

‘A mixed methods approach of University student’s attitudes surrounding schizophrenia, before and after exposure to a video vignette showcasing a positive example of living with schizophrenia.’

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Science (hons) in Applied Psychology

Declarations.

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3. Perceptions of schizophrenia

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Abstract.

Schizophrenia is a highly complex and stigmatised psychological disorder whereby psychotic episodes and altered cognitive functioning are predominant symptoms severely affecting an individual's daily life. Stigma and negative attitudes can be damaging to attempts to perform help-seeking behaviours and maintain supportive relationships. This study explores attitudes towards schizophrenia and whether this can be influenced following exposure to a positive example of living with the condition. A mixed between within-subjects ANOVA was conducted comparing attitude scores before and after the intervention of a video vignette of somebody with schizophrenia living a successful and fulfilled life. Thirty-one university students all studying within the discipline of psychology participate. They were required to answer qualitative questions adapted the Community Attitudes to Mental Illness (CAMI) inventory and complete qualitative questions. Mean attitude scores suggest a positive improvement in attitudes, thematic analysis suggested that while participants had positive attitudes overall, the need for further education and knowledge of the disorder also emerged.

Chapter 1 – Literature Review.

Schizophrenia is an extremely complex psychological disorder, affecting around 1% of the population and is strongly associated with greater co-morbidities and reduced life expectancy of up to 15 years against the general population (McCutcheon et al., 2020).

Alongside schizophrenia, individuals are more likely to have other chronic diseases and co-morbidities resulting in frequent admissions to health care services, across both primary and secondary care (Ride, et al., 2020). Not surprisingly the financial implications of this are staggering and it is estimated for schizophrenia public sector spending accounts for around 30% of all spending on adult mental health services in the NHS (Rocks et al., 2019).

According to the American Psychological Association Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5; American Psychiatric Association [APA], 2013) schizophrenia is classified under the schizophrenia spectrum and other psychotic disorders. In order to diagnose schizophrenia and differentiating it from other psychotic disorders, disfunction must present in two or more of the following areas for the majority of the time within a one-month period; hallucinations, delusions, disorganised speech and thinking, severely disorganised behaviour or catatonia and negative symptoms.

Existing psychopathological research identifies the nature of delusions as largely centred around ideas of grandiosity, irrational jealousy and persecution presenting as absolute fixed beliefs, thus making them highly resistant to the opposing viewpoints of reality (Gonzalez-Rodriguez & Seeman, 2022). Other positive symptoms include visual, auditorial and sensory hallucinations, unusual beliefs and thought and perception disturbances (Walton et al., 2017).

Negative symptoms include impaired cognition, memory, communication difficulties, problems with attention and motivation, diminished or lack of expression or emotions and compromised executive functioning (Patel et al., 2014). In addition, such negative symptoms will often act as a precursor to and remain present throughout a psychotic episode (Lyne et al., 2018).

Moreover, schizophrenia is a highly heritable, multi-domain psychiatric disorder with a lifetime prevalence of approximately 1% (Owen et al., 2023), increasing considerably when familial history is present (Trifu et al., 2020). Additionally, evidence suggests that having close family members with schizophrenia is highly correlated with a younger age of onset of the disorder; typically, this is around early twenties for males and late twenties/early thirties for females, along with poorer overall outcomes (Sada-Fuente et al., 2023).

A nation-wide study from the Danish National Twin Register looked at heritability rates between 206 pairs of twins – 54 diagnosed with schizophrenia (n=32 monozygotic, n=22 dizygotic), and 49 healthy control pairs (n= 29 monozygotic, n= 20 dizygotic) and found concordance among certain cognitive traits of schizophrenia and a genetic aetiology as statistically highly significant (Lemvig et al., 2022).

For individuals with schizophrenia, the range of direct and indirect symptoms which can occur can impact cognitive, social and operational functioning which can be highly distressing and debilitating for the individual and those around them (Musket et al., 2020). Family and carer burden in schizophrenia is a well-established concept made of both intrinsic and extrinsic factors.

A systematic review and qualitative meta-summary by Shiraishi and Reilly (2019) found clear similarities around carer burden in twenty-three studies, ranging from financial implications, traumatic experiences, carer expectation, uncertainties about the future, lack of resources, stigma, conflict and family crisis. Conversely, whilst living or caring for someone with schizophrenia is widely depicted negatively, this study highlighted some of the many positive aspects, citing improved familial relationships, deeper understanding, compassion, resilience, admiration and feelings of togetherness all emerging as common themes.

However, despite this, schizophrenia is largely depicted in a negative and damaging way, it is unsurprisingly a highly stigmatised mental illness, consequences of which are highly damaging to already vulnerable individuals with up to 40% of individuals finding stigma as debilitating as the condition itself, negatively impacting self-esteem and quality of life (Valery & Prouteau, 2020).

Furthermore, as indicated from empirical evidence, unemployment, violence and relationship and family breakdown can further obstruct the ability to integrate into societal roles, thus further enhancing negative perceptions, inequalities and stigma (Ritsner et al., 2006). Existing research associates schizophrenia with extremely negative public perceptions, regarding individuals as aggressive, unstable, unpredictable and dangerous (Angermeyer & Dietrich, 2006). In many cases, the associated stigma of being labelled with schizophrenia is more damaging when compared to other mental illnesses, such as depression (Angermeyer & Matschinger, 2003).

Psychological research into the social-cognitive cause of stigma includes feelings of threat and fear, inter-group prejudice endorsing those feelings and social distancing (Benov et al., 2013). A attribution theory attempts to explain the prevalence of stigmatising behaviours towards mental illness, demonstrating a causal relationship between the labelling of a psychological disorder, thereby eliciting an emotion and a fear response which is validated by like-minded others which in turn results in a behavioural response such as choosing to discriminate, socially distance and withdraw from those seen as undesirable and different to the general population (Johnson-Kwochka et al., 2024).

Corrigan et al. (2003) goes further to propose that attribution theory offers itself to rationalise that the causes of a mental illness, how much of it the person can control and its perceived level of dangerousness consequentially determines individuals discriminatory responses or helping behaviours. Some would say that it can also account for the issue of self-stigma within individuals with schizophrenia (Mak & Wu, 2006). Self-stigma has been described as individuals taking on and accepting an awareness of a self-criticising and sometimes de-humanised view of themselves whereby their previous social identity is replaced with a new shameful identity which they have now acquired due to their illness (Dubreucq et al., 2021).

It is well established that discrimination by way of social distancing has detrimental effects for individuals with schizophrenia as the ability to maintain employment, relationships and friendships can become compromised (Silva et al., 2017). A cross-sectional survey by Thornicroft et al. (2009) interviewed 732 people with schizophrenia and found 47% experienced discrimination around making or keeping friends, 43% from family members, 29% surrounding in employment and 27% from partners/personal relationships. Supportive

social networks are a crucial part of living with schizophrenia offering preventative factors aiding long-term recovery and improved quality of life (National Institute for Health and Clinical Excellence [NICE], 2014).

One study into general public perceptions and attitudes towards schizophrenia explored responses via posts on the social media outlet Twitter. 424 posts were included for data collection, with 80.5% of tweets stigmatising schizophrenia via personal opinion, discounting advertisements and organisational content (Passerello et al., 2019). Examining that further, the different subtypes of stigmatisation comprised of 53.7% mocking, downplaying and trivialising the disorder, 24.4% perceived individuals as dangerous, 7.3% represented inaccurate or ill-informed beliefs, 9.8% wished to socially distance from individuals with schizophrenia and 4.9% represented self-stigma. Social media is a vast source of information and for some could be the one and only platform they would access for discussion and information around mental health related matters. That it is so easily accessible and brings so many unsolicited sources together it is not surprising how it can easily influence attitudes and perceptions around mental health. According to Wojcik and Hughes (2019) the majority of Twitter users are part of the younger demographic on social media (<28 years of age), therefore the possibility that a cohort of young people with schizophrenia would be deterred from seeking help as a result of what they are exposed to on social media is a real concern (Robinson et al., 2019).

Sandhu et al. (2019) explored attitudes of 538 undergraduate medical and psychology students utilising the twelve item Opening Minds Scale for Healthcare Providers (OMS-HC) scale quantifying explicit stigma, and an Implicit Association Test (IAT), measuring implicit bias towards schizophrenia. Findings implicated the psychology students as having

significantly fewer stereotypical negative and stigmatising attitudes as a mean response. Encouragingly, results of this study also concluded that having a diagnosis of a mental illness was significantly associated with decreased rates of explicit stigma comparative across both groups.

Utilising psychology students as research participants into attitudes around schizophrenia can lend itself to identifying strategies and responses to address the issue of stigma (Benov et al., 2013). The justification for using undergraduate psychology students is because in line with existing research, it is hoped that psychology students will possess less prejudicial or stigmatising attitudes, this in turn may help to inform future research regarding the promotion of interventions to bring about attitudinal change.

A randomised controlled trial by Amsalem et al. (2021) looked at reducing stigma using a brief video. 1203 participants were sourced for medical and psychological research and had to be between 18-30 years of age. They were then assigned to three groups: video vignette, written vignette portraying the same content as the video and a non-intervention control group. Much like the video vignette used in this study, it portrayed a successful woman describing her first episode of psychosis and her coping mechanisms enabling her to continue with her career. Self-report questionnaires following the intervention assessed social distancing, stereotypes, social restriction, separateness and perceived recovery. A significant effect emerged for all five sub-groups, with a significant difference for the video vignette group.

Furthermore, given that symptoms and onset of schizophrenia typically begins in early adulthood (Cadge et al., 2019) and the typical mean age of first episode of psychosis and diagnosis ranging from 16-28 years old (National Institute of Mental Health [NIMH], 2024) investigating knowledge and attitudes among students will potentially offer some insight as to how they would perceive or address symptoms if present within themselves or their peer group.

Additionally, psychology students reflect the prime population potentially responsible for patients receiving best practice, evidence-based treatment interventions (Magliano, 2023). The development and promotion of anti-stigma programmes can greatly support such individuals through diagnoses to acute treatment, and to hopefully successful lifelong management of the condition. Ince et al. (2016) states there is a limited amount of intervention available to psychology students around approaches to schizophrenia, reflected by the oftentimes inaccurate viewpoint of some professionals of pharmacological treatments being the most appropriate route. That it is the unwillingness and unawareness to successfully combine pharmacology with psycho-social and educational interventions is demonstrated by poorly controlled and unmanageable symptoms, which often reinforces many professionals' viewpoints of individuals with schizophrenia as unpredictable and dangerous (Valery & Prouteau, 2020).

Furthermore, existing research in this area examines this by evaluating attitudes and knowledge with much of it being qualitative in nature. For example, Cadge et al. (2019) explored lay perceptions and understanding of schizophrenia with semi-structured interviews of twenty students from a British university and found the majority of students had very limited knowledge of schizophrenia. Methodology does not state what subject the students

were studying, simply that those within the school of psychology, medicine, nursing and dentistry were excluded. Responses were considered as lay perceptions, with several confusing it with ‘split personality disorder’ and also Parkinson’s disease. Moreover, there was a general consensus around lack of awareness of the causes and treatment methods for schizophrenia as well as difficulties addressing sources of help and support.

Contrastingly, research by Furnham et al. (2011) explored the knowledge of 426 university students (aged between 18-23 years) of over ninety psychiatric illnesses as classified by the DSM-5. Promisingly 82.4% had heard of schizophrenia, however only half could correctly describe it. Interestingly, 41% of participants were psychology students, with others studying similar disciplines such as psychiatry, medicine and psychoanalysis. Nevertheless, students studying similar subjects to the research question were more emotionally intelligent and had greater literacy skills to be able to define the problems comparative to their peers.

Comparatively, a quantitative study of 115 psychology (n=57) and medicine students (n=58) assessed perceptions of aggressiveness based upon a vignette of a diagnosed schizophrenia patient. The Public Concept of Aggressiveness Questionnaire (PCA) was used to evaluate responses and demonstrated significantly higher scores of perceived aggressiveness and stigmatisation amongst the medical students when compared to the psychology students, despite the vignette itself having no mention of aggression or violence (Fresan et al., 2018). They hypothesised psychology students displayed fewer negative viewpoints of schizophrenia due to a underlaying professional interest and existing knowledge towards psycho-effective disorders, which they can only hope to build upon as their tutoring and careers progress. Mental health disorders account for only one aspect of the

prospectus within the field of medicine, thus making it likely students will have a lesser baseline understanding. Interestingly, only female participants were used as part of the sign-up criteria. It has been suggested that females perceive higher levels of aggressive behaviours overall by way of verbal, self-directed, aggression towards objects and towards others (Denson et al., 2018). It has been suggested that this heightened awareness comes as a reflection of an increased level of personal threat and fear. However, findings reflecting gender and perceived aggression and stigma remain inconclusive (Stuart & Arboleda-Florez, 2001).

Existing research around negative attitudes has raised the concern that the diagnostic term for schizophrenia itself conjures an elicit negative bias amongst the general population. Lack of awareness around schizophrenia is often accompanied by the historical ideology of a ‘split personality’ contributing to detrimental labelling of individuals who are diagnosed (Yamaguchi et al., 2017). One strategy which attempts to overcome this particular challenge is the re-naming of schizophrenia, as pioneered in Japan and some other Asian countries. Whilst several reports published as a result supported the re-naming, there remains to be a lack of empirical evidence demonstrating the potential positive effects to alter perceptions and this remains to be consistently low in non-Asian countries who have not adopted the re-naming strategy (Aker et al., 2016).

Cultural attitudes and perceptions of schizophrenia can deter individuals from accessing appropriate therapies and support. With schizophrenia being the most common mental health disorder in Africa, it is evidenced by Boti et al. (2020) that only 10% of these people ever receive appropriate treatment in Ethiopia, one country where it is vastly becoming a matter of public health concern. In this instance, a fundamental lack of

knowledge around what causes the disorder coupled with attempts to treat it with spiritual and traditional ideologies preferred to modern day approaches appear to have widely detrimental affects (Ayano et al., 2017).

Furthermore, this study aims to identify whether exposure to a positive intervention can influence individuals' attitudes in a positive manner. It has been suggested that this type of in direct contact approach, similar to an appropriate, multi-faceted stigma reduction strategy by way of increasing awareness and exposure to mental health conditions can result in decreased negative attitudes towards individuals diagnosed with schizophrenia (NICE, 2024).

Stubbs (2014) conducted a review of the literature examining interventions aimed at reducing stigma in mental illness and their effectiveness. The interventions were classified under three conditions: education, contact with a diagnosed patient (direct or indirect) or a combination of both and were aimed specifically at psychology and medical students. The educational element was further sub-categorised into a structured educational session, role play and informational email/electronic resource. Four out of five of the interventions showed a significant reduction in stigma and improved attitudes overall. Bayar et al. (2009) demonstrated the effectiveness of web-based education among 205 psychiatry professionals and psychology students in residency. Participants in the experimental group (n=100) were asked to complete a questionnaire reflecting 9 stigmatising statements and to what extent did they agree or not agree with it via a 7-point Likert scale. They also received an educational email prior to the completion of the questionnaire. The control group (n=105) were asked to complete the same questions without receiving the educational email. Both groups were equal with regards to number of psychiatrists and residency students. Data analysis implied

participants in the experimental group who had received the educational resource displayed significantly fewer negative attitudes when compared to the control group, especially with regards to attitudes around social distancing.

This study demonstrates educational approaches as effective in improving perceptions and attitudes towards schizophrenia. However, Stubbs (2014) argues that there is not enough empirical evidence to suggest educational-based interventions alone remains successful long-term. Magliano et al., (2016) explored whether psychology students' attitudes can be influenced by educational initiatives and found no real improvement amongst those who had received some form of education and contact sessions (be it direct or indirect) with people with schizophrenia, concluding both methods equally effective and continued to be so at the one-month follow up period.

Predominantly this study aims to contribute to the existing pool of research around successful interventions for addressing attitudes towards schizophrenia. Contact (direct/indirect) are elements used to tackle stigma with virtual teaching environments and educational resources offering promising results, particularly amongst public sector workers (Silva et al., 2017). Improving attitudes of psychology students towards schizophrenia remains fundamental in reducing stigmatisation and increasing positive attitudes around the condition, allowing for successful and purposeful reintegration strategies into society (Fresan et al., 2018).

Ultimately, further education is needed about schizophrenia, particularly across the general population in order to reduce discrimination, stigmatisation, promote diversity and social inclusion for individuals living with schizophrenia (Silva et al., 2017).

Therefore, the objective of this research proposal is to explore attitudes, knowledge and beliefs around schizophrenia as a mixed methods approach, by combining a quantitative survey methodology incorporating qualitative free text in order to answer the following research questions - What factors (if any) will influence changes in university students' knowledge, perceptions and beliefs regarding schizophrenia after exposure to the positive video vignette. This study also aims to answer the following hypothesis: Participants' attitudes of schizophrenia will improve following exposure to a positive example of living with schizophrenia.

This approach successfully combines the ability to measure the variables with descriptive responses in relation to real-life context, offering a comprehensive attempt to answer the research question (Clark, 2019). The cohort of participants for this study was university students studying a psychology-based degree, in an attempt to add to the vast majority of existing research into implicit and explicit attitudes towards schizophrenia which is largely comprised of psychology, medical and nursing students as the main participant group.

Chapter 2 – Method.

Participants

Participants included in this study comprised of a volunteer sample of university students from a West Wales University studying within the Psychology department at University of Wales Trinity Saint Davids (UWTSD). The study was available to students attending both the Carmarthen and Swansea Bay campus, regardless of their year of study and both full and part-time students were eligible to take part in the study. Inclusion criteria required that all participants had to be over the age of 18 and all able to provide valid consent. Participants were made aware of the study via the Experimental Management System (EMS) page, available on the Academic Discipline of Psychology home page on Moodle and those who wished to participate signed-up voluntarily.

Volunteer sampling generated 31 participants (27 female, four male) sub-divided into three age groups: 18-25 years (n=14), 26-39 years (n=8) and 40 and above (n=9). This sample size is in line with existing recommendations for this type of research allowing ecological validity and data saturation (Cadge et al., 2019).

Design

A mixed between within-subjects ANOVA was used for the design of this study, along with five open-ended free text questions to obtain both quantitative and qualitative data. The within subjects variable (IV1) was the time interval – before exposure to the video vignette and, after exposure to the vignette which demonstrated an individual living positively with a schizophrenia diagnosis. The between subjects variable (IV2) was the

difference between participant age groups. The dependent variable (DV) consisted of participant attitude scores of schizophrenia before and after the positive intervention.

Analysis of quantitative data was carried out via the most current version of IBM SPSS Statistics by a mixed between within subjects analysis of variance. Thematic analysis was performed to analyse the qualitative data.

Materials

Quantitative data was measured via a five-point Likert scale measuring attitudes towards schizophrenia and the difference in these across time (before and after exposure to a positive intervention). These questions were adapted from an original version of the Community Attitudes to Mental Illness (CAMI) inventory to assess attitudes across three domains: Fear and exclusion, Social Control and Goodwill (Wolff et al., 1996). Such attitude and rating scales are commonly used as a validated psychometric tool in psychology, including statements to answer in order to answer the research hypothesis (Taherdoost, 2019).

A series of 19 statements were used and participants were required to state to what extent they concurred with each statement, ranging from Strongly Disagree, Somewhat Disagree, Neither Agree or Disagree, Somewhat Agree, Somewhat Disagree. The highest possible score could be 95, indicating a lower level of prejudicial beliefs and attitudes. The lowest possible score could be 19 indicating greater levels of prejudice and fear.

The Cronbach's α indicates the degree of reliability of a scale, with acceptable scores between 0.70-0.95. This version of the CAMI demonstrated some heterogeneity in its coefficients with a Cronbach score of 0.80 (Sanabria-Mazo et al., 2023).

Procedure

Participants could take part in this study in a number of ways, either by using a Personal Computer, university campus computers, laptop, smart phone or tablet. Due to this being an online study, good internet/WiFi connectivity was needed for participants to be able to connect to the Academic Discipline of Psychology home page on Moodle. Additionally, a fully working screen and audio output or suitable subtitles facility was required in order to see and hear the content of video integrated into the body of the study.

The study title including a brief description of what is to be expected of participants was available via the EMS webpage. Participants wishing to take part in the study were required to sign up to the EMS portal as a participant and were then provided with a link to the study via the online platform 'Qualtrics'. In order to ensure participants are fully informed about the nature and intent of the study, a study information page (see appendix C) was available to all students outlining the purpose of the study and the expected time it would take to complete. Obtaining written consent was not possible due to it being an online study, therefore after reading the study consent form (see appendix D) and agreeing to the statements, participants were informed that if they wish to participate the action of clicking 'Next' at the bottom of the consent form indicates consent had been given. An example of a consenting statement is as follows; 'I understand that participation in this study is entirely voluntary, and I am free to withdraw participation at any point without giving a reason.'

Participants were also informed that all responses are confidential and anonymised and all data would be stored in accordance with the University Data Protection Act and only

available to the principal researcher and dissertation supervisor, the contact details of which were provided by way of university email address.

Once happy to consent participants were then taken into the main body of the study, beginning with an initial attitude questionnaire surrounding schizophrenia, scored on a 1–5-point Likert scale (see appendix E) adapted from the Community Attitudes to Mental Illness questionnaire (Wolff et al., 1996).

Following this, participants were required to view a video vignette via a link embedded into the survey (see appendix F). The video is sourced from YouTube and available in the public domain titled ‘Schizophrenia in real life: Discover how Bethany succeeds at work.’ On completion of the video, participants were asked to answer the same attitude questions for a second time. They were then invited to answer five open ended, free text questions (see appendix G) to provide the raw data for qualitative analysis, adapted from Cadge et al. (2019). An example of qualitative questioning is as follows; ‘In your opinion, is it possible for a person with schizophrenia to recover and live a ‘normal’ life? Please explain your answer.’

In order to analyse and interpret the data, thematic analysis was performed as is the recommendation for sound critique of qualitative research within psychology (Braun & Clarke, 2021). During this stage it was vital that the researcher familiarised themselves fully with the responses, making sure a clear understanding of the answers was obtained. It was equally as important to consider the responses in a non-judgemental and professional manner, given the nature of the topic area and the questions asked. Once all responses had been critiqued, coding of the data identified the emergence of certain themes within the text which

could then be used to answer the research question. Altogether, sixteen codes and four themes were identified for in-depth discussion and critique within the Results section.

On completion of the qualitative questionnaire, participants were then directed to the study debrief form (see appendix H), where a final opportunity to withdraw from the study was offered. They were reminded that all responses would remain anonymous and confidential and would not be able to be traced back to them. Once happy to submit their responses, participants were instructed to click the submit button, which enabled their data to be stored and the survey completed.

Chapter 3 – Results.

Quantitative data collection

The following section displays the results for attitudes and time (before and after exposure to a positive intervention). Table 1 contains the Means and Standard Deviations for attitude scores across each of the three age groups both pre and post intervention.

Table 1

Mean and Standard Deviation scores for Attitude and Time

Measure	Age Group	<i>M</i>	<i>SD</i>	<i>n</i>
Attitude Time 1	18-25	48.14	5.25	14
	26-39	54.75	7.94	8
	40 and above	49.45	3.43	9
	Total	50.23	6.12	31
Attitude Time 2	18-25	56.57	5.35	14
	26-39	57.75	3.62	8
	40 and above	56.45	2.92	9
	Total	56.84	4.24	31

Note. The lower the mean attitude score, the more negative the attitude towards schizophrenia.

Table 1 shows the youngest age group (18-25 years) had the lowest mean attitude scores before the intervention ($M=48.14$) and the largest improvement of attitude scores across all three age groups with a post intervention mean attitude score of ($M=56.57$). The

middle age group (26-39 years) had the highest overall mean attitude scores both before and after the intervention ($M=54.75$ and $M=57.75$ respectively). This suggests that the younger participants originally held more negative views towards schizophrenia than their older counterparts but were more open to change these perceptions following exposure to the positive intervention.

When combining the total mean attitude scores across all three age groups, before and after exposure to the intervention, an increase in these scores post intervention suggests a positive improvement in participants attitude towards schizophrenia ($M=50.23$ and $M=56.84$ respectively). Thus, supporting the hypothesis - participants attitudes of schizophrenia will improve following exposure to a positive example of living with schizophrenia.

A mixed between within subjects ANOVA was conducted to compare attitude scores before the positive intervention at Time 1, and attitude scores after the positive intervention at Time 2 across all three age groups.

A Levene's Test shows that the assumption of homogeneity of variance is violated (.01) however according to Stevens (2002) an analysis of variance is reasonably robust to violations of this assumption, provided the size of the groups is reasonably similar on a ratio of 1:5, therefore it was decided to proceed. The Box's test of equality of covariance is .04, which does not violate this assumption.

Mauchly's test of Sphericity indicated that the assumption had been violated, ($X^2 = .0$), $df = 0$, $p = .0$ therefore Greenhouse-Geisser corrections were applied.

The results of the mixed between within subjects ANOVA showed there was a significant interaction between age group and time, Wilks' Lambda = .69, $F(2, 28) = 6.46$, $p = .005$, partial $\eta^2 .316$, and there was a significant main effect of time between pre and post intervention, Wilks' Lambda = .23, $F(1, 28) = 93.87$, $p = <.001$, partial $\eta^2 .770$, indicating that participants attitudes improved as a result of the intervention.

The main effect comparing age groups across pre and post intervention was not significant $F(2, 28) = 1.81$, $p = .18$, partial $\eta^2 .115$, suggesting that there were no differences between each of the three age groups in attitudes towards schizophrenia.

Qualitative data collection

Qualitative raw data was analysed using thematic analysis, identifying sixteen codes (see Appendix I) and four themes; knowledge of symptoms and causes, social and emotional impact, positive attitudes and negative attitudes. Figure 1 represents the results for knowledge of symptoms and causes with the corresponding codes. Figure 2 represents the results for social and emotional impact with the corresponding codes. Figure 3 represents the results for positive attitudes with the corresponding codes. Figure 4 represents the results for negative attitudes with the corresponding codes.

Figure 1

Diagrammatical Representation of Results for Knowledge of Symptoms and Causes and Corresponding Codes

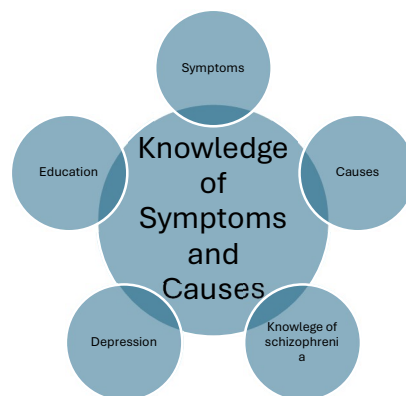


Figure 2

Diagrammatical Representation of Results for Social and Emotional Impact and Corresponding Codes

**Figure 3**

Diagrammatical Representation of Results Positive Attitudes and Corresponding Codes

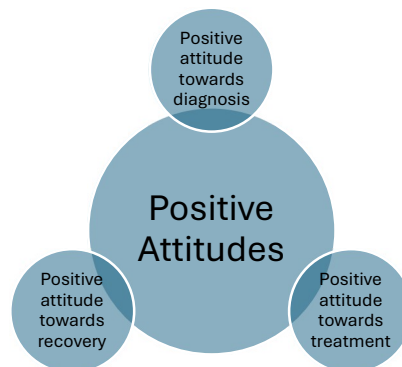
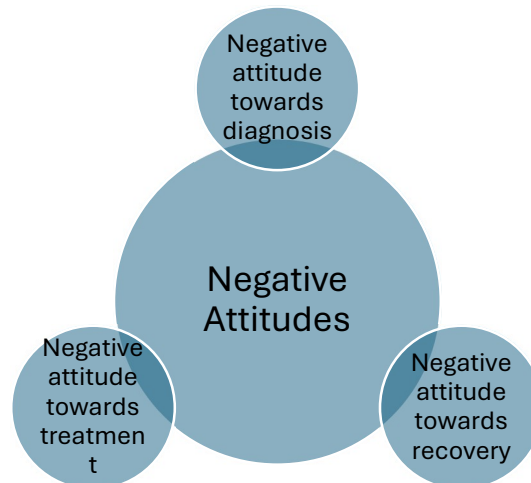


Figure 4

Diagrammatical Representation of Results Negative Attitudes and Corresponding Codes



Supportive quotes are presented for each theme (Table 2), along with the page and line number as to where the quote can be found in the raw data.

Table 2

Themes Identified from Thematic Analysis

Theme	Quote Keyword	Page/line number
Knowledge of symptoms and causes	‘mental illness that, if left untreated, will cause the person to have hallucinations, psychotic episodes, diminished cognitive functions, and delusions.’	Page 1; line 6-7
	‘symptoms of schizophrenia can severely impact a person's mental and physical health’	Page 2; line 53-54

	‘mental health condition which involves hearing voices and believing unreal things.’	Page 2; line 68
	‘Causes are not fully known other than it is a brain abnormality and can run in families’	Page 1; line 25-26
	‘It is a manageable condition’	Page 1; line 7-8
Social and Emotional Impact	‘lack of desire to engage in activities, withdrawal from social connection’	Page 1; line 20
	‘can also cause them to withdraw from their family and friends’	Page 6; line 180-181
	‘I would feel sorry for them’	Page 11; line 355
	‘Support is key for individuals to live a full and satisfied life.’	Page 12; line 401-402
Positive attitudes	‘finding the right medical treatment and therapist. It may take time but recovery and reaching life goals is possible.’	Page 11; line 375-376

	‘They are still capable of everything.’	Page 12; line 401
	‘Everyone’s experience with schizophrenia is different and there is no reason why someone couldn't lead a "normal life" if medication and other support in available to them.’	Page 13; line 421-423
Negative attitudes	‘People who suffer with schizophrenia normally cannot function as a normal member of society and require assistance’	Page 10; line 338
	‘It would change how I approach that individual’	Page 11; line 370
	‘I would be more worried about socialising with them’	Page 10; line 332-333

Chapter 4 – Discussion.

Quantitative data

Analysis of the quantitative data demonstrates that within the three age groups, participants from the youngest age group (18-25 years) had higher overall attitude scores before the intervention, but also the biggest improvements in attitude post intervention and this was demonstrative across all age groups.

A similar study exploring the effect of an anti-stigma educational intervention was carried out by Kosyluk et al. (2016). One hundred and ninety-eight students participated, with a mean age of 21 years and were assigned to three groups; contact-based intervention; education-based intervention and a control group. The educational intervention group viewed an anti-stigma presentation, challenging common myths and preconceptions, something which the lady in the video vignette in this study also spoke passionately about. Among this young demographic, it was concluded that educational interventions were an effective strategy in improving attitudes and reducing stigma towards individuals with severe mental health disorders. Corrigan et al. (2001) states initiatives for improving attitudes towards individuals with mental health conditions are most successful when they fall into three distinct categories: education, protest and contact.

Moreover, meta-analysis from 72 outcome studies exploring educational interventions towards mental illnesses found an educational approach worked best among adolescents and young adults (Corrigan et al., 2012). Furthermore, statistical significance was increased when education and contact interventions were utilised in a mixed approach. One suggestion as to

why this is, implies that comparative to older participants younger adults are likely to have fewer fixed beliefs around mental illness and therefore are more receptive to the influence of positive educational strategies.

However, Stuhlmiller (2005) advised against a mixed approach, believing this could reinforce predetermined negative attitudes in some individuals, particularly if they have had limited or no exposure to a person diagnosed with a mental health disorder and were exposed to them during an acute phase.

Conversely, in a before and after interventional study with nursing students, fear-reducing interventional strategies that normalised the issue of mental illness in both acute and stable stages were statistically significant in reducing negative attitudes. Post indirect exposure to a video vignette, researchers reported a significant positive effect to mental health attitudes (Bingham & O'Brien, 2018).

Moreover, considering the mean attitude scores for all three age groups, pre and post exposure to the intervention in this study demonstrated an improvement in attitude scores post intervention further suggesting a positive effect for participant attitudes towards schizophrenia. Thus, supporting the hypotheses that participants attitude and knowledge of schizophrenia will improve following exposure to a positive example of living with the condition.

This is fundamentally important in reducing stigma and stereotypical attitudes among psychology students, many of which may go on to have professional encounters with psychiatric patients. Existing negative stereotypes typically view people with schizophrenia

as unstable, aggressive and socially undesirable. The maintenance of such stereotypes in a professional capacity could indeed prevent provision of appropriate treatment methods (Mannarini & Rossi, 2019).

Qualitative data

The main aim of qualitative data analysis was to explore knowledge and attitudes around schizophrenia and to what extent (if any) would this be influenced post exposure to a positive intervention.

Knowledge of symptoms and causes

Throughout analysis of the data, participants knowledge of the symptoms and causes of schizophrenia emerged as a current theme. The majority of participants (84%) demonstrated good knowledge of auditory or visual hallucinations, delusions and disorganised speech and behaviours presenting as positive symptoms and decreased emotional response and dysfunction and social withdrawal as negative symptoms, as per the American Psychological Association Diagnostic and Statistical Manual of Mental Health Disorders (APA, 2013).

However, 16% of participants were unable to identify any specific symptoms of schizophrenia, classifying it broadly as a ‘mental illness or disorder’ or more specifically comparing it to other psycho-affective disorders such as bipolar, split personality or multiple personality disorder.

Participants delivered a mixed response for aetiology and cause of the disorder of genetic and biological factors. Environmental causes were mentioned by only one participant. This is congruent with results from a comparison study by Mannarini et al. (2020) of causal beliefs of schizophrenia from 4 groups of participants; mental health professionals, psychology students, patients with schizophrenia and relatives of people with schizophrenia. The psychology students reported greater genetic, neurological and biological causes, comparative to the mental health professionals who cited more environmental and psychosocial causal attributions. They hypothesised increased knowledge and awareness were influenced by how much exposure and experience participants had with individuals with schizophrenia.

Therefore, the need for increased knowledge and education towards schizophrenia was also identified via content analysis. Many participants stated that they would wish to educate themselves further on the disorder in order to be better able to help and support individuals with schizophrenia.

‘I would be worried that I would say the incorrect thing and create a complex situation.’

One participant in particular commented that, as a family, they had educated themselves around the signs, symptoms and management of the condition and in doing so this had dramatically helped in the understanding and support they were able to offer to a close family member who had been diagnosed with schizophrenia.

‘I have a brother who was diagnosed 12 years ago, it changed our approach to him as a family we all learned how to recognise and diffuse an episode, rather than blame situations on behavioural and environmental factors, we understood it was actually a cognitive distortion.’

Figures from the World Health Organisation (WHO, 2001) suggest one in four households has at least one family member with a complex psychiatric disorder. As is often the case, it is the family members who often take on the significant role of becoming the primary care- giver, and certainly this is true in the early stages of onset and diagnosis (Rosland et al., 2012). The impact of carer burden for those living with individuals with schizophrenia is widely known, with lack of education and support, chronic stress, personal safety and psychological distress (Rahmani et al., 2019) affecting resilience and contributing to carer burnout and potential breakdown of family relationships (Iseselo et al., 2016).

Increased knowledge and understanding was also linked to participants feeling more confident in their approach, particularly during a psychotic episode or relapse. Dziwota et al. (2018) identifies family psychoeducation as an effective coping strategy to overcome carer burden improving attitudes and familial relationships. Furthermore, increased knowledge and education provides families with higher levels of tolerance, understanding, empathy, preservation of safety and well-being all positively contributing to the non-pharmacological treatment and overall quality of life (Ribe et al., 2018). Essentially, increased awareness allows for better resources to not only support the individual with schizophrenia but reduce stigma and stereotypical attitudes.

Social and emotional impact

Overall, fifteen participants commented on the social and emotional impact of living with schizophrenia symptoms, in particular how feelings and emotions may be negatively influenced during a symptomatic episode or relapse. This in turn, lead to acknowledgement that many individuals would withdraw from society, family and friends.

‘The symptoms of schizophrenia can severely impact a person’s mental and physical health, by causing them to isolate themselves from others and society (potentially from paranoia).’

Social isolation and loneliness are common debilitating factors in psychopathology, often continuing as a lifelong occurrence as well as being linked to poor coping strategies, low self-esteem, substance abuse, suicidal ideation and early mortality (Correll et al., 2022). Not only does social isolation occur due to multi-faceted reasons such as withdrawal from education and employment and breakdown between family and supportive relationships (Green et al., 2018) but a psychobiological effect should also be considered.

For instance, the ability to infer the correct emotional state and intent of others is often impaired in schizophrenia and other psychotic disorders. This is further evidenced in schizophrenia, particularly if positive symptoms of the disorder are also present (Bora et al., 2009). In this study, nine responses identified the emotional impact of schizophrenia, both for the person diagnosed as well as the impact this can have upon family and friends. One participant simply described somebody with schizophrenia as ‘emotional’ but did not elaborate on this.

A systematic literature review of self-reported difficulties in emotional regulation for people with psychosis by Lawlor et al. (2020) considered this issue. Overall individuals reported difficulties in the following areas: clarity of emotions, emotional acceptance – of their feelings and others, motivating themselves in certain behaviours when experiencing negative emotions and willingness to experience emotional distress in order to participate in and achieve meaningful goals, as part of the recovery process.

Meta-analysis of neuroimaging studies of people with psychotic disorders highlight atypical neural activity in the amygdala and fusiform regions of the brain, which are responsible for emotional response, social cognition and face recognition (Dominguez-Borras & Vuilleumier, 2022).

When asked if they thought it possible that someone with schizophrenia could recover and live a ‘normal’ life, 16 participants identified the importance of good social support, and how this is a particularly important aspect of treatment, recovery and living a ‘normal’ life.

“‘Yes, through a supportive community of friends and family... may take time but recovery and reaching life goals is possible.’

A cross-sectional analysis by Roosenschoon et al. (2019) explored recovery determinants for 187 schizophrenia patients in an outpatient setting. Using structural equation modelling they identified personal, functional and clinical associations as vital aspects of recovery. They identified significant correlation coefficients between social support as part of personal recovery and functional capacity, more so than clinical or symptomatic recovery.

Results of a qualitative systematic review by Cam et al. (2020) identified social support as a main theme for recovery in nine of the fourteen studies. In this instance social support ranged from patience, understanding, visiting and enjoying shared experiences whereby individuals who felt supported in these areas reported better self-esteem, reduced stigma, optimistic outlook towards the future and overall improved quality of life.

Dziwota et al. (2018) elaborates on this, stating social support is an essential part of recovery and provides a good coping mechanism when dealing with a symptomatic phase of the disorder. In addition to this, empowering people with schizophrenia with the correct social skills is a key part of recovery as they can learn behaviours to enable them to function appropriately in certain situations.

Positive attitudes

When asked about recovery, aside from the importance of social support as mentioned above, positive attitudes were typically synonymous with regards to medication as most successful for recovery. There is a possibility that this was influenced by the person in the video vignette sharing her personal opinion of how important she considered medication in combination with her family support and therapy to be in her journey towards recovery.

Current guidelines from the British Association for Psychopharmacology (Barnes et al., 2020) emphasise the importance of rapid medication initiation, particularly during the first episode of psychosis. Furthermore, long term compliance and monitoring is required to ensure correct metabolic doses are delivered and to minimise adverse side effects and patient responsibility to continue taking them, even when they feel well (Stahl et al., 2021).

Nevertheless, responses identified awareness of both pharmacological and non-pharmacological treatments, and 52% of participants identifying the importance of a combined treatment method approach to facilitate recovery.

‘By using a combination of talking therapies and drugs/medicine, this allows an individual with schizophrenia to experience alleviated symptoms, therefore making their daily life much easier.’

It is evidenced that medication along with supportive therapies such as cognitive behavioural therapy (CBT) can improve psychotic related symptoms. Morrison, (2019) looked at comparisons between psychosocial and pharmacological therapies. A randomised controlled trial of 75 patients assigned to three groups: CBT only (n=26), pharmacological treatment only (n= 24) and CBT plus antipsychotics (25). Results demonstrated positive effect sizes and psychiatric symptoms markedly reduced across all conditions. However, a significant difference was evident between the CBT only and CBT plus antipsychotic group, with the later also maintaining better positive and negative symptom scores at the six and twelve month follow up.

Despite CBT and antipsychotic medications regarded as the gold standard of care, observed effects from clinical trials reflect only a moderate number of patients who benefit from this with regards to relapse prevention. However, the largest clinical trial for relapse prevention demonstrated no significant benefit from CBT, in comparison to CBT and treatment as usual (Leucht et al., 2012). However, two trials that examined the combined

effect of antipsychotic medications plus CBT found no advantage for the combination above CBT alone (McGorry et al., 2013).

When asked if their approach to a friend or family member being diagnosed with schizophrenia would change after viewing the video vignette, 58% (18) of participants said they would like to think they would still interact with them in the same way.

‘This would not change my approach...Patience and understanding are needed on a bad day.’

One participant commented specifically on the positive impact the video vignette had had.

‘From seeing that video it can be seen...even with challenges, they are strong and want to carry on living their lives.’

Research from Economou et al. (2012) demonstrated the impact educational intervention has towards anti-stigma attitudes and mental health within adolescents and young adults. An educational intervention was delivered to 616 participants and was found to be relevant to the positive change noted in attitudes to social distancing on completion of the intervention and also at the twelve month follow up point. This transitional period is identified as key the age groups when forming lasting attitudes and perceptions towards mental health (Bradbury, 2020). Considering that the mean age of onset of psychotic symptoms is 16-28 years of age (Cadge et al., 2019) it can be argued that application of education and interventional strategies across educational settings would be beneficial within

this at-risk cohort to improve symptom awareness, diagnosis and long-term outcomes (Liu, 2025).

The relevance of this in today's society is reflected in estimations that whilst one in five adolescents will experience symptoms of a psychological disorder, only around 20% will actively seek professional help, due to fear of stigmatising attitudes (World Health Organisation, 2005). Conclusions from this study suggest that such interventions should be provided consistently throughout school and college years to increase exposure and awareness, thus maintaining anti-stigma attitudes going forward into adulthood.

Negative attitudes

Social isolation and avoidance are popular barriers cited in existing research surrounding stigmatising attitudes towards schizophrenia (Jorm & Oh, 2009). When asked if their approach to a friend or family member being diagnosed with schizophrenia would change, 42% of participants stated they would approach them differently, mainly through concern of causing or exacerbating any psychological distress.

‘I would be more worried about socialising with them as I wouldn’t want to say the wrong thing and upset them.’

Social distancing towards individuals with schizophrenia is largely cited as a result of perceived fear of aggressiveness and dangerousness (Morgan et al., 2018). Not only does it have huge implications for overall mortality, quality of life, recovery outcomes but public

attitudes towards social distancing is also a matter of public health concern (Stuart & Arboleda-Florez, 2001).

The Time to Change national anti-stigma and discrimination programme established in England delivered social marketing and education to adults and secondary school pupils. Outcome measures looked at mental health knowledge, general attitudes and social distancing. Longitudinal evaluation of trends showed significant improvements in knowledge, attitudes and desire for social distancing, with the biggest shift in attitudes reported by women over the nine-year period (Robinson & Henderson, 2019).

Schizophrenia is a highly stigmatised mental illness, the consequences of which are highly damaging to vulnerable individuals, with up to 40% finding stigma as debilitating as the condition itself, negatively impacting self-esteem and quality of life (Valery & Prouteau, 2020).

Additionally, stigmatising attitudes towards mental health disorders is well known among adolescents and this is largely due to such factors as lack of knowledge, development of self-identity, peer pressure and support - seeking behaviours attitudes and behaviours (DeLuca, 2020).

Grausgruber et al. (2007) explored social distancing attitudes towards people with schizophrenia as a comparative measure between members of the public, patient relatives and mental health professionals. Findings suggest a relationship between level of education of the disorder and the level of social distancing, with the professional group displaying fewer prejudicial attitudes. Additionally, causal reasoning was highly attributed with level of social

distancing. For example, those who associated aetiology with stress or traumatic life events held lower social distancing attitudes compared to those who attributed the condition to a 'weak character' or because individuals were unable to control their mental health. Whilst family members and mental health professionals demonstrated fewer negative attitudes towards desire to social distance, the patterns of social distancing remained the same. For instance, attitudes towards having someone with schizophrenia living next-door compared to letting them look after their child.

This study demonstrates that psychology student attitudes and perceptions surrounding the mental health condition schizophrenia can be positively influenced by exposure to a positive example of living with the condition. This research highlighted the significant impact exposure and in direct contact intervention can have in the understanding that individuals with schizophrenia and how application of such measures has greater effectiveness within a younger demographic. Implication of the themes demonstrate considered and open responses offered by the participants.

Recommendations/limitations

Responses from thirty-one participants were included in data analysis. However, a larger sample size would allow for greater ecological validity and data saturation. Nevertheless, this sample size is in line with existing recommendations for this type of psychological research allowing ecological validity and data saturation (Cadge et al., 2019).

The current study adds to the existing knowledge surrounding attitudes towards schizophrenia in psychology students and could provide relevant points to apply when

considering other variables and disciplines. For example, the current study did not compare attitude responses of psychology students in different years of study, nor did it consider gender differences.

There are very few existing studies looking specifically at the effects of an educational intervention by video vignette alone, so this study contributes to the value of such an approach. Additionally, sharing a video resource can be cheaper and easier to share to a wider audience with the use of social media for example, when compared to other methods. However, further research would recommend re-assessing attitudes at defined follow up points, to further assess long-term sustainability and efficiency.

Regarding data collection, adapting the qualitative questions could potentially allow for more precise responses, contributing to clearer differentiation of themes to prevent some overlap in these responses.

Conclusion

Intervention and education are two elements used to tackle stigma with virtual teaching environments and educational resources offering promising results (Silva et al., 2017). Moreover, campaigns to address this issue alongside perceived level of dangerousness and desire to socially distance, could have greater overall efficiency. Ultimately, more education and knowledge are needed about stigmatisation in order to reduce discrimination, promote diversity and social inclusion for individuals living with schizophrenia, particularly among the adolescent/early adulthood age groups (Silva et al., 2017).

Further initiatives are needed from educational institutions and public health stakeholders in order to take this further to psychology students and those likely to have professional contact, be in directly or indirectly with people living with this condition. Also to tackle negative stereotypes which may exist within the adolescent/early adult population, the age range where typically individuals will experience onset of symptoms and first episode of psychosis. Reducing negative stereotypical attitudes within this age range aims to empower more young people to be forthcoming when seeking advice or treatment if they should experience symptoms of the disorder within themselves or peers. Overall treatment and recovery markers are more effective with prompt and early recognition and initiation.

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Appendix A – Research Proposal Form

ECPS6001: Psychology Empirical Project
Research Proposal

Student Name and University ID number:	Stephanie Reynolds 2015091
Proposed Supervisor's name:	Karen Eaton-Thomas

Psychology Research Area (tick all that apply)

Social Psychology	Developmental Psychology	Biological Psychology	Forensic Psychology
Health Psychology	Individual Differences	Educational Psychology	Political Psychology
Cognitive Psychology	Clinical Psychology √	Counselling Psychology	Occupational Psychology
<i>Other: indicate briefly (not included in word count)</i>			

Proposed Study Design (tick all that apply)

Quantitative	Experimental	Applied (with UWTSD students)	Online Questionnaire Survey
Qualitative	Quasi Experimental	Focus Groups	Online
Mixed Methods √	Applied (with external organisation)	Interviews	Lab-based study

<i>If Applied, and involving an external organisation, please indicate your plans for gaining appropriate approvals from the organisation: (not included in the word count)</i>		<i>Other study design: indicate briefly (not included in word count)</i>	

Suggested Research Title/Area:

A mixed methods approach of University students' attitudes surrounding schizophrenia before and after exposure to a positive example of living with schizophrenia.

Background: 250 words

Schizophrenia is an extremely complex psychological disorder, characterised by a wide range of symptoms which can be highly distressing and debilitating. Positive symptoms include visual and auditory hallucinations, delusional thinking and unusual beliefs while negative symptoms include impaired cognition, memory, attention and compromised executive functioning (Patel et al., 2014). Schizophrenia affects around 1% of the population and is associated with greater co-morbidities and reduced life expectancy of up to 15 years against the general population (McCutcheon et al., 2020).

Schizophrenia is a highly stigmatised mental illness, consequences of which are highly damaging to vulnerable individuals, with up to 40% finding self-stigma as debilitating as the condition itself, negatively impacting self-esteem and quality of life (Valery & Prouteau, 2020). Existing research associates schizophrenia with extremely negative public

perceptions, regarding individuals as aggressive, unstable, unpredictable and dangerous (Angermeyer & Dietrich, 2006). Unemployment, violence, family breakdown and relationship problems may further prevent the ability to integrate into society, enhancing negative perceptions and stigma (Ritsner et al., 2006).

Rationale of this study is to explore the stigma surrounding schizophrenia and whether individuals' perceptions can be influenced through exposure to a positive example of living with schizophrenia via video/vignette. Intervention and education are two elements used to tackle stigma with virtual teaching environments and educational resources giving positive results within the public sector (Silva et al., 2017).

It is expected that psychology students will have fewer negative attitudes, given they are likely to have some existing knowledge of the disorder. Much research relating to knowledge and perceptions of schizophrenia are quantitative in nature, however the purpose of this research is to explore perceptions and beliefs about schizophrenia as a mixed methods approach. Ultimately, more education and knowledge is needed about stigmatisation in order to reduce discrimination, promote diversity and social inclusion for individuals with this disorder (Silva et al., 2017).

Please state the main research question(s) or hypotheses(s): (100 words max)

What are university students' attitudes and knowledge about the mental health condition 'schizophrenia' after viewing a video/vignette of a positive example of living with a schizophrenia diagnosis.

Hypothesis 1 – Participants attitudes towards a diagnosis of schizophrenia will improve following exposure to a positive example of living with schizophrenia.

Methodological Details (500 words)

Participants will be University students from a West Wales University studying a psychology related course. The study will be made available for both full and part-time students regardless of their year of study. Approximately thirty participants will be needed who will voluntarily sign up for the study available to them via the Experiment Management System (EMS) on the Academic Discipline of Psychology home page on Moodle.

A mixed methods approach will be used incorporating both a Likert scale and space for free text answers in order to obtain sufficient quantitative and qualitative data around the subject area. Quantitative data will be analysed using the most current version of IBM SPSS Statistics. Qualitative data will be analysed via thematic analysis by the principal researcher.

The independent variable (IV) will be time – before exposure to the video/vignette and after exposure demonstrating living positively with a schizophrenia diagnosis. There will be two dependant variables (DV): 1) attitude and 2) knowledge scores of schizophrenia before and after the positive intervention.

The study title as well as a brief description will be available via EMS. Participants wishing to take part in the study must sign up and they will be provided with a link to the study via the online platform 'Qualtrics'. Firstly, they will be presented with an information page outlining the purpose and expectations of the study, before being directed to the consent page. If they choose to continue, they will then be directed to the first questionnaire. Participants will be reminded that responses will remain confidential and anonymous and only visible to the principal researcher and their supervisor, and that they are free to withdraw from the study at any point. The contact details of the researcher and supervisor will be provided at the beginning and the end of the study. Once happy to consent participants will be taken into the main body of the study, beginning with an initial attitude and knowledge questionnaire surrounding schizophrenia, to be answered via a 1-5 Likert scale.

Then, a video/vignette of a person(s) discussing living with a schizophrenia diagnosis positively will be available to watch. This resource will be available in the public domain and sourced from TEDx, YouTube or some other such platform. Therefore, participants

will need to complete the study on a PC, laptop or digital device with a fully working screen and speakers which would allow video and audio output to be played.

Once they have watched the video, participants will then be asked approximately 4-5 qualitative attitude and knowledge questions and will be able to type their responses via free text. Therefore, they will need to complete the study on a device with a keyboard facility. There will be some instruction asking participants to consider their responses thoughtfully and provide as much detail and explanation as possible when answering the questions. Questions will explore participants thoughts, feelings and perceptions of schizophrenia as a result of viewing the video/vignette. Following this, they will be asked to repeat the quantitative attitude and knowledge questions that they completed at the beginning of the study. Upon completion, a debrief will be offered along with a reminder of the study aims and objectives. Additionally, contact details of the principal researcher and supervisor will be available via university email. Signposting to additional resources will be made available, should any participant require any further reading, information or support. At the end, participants will be informed they have completed the survey and thanked for their time and contribution.

Key Ethical considerations (150 words)

Due to the sensitive nature of this study exploring schizophrenia attitudes and beliefs around schizophrenia, it is advised that anyone who may be sensitive to this topic should not take part. This will be made clear to participants - as well as full disclosure of aims of the study and how they are expected to contribute - alongside the study title during the

sign-up process. It is the responsibility of the principal researcher and supervisor to minimise any potential psychological harm or distress, eliminating any element of deception.

In line with the British Psychological Society (BPS) Code of Human Research Ethics (2021) informed consent will be obtained prior to sign up and in order to respect dignity, participants will also be informed that responses will be anonymous and confidential and any data provided will not be personally identifiable to any person(s).

Throughout the study participants can actively withdraw from taking part at any point by simply closing their browser. Even upon completion of the study, participants have the right to withdraw their responses at any point before clicking the final 'Submit' button, and it will not be used in data analysis.

Due to the online nature of this study, additional resources will be available by signposting to relevant organisations/charities. Participants will also be able to contact the principal researcher/supervisor should they require further information.

Reference list.

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Appendix B – Ethical Approval Form

APPLICATION FOR ETHICAL APPROVAL

RESEARCH STUDENTS

This form is to be completed by the student within **SIX** months for full-time students and **TWELVE** months for part time students, after the commencement of the research degree or following progression to Part Two of your course.

Once complete, submit this form via the ***MyTSD Doctoral College Portal*** at (<https://mytsd.uwtsd.ac.uk>).

This document is also available in Welsh.

RESEARCH STAFF ONLY

All communications relating to this application during its processing must be in writing and emailed to pgresearch@uwtsd.ac.uk , with the title 'Ethical Approval' followed by your name.

STUDENTS ON UNDERGRADUATE OR TAUGHT MASTERS PROGRAMMES should submit this form (and receive the outcome) via systems explained to you by the supervisor/module leader.

In order for research to result in benefit and minimise risk of harm, it must be conducted ethically. A researcher may not be covered by the University's insurance if ethical approval has not been obtained prior to commencement.

The University follows the OECD Frascati manual definition of **research activity**: “creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications”. As such this covers activities undertaken by members of staff, postgraduate research students, and both taught postgraduate and undergraduate students working on dissertations/projects.

The individual undertaking the research activity is known as the “principal researcher”.

Ethical approval is not required for routine audits, performance reviews, quality assurance studies, testing within normal educational requirements, and literary or artistic criticism.

Please read the notes for guidance before completing ALL sections of the form.

This form must be completed and approved prior to undertaking any research activity. Please see Checklist for details of process for different categories of application.

SECTION A: About You (Principal Researcher)

1	Full Name:	Stephanie Reynolds			
2	Tick all boxes that apply:	Member of staff:	☐	Honorary research fellow:	☐
	Undergraduate Student	☒	Taught Postgraduate Student	☐	Postgraduate Research Student

3	Institute/Academic Discipline/Centre:	Psychology and Counselling
4	Campus:	Carmarthen
5	E-mail address:	2015091@student.uwtsd.ac.uk
6	Contact Telephone Number:	
For students:		
7	Student Number:	2015091
8	Programme of Study:	BSc Applied Psychology
9	Director of Studies/Supervisor:	Karen Eaton-Thomas

SECTION B: Approval for Research Activity

1	Has the research activity received approval in principle? (please check the Guidance Notes as to the appropriate approval process for different levels of research by different categories of individual)	YES	☒	NO	☐
					Date
2	If Yes, please indicate source of approval (and date where known): Approval in principle must be obtained from the relevant source prior to seeking ethical approval	Research Degrees Committee	☐		
Institute Research Committee		☐			
Other (write in) Dissertation supervisor Karen Eaton-Thomas		☒	13/08/2024		

SECTION C: Internal and External Ethical Guidance Materials

	Please list the core ethical guidance documents that have been referred to during the completion of this form (including any discipline-specific codes of research ethics, location-specific codes of research ethics, and also any specific ethical guidance relating to the proposed methodology). Please tick to confirm that your research proposal adheres to these codes and guidelines. You may add rows to this table if needed.	
1	<u>UWTSD Research Ethics & Integrity Code of Practice</u>	☒
2	UWTSD Research Data Management Policy	☒
3	UWTSD Student Code of Conduct	☒
4	UWTSD Data Protection and Storage Protocol	☒
5	BPS Code of Ethics and Conduct (2021)	☒
6	BPS Code of Human Research Ethics (2021)	☒
7	BPS Ethics Guidelines for Internet-mediated Research (2021)	☒
8	BPS Data Protection Regulations – Guidance for Researchers (2018)	☒

SECTION D: External Collaborative Research Activity

If there are external collaborators then you should gain consent from the contact persons to share their personal data with the university. If there are no external collaborators then leave this section blank and continue to section E.

1	Institution	
2	Contact person name	
3	Contact person e-mail address	
4	Is your research externally funded?	YES ☐ NO ☐
5	Are you in receipt of a KESS scholarship?	YES ☐ NO ☐
6	Are you specifically employed to undertake this research in either a paid or voluntary capacity?	Voluntary YES ☐ NO ☐
7		Employed YES ☐ NO ☐
8	Is the research being undertaken within an existing UWTSD Athrofa Professional Learning Partnership (APLP)?	If YES then the permission question below does not need to be answered. YES ☐ NO ☐
9	Has permission to undertake the research has been provided by the partner organisation?	(If YES attach copy) If NO the application cannot continue YES ☐ NO ☐

Where research activity is carried out in collaboration with an external organisation

10	Does this organisation have its own ethics approval system?	YES	☐	NO	☐
	If Yes, please attach a copy of any final approval (or interim approval) from the organisation (this may be a copy of an email if appropriate).				

SECTION E: Details of Research Activity

1	Indicative title:	A mixed methods approach of University student's attitudes surrounding schizophrenia, before and after exposure to a video vignette showcasing a positive example of living with schizophrenia.			
2	Proposed start date:	November 2024	Proposed end date:	May 2025	
	Introduction to the Research (maximum 300 words per section) Ensure that you write for a <u>Non-Specialist Audience</u> when outlining your response to the points below: <i>Purpose of Research Activity</i> <i>Proposed Research Question</i> <i>Aims of Research Activity</i> <i>Objectives of Research Activity</i> Demonstrate, briefly, how <u>Existing Research</u> has informed the proposed activity and explain <i>What the research activity will add to the body of knowledge</i> <i>How it addresses an area of importance.</i>				
3	Purpose of Research Activity Schizophrenia is an extremely complex psychological disorder, characterised by a wide range of symptoms which can be highly distressing and debilitating (World Health Organisation [WHO], 2022). Positive symptoms include visual and auditory hallucinations, delusional thinking and unusual beliefs while negative symptoms include impaired cognition, memory, attention and compromised executive functioning (Patel et al., 2014). Schizophrenia affects around 1% of the population and is associated with greater co-morbidities and reduced life expectancy of up to 15 years against the general population (McCutcheon et al., 2020). Schizophrenia is a highly stigmatised mental illness, consequences of which are highly damaging to vulnerable individuals, with up to 40% finding stigma as debilitating as the condition itself, negatively impacting self-esteem and quality of life (Valery & Prouteau, 2020). Existing research associates schizophrenia with extremely negative public perceptions, regarding individuals as aggressive, unstable, unpredictable and dangerous (Angermeyer & Dietrich, 2006). Unemployment, violence, family				

breakdown and relationship problems may further prevent the ability to integrate into society, enhancing negative perceptions and stigma (Ritsner et al., 2006).

Intervention and education are two elements used to tackle stigma with virtual teaching environments and educational resources offering promising results (Silva et al., 2017). Ultimately, more education and knowledge is needed about stigmatisation in order to reduce discrimination, promote diversity and social inclusion for individuals living with schizophrenia (Silva et al., 2017).

Therefore, the rationale of this study is to explore if it may be possible to reduce the stigma and negative perceptions surrounding schizophrenia through exposure to a positive example of living with the condition via a video vignette. It is acknowledged that psychology students will potentially hold fewer negative attitudes, given they are likely to have some existing knowledge of the disorder, however, much research relating to knowledge and perceptions of schizophrenia are quantitative in nature. Thus it is the purpose of this research to explore perceptions and beliefs about schizophrenia as a mixed methods approach, including both quantitative and qualitative means of data analysis.

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4	Research Questions 1. What are university students' knowledge, perceptions and beliefs about the mental health condition schizophrenia, before and after viewing a video/vignette of a positive example of living with a schizophrenia diagnosis? 2. What factors (if any) will influence changes in university students. knowledge, perceptions and beliefs regarding schizophrenia after exposure to the positive video vignette? Hypothesis 1 – Participant attitudes of schizophrenia will improve following exposure to a positive example of living with schizophrenia.
5	Aims of Research Activity The aim of this research is to investigate the following: a) Initial perceptions, beliefs and knowledge surrounding schizophrenia and b) whether these can be positively influenced after exposure to a video vignette depicting a positive example of living with a schizophrenia diagnosis.
6	Objectives of Research Activity The objective of this study is to utilise a mixed methods approach to explore university student's knowledge, perceptions and beliefs about schizophrenia. Participants will be asked to answer quantitative questions, followed by a video vignette showcasing a positive example of living with the condition. Following this, the quantitative questions will be repeated for comparison, before concluding with qualitative questions where individuals have the opportunity to express their responses to open ended free text questions.

	Proposed methods (maximum 600 words) Provide a brief summary of all the methods that may be used in the research activity, making it clear what specific techniques may be used. If methods other than those listed in this section are deemed appropriate later, additional ethical approval for those methods will be needed. You do not need to justify the methods here, but should instead describe how you intend to collect the data necessary for you to complete your project.
7	1. Participants will be University students from a West Wales University studying a psychology related course. The study will be made available for both full and part-time students regardless of their year of study. A convenience sample of approximately 30 - 40 participants will be needed. Participants will voluntarily sign up for the study made available to them via the Experiment Management System (EMS) on the Academic Discipline of Psychology home page on Moodle. This sample size is in line with existing recommendations for this type of research allowing ecological validity and data saturation (Cadge et al., 2019). 2. The study title including a brief description of what is expected of participants will be available via EMS. Participants wishing to take part in the study must sign up to the EMS portal and they will be provided with a link to the study via the online platform 'Qualtrics'. Upon clicking the link to enter the survey, they will be presented with an online study information page (see appendix C) outlining the purpose and expectations of the study and approximate time it will take to complete, before being directed to the consent page (see appendix D) containing a series of statements which they must tick to be able to continue, for example 'I understand that participation in this study is entirely voluntary, and I am free to withdraw participation at any point without giving a reason,' and 'I understand that the information provided by me will be held confidentially. This data will be stored in accordance with the University Data Protection Act.'. Then, by clicking the 'next' arrow at the bottom of the page, participants are informed that this will be taken as their consent to take part in the study. Participants will be reminded that their responses will remain confidential and anonymous and only visible to the principal researcher and their dissertation supervisor, and that they are free to withdraw from the study at any point by closing their browser. 3. The contact details of the researcher and supervisor will be provided at the beginning and the end of the study, by way of university email addresses. Once happy to consent participants will be taken into the main body of the study, beginning with an initial knowledge and attitude questionnaire surrounding schizophrenia, which will be scored on a 1–5-point Likert scale (see appendix E) adapted from the Community Attitudes to Mental Illness questionnaire (Wolff et al., 1996).

	4. Following this, participants will be required to view a video via a link embedded into the survey (see appendix F). The video is sourced from YouTube and available in the public domain – ‘Schizophrenia in real life: Discover how Bethany succeeds at work.’ On completion of the video, they will be asked to answer the same knowledge and attitude scale for a second time. They will then be invited to answer five open ended free text questions (see appendix G) to provide data for qualitative analysis, adapted from Cadge et al. (2019). 5. On completion of the questionnaire, they will be directed to the study debrief form (see appendix H), where they will be offered a final opportunity to withdraw from the study. They will be reminded that all responses provided will remain anonymous and confidential and will not be able to be traced back to them. If happy to submit their responses, they will need to click the submit button, which will enable their data to be stored and the survey will be completed. 6. The quantitative data will be analysed using the most current version of IBM SPSS Statistics. The independent variable (IV) will be time – before exposure to the video and after exposure demonstrating living positively with a schizophrenia diagnosis. There will be two dependant variables (DV): 1) attitude {perception and beliefs}, and 2) knowledge scores of schizophrenia before and after the positive intervention. The qualitative data will be analysed through Braun & Clark’s (2021) Reflexive Thematic Analysis.
	Location of research activity Identify all locations where research activity will take place.
8	Participants will be able to complete this study on university campus computers, or at home or any location on personal devices once connected to the Academic Discipline of Psychology home page on Moodle.
	Research activity outside of the UK If research activity will take place overseas, you are responsible for ensuring that local ethical considerations are complied with and that the relevant permissions are sought. Specify any local guidelines (e.g. from local professional associations/learned societies/universities) that exist and whether these involve any ethical stipulations beyond those usual in the UK (provide details of any licenses or permissions required). Also specify whether there are any specific ethical issues raised by the local context in which the research activity is taking place, for example, particular cultural and/or legal sensitivities or vulnerabilities of participants. If you live in the country where you will do the research then please state this.
9	N/A

10	Use of documentation not in the public domain: Are any documents NOT publicly available?	NO	☒
		YES	☐
11	If Yes, please provide details here of how you will gain access to specific documentation that is not in the public domain and that this is in accordance with the current data protection law of the country in question and that of England and Wales.		

	Does your research relate to one or more of the seven aims of the Well-being of Future Generations (Wales) Act 2015?	YES	NO
12	A prosperous Wales	☐	☐
13	A resilient Wales	☐	☐
14	A healthier Wales	☐	☐
15	A more equal Wales	☒	☐
16	A Wales of cohesive communities	☐	☐
17	A Wales of vibrant culture and thriving Welsh language	☐	☐
18	A globally responsible Wales	☐	☐
19	If YES to any of the above, please give details:		
	By providing participants with a positive intervention strategy, it is hoped that this will show improvements in participants knowledge, perception and beliefs about Schizophrenia.		

SECTION F: Scope of Research Activity

	Will the research activity include:	YES	NO
1	Use of a questionnaire or similar research instrument?	☒	☐
2	Use of interviews?	☐	☒
3	Use of focus groups?	☐	☒
4	Use of participant diaries?	☐	☒
5	Use of video or audio recording?	☒	☐
6	Use of computer-generated log files?	☐	☒
7	Participant observation with their knowledge?	☐	☒
8	Participant observation without their knowledge?	☐	☒
9	Access to personal or confidential information without the participants' specific consent?	☐	☒
10	Administration of any questions, test stimuli, presentation that may be experienced as physically, mentally or emotionally harmful / offensive?	☐	☒
11	Performance of any acts which may cause embarrassment or affect self-esteem?	☐	☒

12	Investigation of participants involved in illegal activities?	☐	☒
13	Use of procedures that involve deception?	☐	☒
14	Administration of any substance, agent or placebo?	☐	☒
15	Working with live vertebrate animals?	☐	☒
16	Procedures that may have a negative impact on the environment?	☐	☒
17	Other primary data collection methods. Please indicate the type of data collection method(s) below.	☐	☒
	Details of any other primary data collection method:		

If NO to every question, then the research activity is (ethically) low risk and **may** be exempt from **some** of the following sections (please refer to Guidance Notes).

If YES to any question, then no research activity should be undertaken until full ethical approval has been obtained.

SECTION G: Intended Participants

If there are no participants then do not complete this section, but go directly to section H.

	Who are the intended participants:	YES	NO
1	Students or staff at the University?	☒	☐
2	Adults (over the age of 18 and competent to give consent)?	☒	☐
3	Vulnerable adults?	☐	☒
4	Children and Young People under the age of 18? (Consent from Parent, Carer or Guardian will be required)	☐	☒
5	Prisoners?	☐	☒
6	Young offenders?	☐	☒
7	Those who could be considered to have a particularly dependent relationship with the investigator or a gatekeeper?	☐	☒
8	People engaged in illegal activities?	☐	☒
9	Others. Please indicate the participants below, and specifically any group who may be unable to give consent.	☐	☒
	Details of any other participant groups:		

	Participant numbers and source Provide an estimate of the expected number of participants. How will you identify participants and how will they be recruited?	
10	How many participants are expected?	To carry out this study, 30 - 40 participants will be required.
11	Who will the participants be?	Participants will be University students studying within the Psychology department at UWTSD and all over the age of 18 and able to give valid consent.
12	How will you identify the participants?	Participants will sign up for the study via the Experimental Management System (EMS) portal accessible on the discipline Moodle page, should they wish to do so.

	Information for participants:	YES	NO	N/A
13	Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	☒	☐	☐
14	Will you tell participants that their participation is voluntary?	☒	☐	☐
15	Will you obtain written consent for participation?	☐	☒	☐
16	Will you explain to participants that refusal to participate in the research will not affect their treatment or education (if relevant)?	☒	☐	☐
17	If the research is observational, will you ask participants for their consent to being observed?	☐	☐	☒
18	Will you tell participants that they may withdraw from the research at any time and for any reason?	☒	☐	☐
19	With questionnaires, will you give participants the option of omitting questions they do not want to answer?	☒	☐	☐
20	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	☒	☐	☐
21	Will you debrief participants at the end of their participation, in a way appropriate to the type of research undertaken?	☒	☐	☐
22	If NO to any of above questions, please give an explanation			
	Written informed consent will not be possible, since the study will be conducted online. However participants will be informed that if they choose to complete the study, by clicking on the 'next' arrow at the bottom of the consent page, they are indicating their consent to take part.			

	Information for participants:	YES	NO	N/A
24	Will participants be paid?	☐	☒	☐
25	Is specialist electrical or other equipment to be used with participants?	☐	☒	☐
26	Are there any financial or other interests to the investigator or University arising from this study?	☐	☒	☐
27	Will the research activity involve deliberately misleading participants in any way, or the partial or full concealment of the specific study aims?	☐	☒	☐
28	If YES to any question, please provide full details			

SECTION H: Anticipated Risks

	Outline any anticipated risks that may adversely affect any of the participants, the researchers and/or the University, and the steps that will be taken to address them. If you have completed a full risk assessment (for example as required by a laboratory, or external research collaborator) you may append that to this form.		
1	Full risk assessment completed and appended?	Yes	☐
		No	☒
2	Risks to participants For example: sector-specific health & safety, emotional distress, financial disclosure, physical harm, transfer of personal data, sensitive organisational information		
	Risk to participants: 1. There is a possibility that some participants may feel contributing in this study would cause them to experience emotional distress. Questions will focus on knowledge, beliefs and perceptions of schizophrenia which some may find challenging, particularly if they have personal experience relating to this disorder.	<i>How you will mitigate the risk to participants:</i> 1. The researcher will work diligently within the BPS Code of Human Research Ethics (2021) and UWTSD Research Ethics and Integrity Code of Practice to prevent emotional distress and ensure participants dignity is maintained. The study information form will clearly outline the nature and content of the study, as will the consent form. The researcher will make sure they have provided as much information as possible making it clear what the study will involve, what is expected of participants and examples of the questions being asked, enabling participants to make a fully informed choice to take part. Participants are reminded that they can withdraw from the study at any point and their responses will not be included in data analysis. Additionally, a study debrief form will outline the aims and objectives of the study, contact details of the researcher and dissertation	

	2. Participants may have concerns surrounding data protection and the safe and appropriate use and storage of their data. 3. Even though the video resource will not deliberately cause offence, some participants may experience emotional distress after viewing it.	supervisor along with signposting to student support services if required. 2. The researcher will inform the participant that all data collected will be handled according to GDPR and the UWTSD policies for Research Data Management, thus ensuring that confidentiality and anonymity will be maintained when collecting, analysing and storing data. Participants requesting any further information surrounding this can contact the researcher. Additionally, participants will be able to withdraw their data, removing it from data analysis at any point prior to the end of the study. After which, all data will be stored anonymously and will not be able to be traced back to them. 3. The researcher will endeavour to protect participants mental wellbeing and dignity at all times throughout this study, complying with the BPS Code of Human Research Ethics (2021) and UWTSD Research Ethics and Integrity Code of Practice. Detailed information surrounding the aims of the study and what is expected from participants will be clearly outlined in the study information sheet and consent form. The video chosen is sourced from YouTube and is available within the public domain and therefore judged as appropriate for general audience viewing. Additionally, participants are reminded that they can withdraw from the study at any point should they wish by simply closing their browser. Additional support will be made available via signposting to student support services at the end of the study, as well as the contact details for the researcher and dissertation supervisor should they have any questions.
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3	If research activity may include sensitive, embarrassing or upsetting topics (e.g. sexual activity, drug use) or issues likely to disclose information requiring further action (e.g. criminal activity), give details of the procedures to deal with these issues, including any support/advice (e.g. helpline numbers) to be offered to participants. Note that where applicable, consent procedures should make it clear that if something potentially or actually illegal is discovered in the course of a project, it may need to be disclosed to the proper authorities	
	N/A	
4	Risks to the investigator For example: personal health & safety, physical harm, emotional distress, risk of accusation of harm/impropriety, conflict of interest	
	Risk to the investigator: 1. The researchers email address will be provided to participants at the end of the study, so there is a potential the researcher could receive negative or distressing emails. 2. The main purpose of this study involves discussing a complex mental health condition. Therefore, there is a possibility the researcher might receive questions or queries beyond their level of knowledge/competence. 3. Due to the sensitive nature of the topic of this study the researcher may be blamed for causing emotional distress. Particularly if a participant is unhappy with some of the questions asked or after viewing the video as they may find it upsetting.	<i>How you will mitigate the risk to the investigator:</i> 1. Any negative or abusive emails will immediately be reported to the dissertation supervisor. Both researcher and participants are expected to operate in a respectful and professional manner, in line with the University Student Code of Conduct. 2. The researcher will work closely with the dissertation supervisor and any issues raised of this nature will be passed onto them immediately. 3. The researcher will adhere to the BPS Code of Human Research Ethics (2021) and UWTSD Research Ethics and Integrity Code of Practice to ensure participants dignity is maintained. The study information form will outline the nature and content of the study, as will the consent form. The researcher will make sure they have provided as much information as possible making it clear what the study will involve, enabling participants to make a fully informed choice to take part. Participants are reminded that they can withdraw from the study at any point and their

		responses will not be included in data analysis. Additionally, a study debrief form will outline the aims and objectives of the study, along with signposting to student support services if required.
5	University/institutional risks For example: adverse publicity, financial loss, data protection	
	Risk to the University: 1. There is a chance the integrity and professional reputation of the University could be negatively impacted if researcher and/or participants fail to comply with ethical codes of practice and research protocols. 2. There is a chance that data obtained for the purpose of this study may be disclosed to a third party or any individual aside from those identified as custodians for the data.	<i>How you will mitigate the risk to the University:</i> 1. To minimise this risk the researcher will comply to the University Research Ethics and Integrity Code of Practice and the BPS Code of Ethics and Conduct (2021). Participants will have the opportunity to discuss any aspect of the study with the researcher via email prior to giving final consent to use their data. It is the responsibility of the researcher to conduct themselves in a respectful and professional manner at all times, in line with the University Student Code of Conduct. 2. Data collected will only be used for the intended purpose of this study. The researcher and dissertation supervisor will be identified as persons permitted access to the data. The University Research Ethics and Integrity Code of Practice, the BPS Code of Ethics and Conduct (2021) the principles of GDPR and the UWTSD Research Data Management protocol will be adhered to throughout all stages of data collection, analysis and storage in order to minimise this risk.
6	Environmental risks For example: accidental spillage of pollutants, damage to local ecosystems	
	Risk to the environment: N/A	<i>How you will mitigate the risk to environment:</i> N/A

	Disclosure and Barring Service			
	If the research activity involves children or vulnerable adults, a Disclosure and Barring Service (DBS) certificate must be obtained before any contact with such participants.	YES	NO	N/A
7	Does your research require you to hold a current DBS Certificate?	☐	☒	☐
8	If YES, please give the certificate number. If the certificate number is not available please write "Pending"; in this case any ethical approval will be subject to providing the appropriate certificate number.			

SECTION I: Feedback, Consent and Confidentiality

1	Feedback What de-briefing and feedback will be provided to participants, how will this be done and when?
	All participants will be directed to a debrief page at the end of the study. This will reiterate the aims and objectives of the study, along with reminding them of their final opportunity to withdraw. Participants also have the opportunity to contact the researcher and/or dissertation supervisor should they wish to discuss anything in relation to the study. Signposting to student services will also be available.
2	Informed consent Describe the arrangements to inform potential participants, before providing consent, of what is involved in participating. Describe the arrangements for participants to provide full consent before data collection begins. If gaining consent in this way is inappropriate, explain how consent will be obtained and recorded in accordance with prevailing data protection legislation.
	All participants will be initially directed to a study information page upon clicking the link to the study on Qualtrics, outlining the main aims and objectives of the study. If they decide to take part, they will then be directed to a consent page outlining a series of statements to which they must tick if they agree with them. Once participants have agreed to the statements, they are informed that if they decide to continue onto the survey, by clicking on the `next` button, they are providing their consent to take part.
3	Confidentiality / Anonymity Set out how anonymity of participants and confidentiality will be ensured in any outputs. If anonymity is not being offered, explain why this is the case.

	All participants will only be identifiable to the researcher/dissertation supervisor via a unique identification code generated by EMS. EMS codes will be replaced with a unique identification code for downloading into SPSS from Qualtrics. All data will be anonymous during all phases of this study: data collection, analysis, reporting and storage. Anonymous data will be stored via password protected files on the researchers' OneDrive university account, in line with UWTSD Data Protection and Storage Protocol. The researcher does not have permission to use any data for purposes other than this study or share it with any other persons.
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SECTION J: Data Protection and Storage

	Does the research activity involve personal data (as defined by the General Data Protection Regulation 2016 "GDPR" and the Data Protection Act 2018 "DPA")?	YES	NO
1	<i>"Personal data" means any information relating to an identified or identifiable natural person ('data subject'). An identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person. Any video or audio recordings of participants is considered to be personal data.</i>	☒	☐
	If YES, provide a description of the data and explain why this data needs to be collected:		
2	Participants age and gender will be recorded as part of the descriptive data required in quantitative data analysis.		
	Does it involve special category data (as defined by the GDPR)?	YES	NO
3	<i>"Special category data" means sensitive personal data consisting of information as to the data subjects' – (a) racial or ethnic origin, (b) political opinions, (c) religious beliefs or other beliefs of a similar nature, (d) membership of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), (e) physical or mental health or condition, (f) sexual life, (g) genetics, (h) biometric data (as used for ID purposes),</i>	☐	☒
	If YES, provide a description of the special category data and explain why this data needs to be collected:		
4			

	Will data from the research activity (collected data, drafts of the thesis, or materials for publication) be stored in any of the following ways?	YES	NO
5	Manual files (i.e. in paper form)?	☐	☒
6	University computers?	☒	☐

7	Private company computers?	☐	☒
8	Home or other personal computers?	☐	☒
9	Laptop computers/ CDs/ Portable disk-drives/ memory sticks?	☒	☐
10	“Cloud” storage or websites?	☒	☐
11	Other – specify:	☐	☒
12	For all stored data, explain the measures in place to ensure the security of the data collected, data confidentiality, including details of backup procedures, password protection, encryption, anonymisation and pseudonymisation:		
	All data will be stored electronically, on the researchers university OneDrive account, which is password protected and encrypted. The Qualtrics data will be downloaded anonymously into SPSS and stored on the university OneDrive account.		

Data Protection			
	Will the research activity involve any of the following activities:	YES	NO
13	Electronic transfer of data in any form?	☒	☐
14	Sharing of data with others at the University outside of the immediate research team?	☐	☒
15	Sharing of data with other organisations?	☐	☒
16	Export of data outside the UK or importing of data from outside the UK?	☐	☒
17	Use of personal addresses, postcodes, faxes, emails or telephone numbers?	☐	☒
18	Publication of data that might allow identification of individuals?	☐	☒
19	Use of data management system?	☒	☐
20	Data archiving?	☐	☒
21	If YES to any question, please provide full details, explaining how this will be conducted in accordance with the GDPR and Data Protection Act (2018) (and any international equivalents, where appropriate):		
	All data collected will be stored anonymously in the researchers university Qualtrics account until such time that it is transferred electronically into SPSS in an anonymised format stored on the researchers university password protected OneDrive account.		
22	List all who will have access to the data generated by the research activity:		
	Stephanie Reynolds – Researcher Karen Eaton-Thomas – Dissertation Supervisor		
23	List who will have control of, and act as custodian(s) for, data generated by the research activity:		
	Stephanie Reynolds – Researcher		

24	Give details of data storage arrangements, including security measures in place to protect the data, where data will be stored, how long for, and in what form. Will data be archived – if so how and if not why not.		
	All data collected will be stored anonymously in the researcher's university Qualtrics account until such time that it is transferred electronically into SPSS in an anonymised format stored on the researchers university password protected OneDrive account, in line with the UWTSD Research data Management policy. Upon completion of the research project when finalised marks are obtained from the final exam board, all data obtained will be deleted. All data handling and storage will comply with UWTSD Research Data Management Policy.		
25	Please indicate if your data will be stored in the UWTSD Research Data Repository (see https://researchdata.uwtsd.ac.uk/). If so please explain. <i>(Most relevant to academic staff)</i>		
	N/A		
26	Confirm that you have read the UWTSD guidance on data management (see https://www.uwtsd.ac.uk/library/research-data-management/)	YES	☒
27	Confirm that you are aware that you need to keep all data until after your research has completed or the end of your funding	YES	☒

SECTION K: Declaration

	The information which I have provided is correct and complete to the best of my knowledge. I have attempted to identify any risks and issues related to the research activity and acknowledge my obligations and the rights of the participants. In submitting this application I hereby confirm that I undertake to ensure that the above named research activity will meet the University's Research Ethics and Integrity Code of Practice which is published on the website: https://www.uwtsd.ac.uk/research/research-ethics/		
1	Signature of applicant:	S. Reynolds	Date: 20/10/2024

For STUDENT Submissions:

2	Director of Studies/Supervisor:	Karen Eaton-Thomas	Date: 20.10.2024
3	Signature:	K.M. Eaton-Thomas.	

For STAFF Submissions:

4	Academic Director/ Assistant Dean:		Date:
5	Signature:		

Checklist: Please complete the checklist below to ensure that you have completed the form according to the guidelines and attached any required documentation:

☒	I have read the guidance notes supplied before completing the form.
☒	I have completed ALL RELEVANT sections of the form in full.
☒	I confirm that the research activity has received approval in principle
☐	I have attached a copy of final/interim approval from external organisation (where appropriate)
☐	I have attached a full risk assessment (where appropriate) ONLY TICK IF YOU HAVE ATTACHED A FULL RISK ASSESSMENT
☒	I understand that it is my responsibility to ensure that the above-named research activity will meet the University's Research Ethics and Integrity Code of Practice.
☒	I understand that before commencing data collection all documents aimed at respondents (including information sheets, consent forms, questionnaires, interview schedules etc.) must be confirmed by the DoS/Supervisor, module tutor or Academic Director.

RESEARCH STUDENTS ONLY

Once complete, submit this form via the **MyTSD Doctoral College Portal** at (<https://mytsd.uwtsd.ac.uk>).

RESEARCH STAFF ONLY

All communications relating to this application during its processing must be in writing and emailed to pgresearch@uwtsd.ac.uk , with the title 'Ethical Approval' followed by your name.

STUDENTS ON UNDERGRADUATE OR TAUGHT MASTERS PROGRAMMES should submit this form (and receive the outcome) via systems explained to you by the supervisor/module leader.

Appendix C – Study Information Form



Study Information Sheet

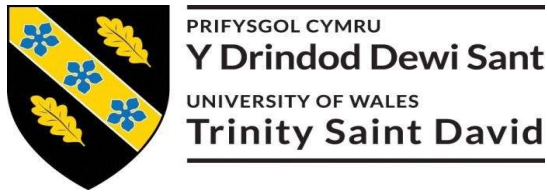
This document provides key information regarding the study and provides details about what will be expected of you as a participant. Therefore, please read this information carefully before providing consent to take part.

- This study aims to investigate knowledge, attitudes and beliefs around Schizophrenia via a mixed methods approach. You will be asked to complete a short qualitative questionnaire, then watch a short video and then answer the questions again, followed by some open-ended questions which requires you to free type your responses. It is asked that you give as much information as possible within these responses.
- It is advisable that you complete this study on a device that allows you to play audio and video or has subtitles to accompany the video.
- Due to this research involving a discussion about your attitudes and beliefs around Schizophrenia, therefore it is strongly advised that you do not take part if you are likely to be uncomfortable or affected by the subject area.
- This study should take approximately 20 minutes to complete.
- At the end of the study you will be provided with a study debrief form as well as the contact details of the principal researcher and dissertation supervisor, should you wish to discuss any issues further.

If you feel you want to leave the study, you can do so at any time by simply closing the browser. All responses are anonymised, so your data will only be identifiable to the researcher via a unique identification code. Once the study has ended, you will be asked if you want your data to be saved as part of the study. If you do not wish for your data to be used, please withdraw from the study.

If you are happy to take part in this study, please read and tick the consent form.

Appendix D – Study Consent Form



Study Consent Form

Please read the following statements and tick if you agree with them:

I understand that this research study is being carried out by a Level 6 Applied Psychology Student as part of their Psychology Empirical Project.

☐

I understand that taking part in this study will involve completing a quantitative questionnaire exploring Knowledge, perceptions and beliefs surrounding schizophrenia, as well as some brief qualitative (free text) questions.

☐

I understand that participation also includes viewing a short video vignette demonstrating living with a positive example of living with a schizophrenia diagnosis.

☐

I understand that his study will take approximately 15 minutes to complete.

☐

I understand that participation in this study is entirely voluntary, and I am free to withdraw participation at any point without giving a reason.

☐

I am aware that if I have concerns about the study, or any of the subject matter raised, I can discuss these concerns with the principal researcher or academic supervisor at any time during or after the study.

☐

I understand that the information provided by me will be held confidentially. This data will be stored in accordance with the University Data Protection Act.

O

I also understand that at the end of the study I will be provided with a debrief and the opportunity to discuss any issues with the principal researcher/academic supervisor.

O

Appendix E - Examples of quantitative questions

1. People with schizophrenia need the same kind of control and discipline as young children
2. One of the main causes of schizophrenia is lack of self-discipline and willpower
3. As soon as someone begins to show signs of schizophrenia, they should be hospitalised
4. Anyone with a history of schizophrenia should be excluded from public office
5. There is something about people with schizophrenia that makes it easy to tell them from normal people
6. The best way to handle people with schizophrenia is to keep them behind locked doors
7. People with schizophrenia should be isolated from the rest of the community
8. I would not want to live next door to someone with schizophrenia
9. Locating people with schizophrenia in residential neighbourhoods does not endanger local residents
10. It is frightening to think of someone with schizophrenia living in residential neighbourhoods
11. Residents have nothing to fear from people with schizophrenia coming into their neighbourhood to obtain mental health facilities
12. Having patients with schizophrenia living within residential neighbourhoods might be good therapy but the risks to the public are too great
13. Locating schizophrenia facilities near a residential area downgrades the area
14. Schizophrenia facilities should be kept well away from residential areas
15. Residents should accept schizophrenia facilities in their neighbourhood to serve the needs of the local community
16. No one has the right to exclude people with schizophrenia from their neighbourhood
17. We have a responsibility to provide the best possible care for people with schizophrenia
18. We need to adopt a far more tolerant attitude towards people with schizophrenia
19. People with schizophrenia don't deserve our sympathy

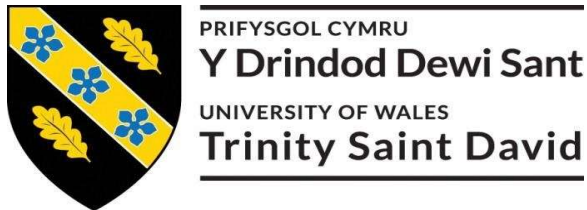
Appendix F - Link to YouTube video 'Schizophrenia in real life: Discover how Bethany succeeds at work.'

https://www.youtube.com/watch?v=kcTIFC_3Vrg

Appendix G - Example of qualitative questions

- 1) In as much detail as possible, please explain what you understand by the term schizophrenia?
- 2) If you had to use 3 words to describe someone with schizophrenia which words would you use?
- 3) Please describe what you know about the signs and symptoms of schizophrenia.
- 4) How would you feel if a relative or friend was diagnosed with schizophrenia and would this change how you approached and socialised with them? If so, why?
- 5) In your opinion, do you believe a person with schizophrenia is able to recover and live a 'normal life?'. Please explain why.

Appendix H - Study Debrief Form



School of Psychology
Carmarthen Campus
Carmarthen

Study Debrief Form

A mixed methods approach of University students' perceptions and beliefs surrounding schizophrenia before and after exposure to a positive example of living with schizophrenia.

Thank you for taking part in this study. The aim of this study was to explore your knowledge, perceptions and beliefs surrounding schizophrenia and whether your initial knowledge, beliefs and perceptions could be positively influenced following exposure to a positive example of living with a schizophrenia diagnosis. This study is based upon research that indicates that educating individuals about the positive elements of schizophrenia, can bring about a positive change in a persons perceptions and beliefs about the condition.

If you wish to withdraw your data from the study, you must inform the researcher now.

After this point, your data will be submitted and not be able to be traced back to you. Your responses will remain confidential and anonymous and will not be made available to any others apart from the principal researcher and the module lead.

Please feel free to take a note of the contact details below, should you need to contact either the researcher or the supervisor.

If taking part in this study has raised any questions, please contact the principal researcher - Stephanie Reynolds (2015091@student.uwtsd.ac.uk) - or the academic supervisor – Karen Eaton-Thomas (k.eatonthomas@uwtsd.ac.uk)

Thank you once again for taking the time to participate in this study.

Stephanie Reynolds

BSc Honours Applied Psychology

University of Wales Trinity Saint David, Carmarthen

Appendix I – Codes and representative colours from qualitative transcripts

Code	Colour
Education	Dark green
Depression	Teal
Positive perception	Dark grey
Negative perception	Maroon
Knowledge	Olive green
Feelings/Emotions	Dark purple
Causes	Light grey
Social isolation	Blue
Behavioural changes	Red
Lack of control	Lime green
Empathy	Pink text
Family/social support	Light blue text
Worry	Orange text
Symptoms of impaired cognitive function	Yellow
Positive attitude to treatment/recovery	Turquoise
Negative attitude to treatment/recovery	Light purple

Appendix J – SPSS raw data output**Within-Subjects
Factors**

Measure: MEASURE_1

factor1	Dependent Variable
1	Tot_attit1
2	Tot_attit2

Between-Subjects Factors

		Value Label	N
Please state your age group	4	4	14
	5	5	8
	6	6	9

Descriptive Statistics

	Please state your age group	Mean	Std. Deviation	N
total attitude 1	4	48.1429	5.24562	14
	5	54.7500	7.94175	8
	6	49.4444	3.43188	9
	Total	50.2258	6.11942	31
total attitude time 2	4	56.5714	5.34522	14
	5	57.7500	3.61544	8
	6	56.4444	2.92024	9
	Total	56.8387	4.24340	31

Multivariate Tests^a

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
factor1	Pillai's Trace	.770	93.860 ^b	1.000	28.000	<.001	.770
	Wilks' Lambda	.230	93.860 ^b	1.000	28.000	<.001	.770
	Hotelling's Trace	3.352	93.860 ^b	1.000	28.000	<.001	.770
	Roy's Largest Root	3.352	93.860 ^b	1.000	28.000	<.001	.770
factor1 * Q3	Pillai's Trace	.316	6.457 ^b	2.000	28.000	.005	.316
	Wilks' Lambda	.684	6.457 ^b	2.000	28.000	.005	.316
	Hotelling's Trace	.461	6.457 ^b	2.000	28.000	.005	.316
	Roy's Largest Root	.461	6.457 ^b	2.000	28.000	.005	.316

a. Design: Intercept + Q3
Within Subjects Design: factor1

b. Exact statistic

Mauchly's Test of Sphericity^a

Measure: MEASURE_1

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon ^b		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
factor1	1.000	.000	0	.	1.000	1.000	1.000

Tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is proportional to an identity matrix.

a. Design: Intercept + Q3
Within Subjects Design: factor1

b. May be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
factor1	Sphericity Assumed	552.144	1	552.144	93.860	<.001	.770
	Greenhouse-Geisser	552.144	1.000	552.144	93.860	<.001	.770
	Huynh-Feldt	552.144	1.000	552.144	93.860	<.001	.770
	Lower-bound	552.144	1.000	552.144	93.860	<.001	.770
factor1 * Q3	Sphericity Assumed	75.963	2	37.982	6.457	.005	.316
	Greenhouse-Geisser	75.963	2.000	37.982	6.457	.005	.316
	Huynh-Feldt	75.963	2.000	37.982	6.457	.005	.316
	Lower-bound	75.963	2.000	37.982	6.457	.005	.316
Error(factor1)	Sphericity Assumed	164.714	28	5.883			
	Greenhouse-Geisser	164.714	28.000	5.883			
	Huynh-Feldt	164.714	28.000	5.883			
	Lower-bound	164.714	28.000	5.883			

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	factor1	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
factor1	Linear	552.144	1	552.144	93.860	<.001	.770
factor1 * Q3	Linear	75.963	2	37.982	6.457	.005	.316
Error(factor1)	Linear	164.714	28	5.883			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	169727.140	1	169727.140	3772.094	<.001	.993
Q3	163.062	2	81.531	1.812	.182	.115
Error	1259.873	28	44.995			

Estimates

Measure: MEASURE_1

factor1	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
1	50.779	1.044	48.640	52.918
2	56.922	.805	55.273	58.571

Pairwise Comparisons

Measure: MEASURE_1

(I) factor1	(J) factor1	Mean Difference (I-J)	Std. Error	Sig. ^b	95% Confidence Interval for Difference ^b	
					Lower Bound	Upper Bound
1	2	-6.143 [*]	.634	<.001	-7.442	-4.844
2	1	6.143 [*]	.634	<.001	4.844	7.442

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Bonferroni.

Multivariate Tests

	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Pillai's trace	.770	93.860 ^a	1.000	28.000	<.001	.770
Wilks' lambda	.230	93.860 ^a	1.000	28.000	<.001	.770
Hotelling's trace	3.352	93.860 ^a	1.000	28.000	<.001	.770
Roy's largest root	3.352	93.860 ^a	1.000	28.000	<.001	.770

Each F tests the multivariate effect of factor1. These tests are based on the linearly independent pairwise comparisons among the estimated marginal means.

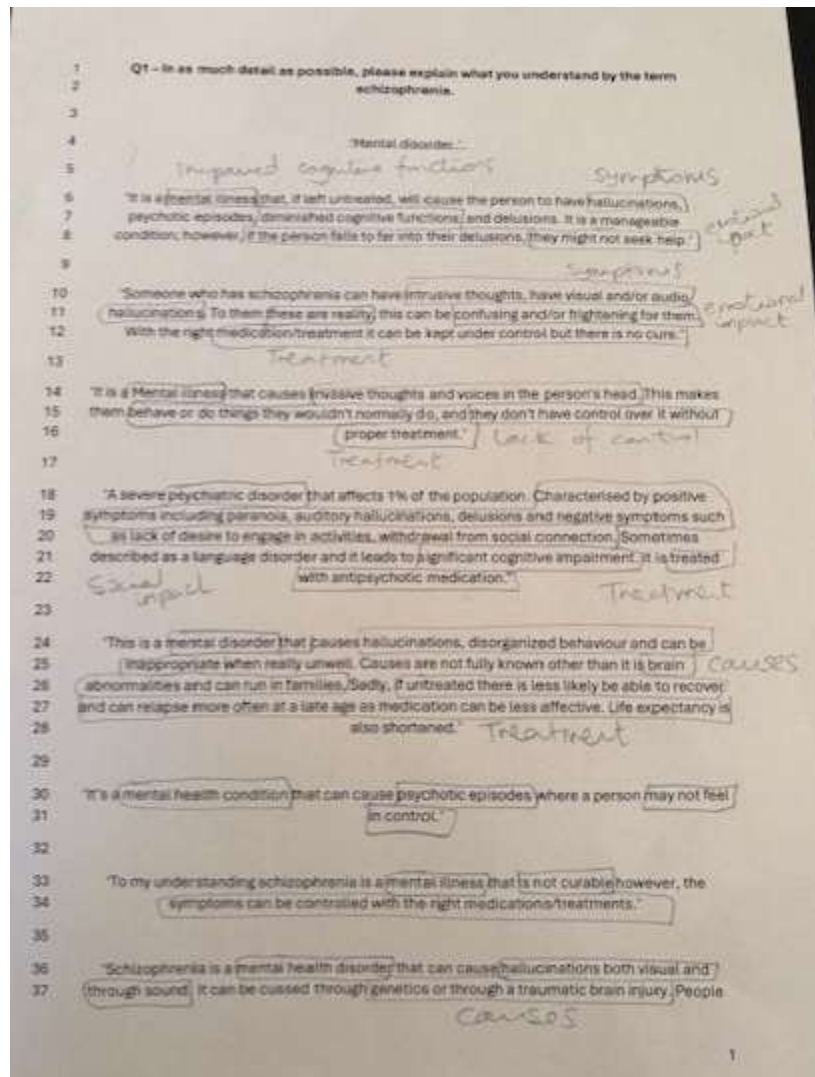
a. Exact statistic

2. Please state your age group * factor1

Measure: MEASURE_1

Please state your age group	factor1	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
4	1	48.143	1.510	45.050	51.235
	2	56.571	1.164	54.187	58.956
5	1	54.750	1.997	50.659	58.841
	2	57.750	1.540	54.596	60.904
6	1	49.444	1.883	45.587	53.301
	2	56.444	1.452	53.471	59.418

Appendix K – Annotated draft of qualitative transcripts.



Dependant on others

who suffer with schizophrenia normally cannot function as a normal member of society and require assistance and medication to keep all hallucination under control.

'I understand schizophrenia as a mental disorder.'

'Schizophrenia is a mental illness/disorder that influences a person's thoughts, feelings and behaviour. Research is still being conducted to determine a primary cause of the disorder, therefore there is no exact cause. However, researchers suggest that schizophrenia is caused by a chemical imbalance, particularly by an increased level of dopamine. Other researchers suggest that environmental factors play a role in an individual's likelihood of developing schizophrenia. Some frequent symptoms of schizophrenia include hallucinations, delusions, disorganised thinking and speech, and changes in mood. Schizophrenia impacts an individual's cognitive, motor and social abilities. An individual with schizophrenia may experience hallucinogenic thoughts whereby they hear or see things that are not observed by others, for instance, hearing voices. An individual with schizophrenia may experience feelings of paranoia, whereby they feel that certain people are against them or out to hurt them. The symptoms of schizophrenia can severely impact a person's mental and physical health, by causing them to isolate themselves from others and society (potentially from paranoia).'

causes

affects
social
abilities

Social impact

'A multiple personality disorder which can appear on the surface at any given time.'

'People that suffer from symptoms such as auditory and/or visual hallucinations, delusions, paranoia and other symptoms.'

'A mental health disorder in which people struggle with delusions and hallucinations.'

'An individual who suffers from schizophrenia suffers distortion in their thoughts, feelings and emotions, making it difficult to carry out normal day to day activities. People with this disorder may suffer auditory or visual delusions, but treatment helps to control these.'

'A mental health condition which involves hearing voices and believing unreal things.'

emotional

'People who have or have suffered with a mental illness which covers a wide range of hurt from voices in their head to not understanding those who love them and want the best for them.'

'A mental health condition where you see and hear things that aren't there.'

psychiatric disorder

74 "To experience auditory or visual hallucinations that change a person's perception of reality. It is
 75 different for everyone. *individual differences*

76

77 "It is a mental illness where there are voices inside your head which take over your thoughts
 78 and control you. It is a mental illness that can't be helped by just yourself, by either a type of
 79 therapy or (and) medication. *Treatment*

80 *lack of control*

81 "It is a mental illness that affects people's day to day lives and the way their mind thinks."

82

83 "It is a mental health condition that affects someone's thoughts and behaviour."

84

85 "Schizophrenia from my understanding is where a person has one or several voices in their head
 86 that is telling them to do things, things they may not necessarily want to do, but they can also
 87 be saying things in a bribing manner. 'If you don't do this then this will happen' etc."

88 *lack of control*

89 "Schizophrenia is a mental disorder that affects a person's thoughts, feelings and behaviours."

90 *Emotional impact*

91 "Schizophrenia is a mental health condition, it affects their reality, for example hearing voices."

92

93 "I've been looking after people with schizophrenia for the last 9 years which all live in residential
 94 areas. Its term use for people who need medication to help them."

95

96 "Schizophrenia is a mental health condition where you may see, hear or believe things that are
 97 not real." *distorted reality*

98

99 "Someone who hears voices and has hallucinations"

100

101 "Voices within your head, hallucinations that make you believe people are around you."

102

103 *Split personality*

104

105 "I understand that it is a mental illness or a neurological disorder. The lady in the video with
 106 schizophrenia surprised me as she was very normal. I know that isn't a particularly good way of
 107 putting it but basically if I did not know she had schizophrenia I would not have known she had

3

108 it. Back to the question I essentially thought it was similar to bipolar disorder but I thought it
 109 was more constant, as in individuals with schizophrenia did not have episodes but were more
 110 long term. Like in the video she said that in her exam she had a psychotic episode, initially I
 111 thought those episodes were more permanent lasting a lot longer. I imagine they do last more
 112 than exam length, but I originally thought that they were last months, years or forever.

113

114 Q2 - If you had to use 3 words to describe someone with schizophrenia, which words
 115 would you use?

116

117 "Paranoid, ill, issues."

118

119 "Confused, able, scared." *Emotional*

120 *Positive*

121 "Misunderstood, scared, normal." *Emotional*

122

123 "Not in control." *Lack of control*

124

125 "Unwell, confused, misunderstood."

126

127 "Fun, clever, spontaneous." *Positive*

128

129 "A person with mental health issue."

130

131 "Scared, misunderstood, and human."

132

133 "Non-lucid, unwell, venerable."

134

135 "Stigma, mental instability, distress."

136

137 "Misunderstood, misjudged, complicated."

138

139 "Human, unpredictable, and scared."

140

4

141	'Paranoid and mentally unwell.'
142	
143	'Mentally unwell and unpredictable.'
144	
145	'Vulnerable, confused, scared.'
146	
147	'Disorganised, paranoid and unsettled.'
148	
149	'Hurting, suffering in pain.' <i>Emotional</i>
150	
151	'Creative, strong, interesting.' <i>Positive</i>
152	
153	'BI, normal, intelligent.'
154	
155	'Misunderstood, human, complex'
156	
157	'Misunderstood, mistreated, vulnerable.'
158	
159	<i>Lack of control</i> 'Frightened, unsure, erratic (depending on a situation).'
160	
161	'Unpredictable, Dependant and complex'
162	
163	'Different brained people.'
164	
165	'Paranoid unkept'
166	
167	'Paranoid, confused, volatile.'
168	
169	'Scared. On edge.' <i>Emotional</i>
170	
171	'Unknowing, mental, voices.'

172 Confused upset hurting. Emotional

173

174 "Troubled, unfortunate, normal."

175

176 Q3 - Please describe what you know about the signs and symptoms of schizophrenia.

177

178 "Numbness, Paranoia."

179

180 "I know it starts around the early twenties and goes from subtle signs to the more serious ones.

181 These can be hallucinations, voices that only they can hear. It can also cause them to withdraw

182 from their family and friends. It affects cognitive processes, causes delusions, and even causes

183 abnormal motor behaviour."

184 Social impact

185 "Hallucinations, anxiety, depression, mania."

186 LOC

187 "Isolation, erratic behaviour, possibly psychotic bursts."

188

189 "Withdraws from social environments, lack of interest in usual activities, could display

190 disjointed movements, and disjointed language when speaking, struggling with cognitive tasks,

191 suffering from delusions/disorganised thought and having auditory hallucinations (hearing

192 voices)."

193

194 "Not acknowledging your presence, talking to someone that isn't there, self-harming, behaves

195 out of character and disorganised."

196

197 "Manic behaviour, person appears to be talking to themselves, withdraw, cannot sleep."

198

199 "Some of the signs and symptoms of schizophrenia are: visual hallucinations, hearing voices,

200 feeling confused, lack of interest in things they used to enjoy, paranoia, anxiety, and

201 depression."

202 Depression/Anxiety

203 "Anti-social behaviour, hallucinations both verbal and through sound."

204

205 "Numbness, paranoia, hallucinations."

6

- 206 'Hallucinations are a common symptom - refers to seeing, hearing, feeling something that
 207 appears to be real but only exists in the mind. Delusions are another frequent symptom - this is
 208 a firm belief in something that is untrue. This is often exhibited in an individual with
 209 schizophrenia through feelings of paranoia (thinking that they are being harmed or harassed
 210 when they are not). Confused thinking and speech occurs whereby a person experiences
 211 difficulty keeping track of their thoughts and conversations. Some people tend to drift from one
 212 idea to another due to difficulty concentrating. Signs include withdrawing from friends and
 213 family, having trouble sleeping, feeling frustrated or depressed and lacking motivation.' *Impaired Cognitive Function*
- 214 'I do not know any.' *Depression*
- 217 'Hearing and/or seeing things that are not there, paranoid thoughts, the believe that they are
 218 more important than they are (thoughts of grandeur) and self-isolation.'
- 220 'Visual and/or auditory hallucinations, delusions, scattered thinking and self-isolation.'
- 222 'Auditory or visual delusions, distorted thoughts, feelings and emotions, sceptical about the
 223 motives of others.' *Paranoid*
- 225 'Hallucinations, delusions, wanting to avoid family or friends, issues with thinking and cognitive/
 226 activity.' *Negative Cognitive Impact*
- 228 'Change of behaviours, possible dual personalities, screaming.'
- 230 'They hallucinate, delusions and hear voices.'
- 231 *Altered Behaviours* 'Auditory and/or visual hallucinations.'
- 234 'Change in personality, delusional, hallucinations.'
- 236 'I know that their brain processes information differently and they misunderstand situations.'
- 238 'Hallucinations, delusions, disorganized thinking.'

240 "Sometimes erratic behaviour. Person appears to be having a conversation / shouting with
 241 themselves. Sometimes rocking. On occasions there may not be any signs."

242

243 "Hallucinations and delusions."

244

245 "Hearing voices/hallucinations becoming unkept, as I've said above, I look after people with
 246 mental Health."

247

248 "I don't know much about this" *Lack of awareness /*
disorders

249

250 "It is a struggle"

251

252 "Talking to yourself."

253

254 "Confusion/lack of empathy" *Emotional impact*

255

256 "I thought schizophrenia was a long term or possibly permanent psychotic episode. Voices in
 257 their head, talking to themselves, uncontrolled compulsive behaviour."

258

259 **Q4 - How would you feel if a relative or friend was diagnosed with schizophrenia and would
 260 this change how you approached and socialised with them. If so, why?**

261

262 "I have a brother with this problem."

263

264 "Depends on how close they are to me. If it were my best friend or my child, I would definitely
 265 not change a thing apart from getting more educated around the topic. However, if I found out
 266 this about someone who is not in my daily life, I would not try to be involved more. I probably
 267 would feel like I don't know enough about the topic to get involved. Also, it depends on if they
 268 are under treatment, is that treatment working, etc."

269

270 "I would be concerned for them, as it's often the case for someone to stop taking medication
 271 when they feel well, this leads to the return of symptoms and there is such a stigma about this
 272 that I'd be worried others would avoid them. It wouldn't change how I interact with them as they
 273 are still themselves."

Social impact

See view them as 'normal'
Positive attitudes

Lack of awareness

Stigma taking medication

would not change their attitude towards people with Schiz.

274 Like if they would have been diagnosed with any other illness, and not wouldn't change my approach, maybe I will try to find more information to see how I could support better.

275

276 want to give more knowledge

277 I would feel concern and empathy that they are experiencing a difficult mental health disorder.

278 Yes, I would approach them with more care to ensure that they are comfortable in the social scenario but still aim to involve them as much as possible to encourage social interaction and be patient with them. But I would be wary not to worsen symptoms through over tiredness from doing too much.

279 Social inclusion

280

281 cautious

282

283 I would feel saddened knowing they are going through such a hard time and try and support them as much as I possibly can, I would still treat them the same because it is an illness that is out of their control.

284 want to help + support

285 lack of control

286

287 "No."

288 would not change their attitudes towards them

289 I would be concerned for them as it carries such a stigma and is something that must be hard to come to terms with. I don't feel like I would see them any differently so would not feel the need to approach and socialise with them in a way that I wasn't already doing so.

290

291

292

293 Yes, I would not want to do anything to trigger a psychotic episode.

294 cautious to avoid causing symptoms

295 I have a brother which have schizophrenia and since he been diagnostic the relation with him is easier for all my family.

296

297 Positive outcome, improved familial relationships.

298 This would not change how I socialised with them. They would still be treated with respect and kindness. However, I would educate myself about schizophrenia in particular, how to approach this new situation, to ensure that they are being treated appropriately for this new disorder as people with schizophrenia often require more patience and understanding, especially when recently diagnosed or when experiencing a difficult period of symptoms.

299 want more Education

300

301

302

303 want to treat the person with dignity

304 I would probably go up with caution to gather what state of mind they were in, before bringing my child closer to them. Then, if safe, carry on as normal. Still people.

305

306 Do not view them as any different / a threat.

307 I would probably see them less as I understand with schizophrenia can have good and bad times. I would feel worried for them and would want to find them the best help possible.

308 concerned but want them to get better

negative social inclusion

9

Empathy would want them to access to treatment/facilities

308 "I would feel sorry for them and want to get them the best care possible. (may change how)

310 than I see them as I understand people with schizophrenia can have good and bad times and

311 would not want to pressure them to be around people during a bad time."

312 *social isolation* *caution / consider*

313 "I have a brother who was diagnosed 12 years ago, exchanged his approach to him as a family

314 we all learned how to recognise and diffuse an episode, rather than blame situations on

315 behaviour and environmental factors, we understood it was actually a cognitive distortion" *positive impact of educating yourself on the disorder/symptoms*

316 *Education*

317 "If they were diagnosed it would not change the way I would think of them, I would be

318 sympathetic as I understand that the condition might lead to some differences at first in their

319 behaviour."

320

321 "Learn more about the condition and then look at for their particular symptoms and look up how

322 best to help support and guide them."

323 *Education*

324 "I would want to help them"

325 *Empathy*

326 "No, it would not change how I treated them."

327 *Empathy* *Social isolation* *would not change attitude towards them*

328 "I would feel sad as they may withdraw from our relationship, but I would want them to get the

329 help they needed as the voices and thoughts are very difficult to overcome."

330 *care / compassion*

331 "I would support the family member no matter what they were going through."

332

333 "Worried that they will be misunderstood and mistreated, and I would be more worried about

334 socializing with them as I wouldn't want to say the wrong thing and upset them."

335 *social isolation due to lack of education*

336 "This would not change my approach, my good friend's brother has schizophrenia, and I have

337 and will continue to socialise with him. Patience and understanding are needed on a bad day."

338 *Empathy Education*

339 "It would change how I approach that individual, I would be worried that I would say the

340 incorrect thing and create a complex situation"

341 *Apprehension* *worry*

342 "I would be supportive, offering help in the best way. No, because they are the same person I

343 know. They just need some professional guidance from doctors."

10

344

345 "No."

346

347 "I'd be sad for them as I would anyone with a mental health issue, however I'd like to think my

348 attitude towards them wouldn't change."

349

350 "I would be supportive."

351

352 "I would act the exact same around them, maybe with a little more caution."

353 *Maintain my attitudes*

354 "No"

355 *Empathy*

356 "I would feel sorry for them but that would not change my attitude toward them as a person.

357 During an episode I may would have to treat them differently but just keep an eye on them so

358 they don't do something they shouldn't."

359 *caution*

360 Q6 - In your opinion, is it possible for a person with schizophrenia to recover and live a

361 'normal life'? Please explain your answer.

362 *Treatment*

363 "In some way yes, but not recover just kept their issue under control with the medication."

364 *Recovery*

365 "It is, but not without help. Recover to an extent, yes, but I think it will always be in there and

366 their families and friends minds what happens if they get worse again. They can live a normal

367 life, but there will be loads of check-ins from others, maybe they won't leave alone. It kind of

368 depends on what we consider 'normal life'. If it means that everything goes back as it was, no. A

369 few normal, yes."

370 *social impact*

371 "I think it is possible to keep it 'under control' with medication but it is not possible to recover.

372 However, it is possible to live a normal life and do things that others do."

373 *Can live a near normal life*

374 "With a proper treatment and support, yes."

375 *Things essential to recovery*

376 "Yes, through a supportive community of friends and family, finding the right medical treatment

377 and therapist. It may take time but recovery and reaching life goals is possible."

the social / familial impact needed to aid recovery

11

pharmacological treatment

378

379 "Yes, this can be done if caught at a young age and the correct medication is used to help stabilise

380 the condition."

381

382 "Yes, as we saw in the video, it's an illness like any other that sometimes may or may not be

383 needed to be treated."

384

385 "I think that an individual with schizophrenia can recover and lead a 'normal life' due to the

386 medications and treatments that are available to control the symptoms. However, for some

387 when they begin to feel 'normal' they feel they do not need the medication anymore, so they

388 stop taking it."

389 non-compliance with medication; long term uses of

390 "Yes, through medication and therapy, a person can live a normal life."

391

392 "Yes, always when the person with schizophrenia follow their treatment."

393 viewing treatment as vital to recovery

394 "Yes, there are many treatments for people with a schizophrenia that make it easier for them to

395 deal with the symptoms and difficulties that occur with the disorder. Treatments include, drug

396 therapy, cognitive behavioural therapy (CBT), talking therapies - such as family therapies.

397 Antipsychotics are often used, which block the effect of the neurotransmitter dopamine. By

398 using a combination of talking therapies and drugs/medicine, this allows an individual with

399 schizophrenia to experience alleviated symptoms, therefore making their daily life much

400 easier."

401 combined therapies seen as effective

402 "Yes, they are still capable of everything. Support is key for individuals to live a full and satisfied

403 life."

404 family/social support

405 "Personally, I don't believe someone can be cured of schizophrenia. The best way I could

406 describe it is similar to addicts: in the sense an addict will always be a recovering addict/ex-

407 addict. Or with chronic illness they will never be cured from the illness, but they can manage

408 their illness."

409 expect relapses to happen, so must learn

410 in how to adapt + manage

411 "I believe schizophrenia is similar to chronic illness in that it can be managed but not cured."

412 "Yes, with the correct treatment, treatment needs to be consistent to encourage the motivation

413 to lead a normal life."

414 Individuals must be motivated to want to live a 'normal life' post diagnosis

Recovery

415 "I do think it is possible for a person with schizophrenia to recover with the correct treatment
416 and medication to enable them to live a 'normal life'."

417

418 "Yes, with the right help and support. This would be required throughout their lives."

419 *Good support is required long term basis*

420 "Yes, because the woman in the video did."

421 *individual differences*

422 "Yes, absolutely. Everyone's experience with schizophrenia is different and there is no reason
423 why someone couldn't lead a 'normal life' if medication and other support is available to
424 them."

425

426 "Yes, I believe they can have more of a normal life once they find the right treatment for their
427 condition."

428 *Personal response with the right help*

429 "Yes, I think that medications and therapies can help support and improve symptoms of
430 schizophrenia."

431

432 "Yes, with the correct treatment, this can reduce symptoms."

433

434 "Recovery is possible with a medication that works and is taken regularly. A normal life is most
435 certainly possible; however, the individuals also need to have a good support network."

436

437 "Not completely, but they can adapt to live a good life."

438

439 "Yes, from seeing that video it can be seen, medication can allow one to go back to being
440 themselves, even with challenges, they are strong and want to carry on living their life."

441 *Personal motivation to get better*

442 "Yes, long as their medication is right, and they don't stop taking it as then when they can
443 become unwell."

444 *medication non-compliance will have negative effect on*

445 "Yes. With the right treatment and combined therapies, a normal life is attainable and it's no
446 longer the "death sentence" it used to be."

447 *ability to live a 'normal life' recovery*

13

448 "I think so. Medication has come a long way and alongside therapy the person diagnosed can"
 449 live a normal life. I believe it's possible."

450 Yes, medication, hospitalisation/therapy *Social support or*
 451 *was an combined*
 452 *therapies vital*
 453 *to long term*
 454 *recovery*

455 "Maybe not a fully normal life but close to normal. This is due to the fact that a psychotic
 456 episode could occur at any time so then they would need help, I think it is just a fact of
 457 schizophrenia, they can live a close to normal but maybe just not completely "normal".

*uncertainty of what would trigger
 a psychotic episode would always make
 them vulnerable so therefore not fully
 able to live a 'normal life'.*

14

Appendix L – Colour coded draft of qualitative transcripts.

Q1 – In as much detail as possible, please explain what you understand by the term schizophrenia.

‘Mental disorder.’

‘It is a mental illness that, if left untreated, will cause the person to have hallucinations, psychotic episodes, diminished cognitive functions, and delusions. It is a manageable condition; however, if the person falls too far into their delusions, they might not seek help.’

‘Someone who has schizophrenia can have intrusive thoughts, have visual and/or audio hallucinations. To them these are reality, this can be confusing and/or frightening for them. With the right medication/treatment it can be kept under control but there is no cure.’

‘It is a Mental illness that causes invasive thoughts and voices in the person's head. This makes them behave or do things they wouldn't normally do, and they don't have control over it without proper treatment.’

‘A severe psychiatric disorder that affects 1% of the population. Characterised by positive symptoms including paranoia, auditory hallucinations, delusions and negative symptoms such as lack of desire to engage in activities, withdrawal from social connection. Sometimes described as a language disorder and it leads to significant cognitive impairment. It is treated with antipsychotic medication.’

‘This is a mental disorder that causes hallucinations, disorganized behaviour and can be inappropriate when really unwell. Causes are not fully known other than it is brain abnormality and can run in families. Sadly, if untreated there is less likely to be able to recover and can relapse more often at a late age as medication can be less effective. Life expectancy is also shortened.’

‘It's a mental health condition that can cause psychotic episodes where a person may not feel in control.’

‘To my understanding schizophrenia is a mental illness that is not curable however, the symptoms can be controlled with the right medications/treatments.’

‘Schizophrenia is a mental health disorder that can cause hallucinations both visual and through sound. It can be caused through genetics or through a traumatic brain injury. People who suffer with schizophrenia normally cannot function as a normal member of society and require assistance and medication to keep all hallucination under control.’

‘I understand schizophrenia as a mental disorder.’

‘Schizophrenia is a mental illness/disorder that influences a person's thoughts, feelings and behaviour. Research is still being conducted to determine a primary cause of the disorder, therefore there is no exact cause. However, researchers suggest that schizophrenia is caused by a chemical imbalance, particularly by an increased level of dopamine. Other researchers suggest that environmental factors play a role in an individual's likelihood of developing schizophrenia. Some frequent symptoms of schizophrenia include hallucinations, delusions, disorganised thinking and speech, and changes in mood. Schizophrenia impacts an individual's cognitive, motor and social abilities. An individual with schizophrenia may experience hallucinogenic thoughts whereby they hear or see things that are not observed by others, for instance, hearing voices. An individual with schizophrenia may experience feelings of paranoia, whereby they feel that certain people are against them or out to hurt them. The symptoms of schizophrenia can severely impact a person's mental and physical health, by causing them to isolate themselves from others and society (potentially from paranoia).

‘A multiple personality disorder which can appear on the surface at any given time.’

‘People that suffer from symptoms such as auditory and/ or visual hallucinations, delusions, paranoia and other symptoms.’

‘A mental health disorder in which people struggle with delusions and hallucinations.’

‘An individual who suffers from schizophrenia suffers distortion in their thoughts, feelings and emotions, making it difficult to carry out normal day to day activities. People with this disorder may suffer auditory or visual delusions, but treatment helps to control these.’

‘A mental health condition which involves hearing voices and believing unreal things.’

‘People who have or have suffered with a mental illness which covers a wide range of hurt from voices in their head to not understanding those who love them and want the best for them.’

‘A mental health condition where you see and hear things that aren't there.’

‘To experience auditory or visual hallucinations that change a person perception of reality. It is different for everyone.’

‘It is a mental illness, where there are voices inside your head which take over your thoughts and control you. It is a mental illness that can't be helped by just yourself, by either a type of therapy or/and medication.’

‘It is a mental illness that affects people's day to day lives and the way their mind thinks.’

‘It's a mental health condition that affects someone's thoughts and behaviour.’

‘Schizophrenia from my understanding is where a person has one or several voices in their head that is telling them to do things- things they may not necessarily want to do- but they can also be saying things in a bribing manner. “If you don't do this then this will happen” etc.’

‘Schizophrenia is a mental disorder that affects a person's thoughts, feelings and behaviours.’

‘Schizophrenia is a mental health condition. It effects their reality, for example hearing voices.’

‘I've been looking after people with schizophrenia for the last 9 years which all live in residential areas its term use for people who need medication to help them.’

‘Schizophrenia is a mental health condition where you may see, hear or believe things that are not real.’

‘Someone who hears voices and has hallucination.’

‘Voices within your head, hallucinations that make you believe people are around you.’

‘Split personality.’

‘I understand that it is a mental illness or a neurological disorder. The lady in the video with schizophrenia surprised me as she was very normal, I know that isn't a particularly good way of putting it but basically if I did not know she had schizophrenia I would not have known she had

it. Back to the question I essentially thought it was similar to bipolar disorder but I thought it was more constant, as in individuals with schizophrenia did not have episodes but were more long term. Like in the video she said that in her exam she had a psychotic episode, initially I thought those episodes were more permanent lasting a lot longer. I imagine they do last more than exam length, but I originally thought that they were last months, years or forever.'

Q2 – If you had to use 3 words to describe someone with schizophrenia, which words would you use?

'Paranoid, ill, issues.'

'Confused, able, scared.'

'Misunderstood, scared, normal.'

'Not in control.'

'Unwell, confused, misunderstood.'

'Fun, clever, spontaneous.'

'A person with mental health issue.'

'Scared, misunderstood, and human.'

'Non-lucid, unwell, venerable.'

'Stigma, mental instability, distress.'

'Misunderstood, misjudged, complicated.'

'Human, unpredictable, and scared.'

140 'Paranoid and mentally unwell.'

141

142 'Mentally unwell and unpredictable.'

143

144 'Vulnerable, confused, scared.'

145

146 'Disorganised, paranoid and unsettled.'

147

148 'Hurting, suffering, in pain.'

149

150 'Creative, strong, interesting.'

151

152 'Ill, normal, intelligent.'

153

154 'Misunderstood, human, complex'

155

156 'Misunderstood, mistreated, vulnerable.'

157

158 'Frightened, unsure, erratic (depending on a situation).'

159

160 'Unpredictable, Dependant and complex'

161

162 'Different brained people.'

163

164 'Paranoid unkept'

165

166 'Paranoid, confused, volatile.'

167

168 'Scared. On edge, Emotional'

169

170 'Unknowing, mental, voices.'

171 'Confused upset hurting.'

172
173 'Troubled, unfortunate, normal.'

174
175 **Q3 – Please describe what you know about the signs and symptoms of schizophrenia.**

176
177 'Numbness, Paranoia.'

178
179 'I know it starts around the early twenties and goes from subtle signs to the more serious ones.
180 These can be hallucinations, voices that only they can hear. It can also cause them to withdraw
181 from their family and friends. It affects cognitive processes, causes delusions, and even causes
182 abnormal motor behaviour.'

183
184 'Hallucinations, anxiety, depression, mania.'

185
186 'Isolation, erratic behaviour, possibly psychotic bursts.'

187
188 'Withdrawal from social environments, lack of interest in usual activities, could display
189 disjointed movements, and disjointed language when speaking, struggling with cognitive tasks,
190 suffering from delusional/disorganised thought and having auditory hallucinations (hearing
191 voices).'

192
193 'Not acknowledging your presence, talking to someone that isn't there, self-harming, behaves
194 out of character and disorganised.'

195
196 'Manic behaviour, person appears to be talking to themselves, withdraw, cannot sleep.'

197
198 'Some of the signs and symptoms of schizophrenia are: visual hallucinations, hearing voices,
199 feeling confused, lack of interest in things they used to enjoy, paranoia, anxiety, and
200 depression.'

201
202 'Anti-social behaviour hallucinations both verbal and through sound.'

203
204 'Numbness, paranoia, hallucinations.'

‘Hallucinations are a common symptom - refers to seeing, hearing, feeling something that appears to be real but only exists in the mind. Delusions are another frequent symptom - this is a firm belief in something that is untrue. This is often exhibited in an individual with schizophrenia through feelings of paranoia (thinking that they are being harmed or harassed when they are not). Confused thinking and speech occurs whereby a person experiences difficulty keeping track of their thoughts and conversations. Some people tend to drift from one idea to another due to difficulty concentrating. Signs include, withdrawing from friends and family, having trouble sleeping, feeling frustrated or depressed and lacking motivation.’

‘I do not know any.’

‘Hearing and/ or seeing things that are no there, paranoid thoughts, the believe that they are more important than they are (thoughts of grandeur) and self-isolation.’

‘Visual and/or auditory hallucinations, delusions, scattered thinking and self-isolation.’

‘Auditory or visual delusions, distorted thoughts, feelings and emotions, sceptical about the motives of others.’

‘Hallucinations, delusions, wanting to avoid family or friends, issues with thinking and cognitive activity.’

‘Change of behaviours, possible dual personalities, screaming.’

‘They hallucinate, delusions and hear voices.’

‘Auditory and/or visual hallucinations.’

‘Change in personality, delusional, hallucinations.’

‘I know that their brain processes information differently and they misunderstand situations.’

‘Hallucinations, delusions, disorganized thinking.’

239 'Sometimes erratic behaviour. Person appears to be having a conversation / shouting with
240 themselves. Sometimes rocking. On occasions there may not be any signs.'

241
242 'Hallucinations and delusions.'

243
244 'Hearing voices hallucinations becoming unkept, as I've said above, I look after people with
245 mental Health.'

246
247 'I don't know much about this'.

248
249 'It is a struggle'

250
251 'Talking to yourself.'

252
253 'Confusion lack of empathy'

254
255 'I though schizophrenia was a long term or possibly permanent psychotic episode. Voices in
256 their head, talking to themselves, uncontrolled compulsive behaviour.'

257
258 **Q4 – How would you feel if a relative or friend was diagnosed with schizophrenia and would**
259 **this change how you approached and socialised with them. If so, why?**

260
261 'I have a brother with this problem.'

262
263 'Depends on how close they are to me. If it were my best friend or my child, I would definitely
264 not change a thing apart from getting more educated around the topic. However, if I found out
265 this about someone who is not in my daily life, I would not try to be involved more. I probably
266 would feel like I don't know enough about the topic to get involved. Also, it depends on if they
267 are under treatment, is that treatment working, etc.'

268
269 'I would be concerned for them, as it's often the case for someone to stop taking medication
270 when they feel well, this leads to the return of symptoms and there is such a stigma about this
271 that I'd be worried others would avoid them. it wouldn't change how I interact with them as they
272 are still themselves.'

273 'Like if they would have been diagnosed with any other illness, and no I wouldn't change my
274 approach, maybe I will try to find more information to see how I could support better.'

275

276 'I would feel concern and empathy that they are experiencing a difficult mental health disorder.
277 Yes, I would approach them with more care to ensure that they are comfortable in the social
278 scenario but still aim to involve them as much as possible to encourage social interaction and
279 be patient with them. But I would be wary not to worsen symptoms through over tiredness from
280 doing too much.'

281

282 'I would feel saddened knowing they are going through such a hard time and try and support
283 them as much as i possibly can. i would still treat them the same because it is an illness that is
284 out of their control.'

285

286 'No.'

287

288 'I would be concerned for them as it carries such a stigma and is something that must be hard
289 to come to terms with. I don't feel like I would see them any differently so would not feel the
290 need to approach and socialise with them in a way that I wasn't already doing so.'

291

292 'Yes. I would not want to do anything to trigger a psychotic episode.'

293

294 'I have a brother which have schizophrenia and since he been diagnostic the relation with him is
295 easier for all my family.'

296

297 'This would not change how I socialised with them. They would still be treated with respect and
298 kindness. However, I would educate myself about schizophrenia, in particular', how to
299 approach this new situation, to ensure that they are being treated appropriately for this new
300 disorder as people with schizophrenia often require more patience and understanding,
301 especially when recently diagnosed or when experiencing a difficult period of symptoms.'

302

303 'I would probably go up with caution to gather what state of mind they were in, before bringing
304 my child closer to them. Then, if safe, carry on as normal. Still people.'

305

306 'I would probably see them less as i understand with schizophrenia can have good and bad
307 times. I would feel worried for them and would want to find them the best help possible.'

‘I would feel worried for them and want to get them the best care possible. I may change how often I see them as I understand people with schizophrenia can have good and bad times and I would not want to pressure them to be around people during a bad time.’

‘I have a brother who was diagnosed 12 years ago, it changed our approach to him as a family we all learned how to recognise and diffuse an episode, rather than blame situations on behavioural and environmental factors, we understood it was actually a cognitive distortion.’

‘If they were diagnosed it would not change the way I would think of them. I would be empathetic as I understand that the condition might lead to some differences at first in their behaviour.’

‘Learn more about the condition and then look at for their particular symptoms and look up how best to help support and guide them.’

‘I would want to help them’

‘No, it would not change how I treated them.’

‘I would feel sad as they may withdraw from our relationship. But I would want them to get the help they needed as the voices and thoughts are very difficult to overcome.’

‘I would support the family member no matter what they were going through.’

‘Worried that they will be misunderstood and mistreated, and I would be more worried about socializing with them as I wouldn’t want to say the wrong thing and upset them.’

‘This would not change my approach; my good friend’s brother has schizophrenia, and I have and will continue to socialise with him. Patience and understanding are needed on a bad day.’

‘It would change how I approach that individual, I would be worried that I would say the incorrect thing and create a complex situation’

‘I would be supportive, offering help in the best way. No, because they are the same person I know. They just need some professional guidance from doctors.’

343

344

‘No.’

345

346

‘I’d be sad for them as I would anyone with a mental health issue, however I’d like to think my attitude towards them wouldn’t change.’

347

348

349

‘I would be supportive.’

350

351

‘I would act the exact same around them, maybe with a little more caution.’

352

353

‘No’

354

355

‘I would feel sorry for them but that would not change my attitude toward them as a person.

356

During an episode I may would have to treat them differently but just keep an eye on them so they don't do something they shouldn't.’

357

358

359

Q5 – In your opinion, is it possible for a person with schizophrenia to recover and live a ‘normal life?’ Please explain your answer.

360

361

362

‘In some way yes, but not recover just kept their issue under control with the medication.’

363

364

‘It is, but not without help. Recover to an extent, yes, but I think it will always be in there and their families and friends' minds what happens if they get worse again. They can live a normal life, but there will be loads of check-ins from others; maybe they won't leave alone. It kind of depends on what we consider 'normal life'. If it means that everything goes back as it was, no. A new normal, yes.’

365

366

367

368

369

370

‘I think it is possible to keep it ‘under control’ with medication but it is not possible to recover.

371

However, it is possible to live a normal life and do things that others do.’

372

373

‘With a proper treatment and support, yes.’

374

375

‘Yes, through a supportive community of friends and family, finding the right medical treatment and therapist. It may take time but recovery and reaching life goals is possible.’

376

377

378 'Yes, this can be done if caught at a young age and the correct medication is used to help stable
379 the condition.'

380

381 'Yes, as we saw in the video, its an illness like any other that sometimes may or may not be
382 needed to be treated.'

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384 'I think that an individual with schizophrenia can recover and lead a 'normal life' due to the
385 medications and treatments that are available to control the symptoms. However, for some
386 when they begin to feel 'normal' they feel they do not need the medication anymore, so they
387 stop taking it.'

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389 'Yes. Through medication and therapy, A person can live a normal life.'

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391 'Yes, always when the person with schizophrenia follow their treatment.'

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393 'Yes. There are many treatments for people with schizophrenia that make it easier for them to
394 deal with the symptoms and difficulties that occur with the disorder. Treatments include, drug
395 therapy, cognitive behavioural therapy (CBT), talking therapies - such as family therapies.
396 Antipsychotics are often used, which block the effect of the neurotransmitter dopamine. By
397 using a combination of talking therapies and drugs/medicine, this allows an individual with
398 schizophrenia to experience alleviated symptoms, therefore making their daily life much
399 easier.'

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401 'Yes. They are still capable of everything. Support is key for individuals to live a full and satisfied
402 life.'

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405 describe it is similar to addicts; in the sense an addict will always be a recovering addict/ ex-
406 addict. Or with chronic illness they will never be cured from the illness, but they can manage
407 their illness.'

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409 'I believe schizophrenia is similar to chronic illness in that it can be managed but not cured.'

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411 'Yes- with the correct treatment. Treatment needs to be consistent to encourage the motivation
412 to lead a normal life.'

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414 'I do think it is possible for a person with schizophrenia to recover with the correct treatment
415 and medication to enable them to live a 'normal life.'

417 'Yes, with the right help and support This would be required throughout their lives.'

419 'Yes, because the woman in the video did.'

421 'Yes, absolutely. Everyone's experience with schizophrenia is different and there is no reason
422 why someone couldn't lead a "normal life" if medication and other support in available to
423 them.'

425 'Yes, I believe they can have more of a normal life once they find the right treatment for their
426 condition.'

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429 schizophrenia.'

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434 certainly possible; however, the individuals also need to have a good support network.'

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439 themselves, even with challenges, they are strong and want to carry on living their life.'

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442 become unwell.'

444 'Yes. With the right treatment and combined therapies, a normal life is attainable and it's no
445 longer the "death sentence" it used to be.'

447 'I think so. Medication has come a long way and alongside therapy the person diagnosed can
448 live a normal life. I believe it's possible."

449

450 'Yes, medication. hospitalisation/therapy.

451

452 'Yes, with guidance and the right support.'

453

454 'Maybe not a fully normal life but close to normal. This is due to the fact that a psychotic
455 episode could occur at any time so then they would need help. I think it is just a fact of
456 schizophrenia, they can live a close to normal but maybe just not completely "normal".

