessitate further investigation to unpick.

Implications

While differences between volunteers and the general population are consistent with existing literature, reflecting their different familiarity with people with SMI (Angermeyer, Matschinger & Corrigan, 2004), the variability in willingness to interact with someone with SMI between volunteers, relatives and staff offer a more nuanced insight which has received little attention in the research to date. Thus, the findings highlight a potential benefit of shifting attention from comparison with the general populations towards between-group differences in those familiar with SMI, in different capacities. From this, the path towards lessening social distance from people with SMI may be more readily interpreted. Further, the findings cannot be attributed to volunteers' personal characteristics (age and gender), prior direct experience of mental illness (personally or through family/friends) or befriending-specific factors (longevity or satisfaction). As such, applicability of the findings will likely benefit from research focused on other role-specific variables across familiar groups.

Between-group differences may be found in the process leading up to contact with an individual with SMI, including attitudes held prior to the role or differing motivations for seeking contact, both of which warrant further investigation. Alternatively, the experience of contact may differ between groups based on their individual roles. Further research may establish how attitudes to people with SMI contribute to the motivation to volunteer and how they change during the experience as a befriender.

Conclusion

Volunteers' had a lower desire for social distance from individuals with SMI as compared to findings from the general population. Yet, they still showed some tendency for social distance. If even people who volunteer to spend their free time with people with mental illness show this type of social distance, one probably has to question whether social distance – as assessed with these methods– is indeed as a negative factor as previous research has suggested. Our results require to rethink the role and implications of social distance from people with mental illness.

The findings also show that the variables included into this study do not explain differences between befrienders, and the general population with regard to social distance from people with SMI. Future research may establish whether lower social distance is part of the motivation to volunteer as a befriender to people with SMI or develops over time in that role or both. Role-specific experiences may also be relevant to attitudes towards people with SMI, as suggested by the variability in volunteer attitudes compared with other groups familiar with SMI.

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ORCID iD

Sarah Toner https://orcid.org/0000-0003-2133-8601

References

Abayomi, O., Adelufosi, A. O., & Olajide, A. (2013). Changing attitude to mental illness among community mental health volunteers in south-western Nigeria. *International Journal of Social Psychiatry*, *59*, 609–612.

Angermeyer, M. C., Breier, P., Dietrich, S., Kenzine, D., & Matschinger, H. (2005). Public attitudes toward psychiatric treatment. *Social Psychiatry and Psychiatric Epidemiology*, *40*, 855–864.

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*, 163–179.

Angermeyer, M. C., Matschinger, H., & Corrigan, P. W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: Testing a model using data from a representative population survey. *Schizophrenia Research*, *69*, 175–182.

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*, *203*, 146–151.

Baumann, A. E. (2007). Stigmatization, social distance and exclusion because of mental illness: The individual with mental illness as a 'stranger'. *International Review of Psychiatry*, *19*, 131–135.

Bowman, J. T. (1987). Attitudes toward disabled persons: social distance and work competence. *Journal of Rehabilitation*, *53*, 41.

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*, 953–958.

Dietrich, S., Beck, M., Bujantugs, B., Kenzine, D., Matschinger, H., & Angermeyer, M. C. (2004). The relationship between public causal beliefs and social distance toward mentally ill people. *The Australian and New Zealand Journal of Psychiatry*, *38*, 348–354.

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.

Gaebel, W., Zäske, H., & Baumann, A. E. (2006). The relationship between mental illness severity and stigma. *Acta Psychiatrica Scandinavica*, *113*, 41–45.

Grausgruber, A., Meise, U., Katschnig, H., Schöny, W., & Fleischhacker, W. W. (2007). Patterns of social distance towards people suffering from schizophrenia in Austria: A comparison between the general public, relatives and mental health staff. *Acta Psychiatrica Scandinavica*, *115*, 310–319.

Guttman, L. (1974). *The basis for scalogram analysis*. Indianapolis, IN: Bobbs-Merrill College Division.

Hallett, C., Klug, G., Lauber, C., & Priebe, S. (2012). Volunteering in the care of people with severe mental illness: A systematic review. *BMC Psychiatry*, *12*(1), 226.

Henderson, C., & Thornicroft, G. (2009). Stigma and discrimination in mental illness: Time to change. *The Lancet*, *373*, 1928–1930.

IBM Corp. (2016). *IBM SPSS statistics for windows, Version 24.0*. Armonk, NY: IBM Corp.

Jorm, A. F., Angermeyer, M., & Katschnig, H. (2000). Public knowledge of and attitudes to mental disorders: A limiting factor in the optimal use of treatment services. In G. Andrews & S. Henderson (Eds.), Unmet need in psychiatry: Problems, resources, responses (pp. 399–413). New York, NY: Cambridge University Press.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, *92*(6), 1461–1500.

Mokken, R. J. (1971). *A theory and procedure of scale analysis: With applications in political research* (*vol. 1*). Berlin, Germany: Walter de Gruyter.

Mokken, R. J., Lewis, C., & Sijtsma, K. (1986). Rejoinder to The Mokken scale: A critical discussion. *Applied Psychological Measurement*, *10*, 279–285.

Sartorius, N. (2005). Stigma and discrimination because of schizophrenia: A summary of the WPA global programme against stigma and discrimination because of schizophrenia. *World Psychiatry*, *4*(S1), 11–15.

Shih, T. H., & Fan, X. (2008). Comparing response rates from web and mail surveys: A meta-analysis. *Field Methods*, *20*, 249–271.

Thompson, R., Valenti, E., Siette, J., & Priebe, S. (2016). To befriend or to be a friend: A systematic review of the meaning and practice of 'befriending' in mental health care. *Journal of Mental Health*, *25*, 71–77.