ORIGINAL ARTICLE

Prospective cross-sectional study using questionnaire to assess the effect of a different nomenclature for psychiatric illnesses on the perception of these diseases by university students

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Objective To assess the effect of a difference in nomenclature for psychiatric illness on perceptions of university students.

Design Cross-sectional study.

Setting Three local universities in Hong Kong.

Participants A total of 201 university students (undergraduates or postgraduates) were interviewed with a questionnaire.

Main outcome measures Score difference between the new and old nomenclature of each disease for each question of the questionnaire, using a 5-point Likert scale and an integrated score difference for each disease.

Results Of the seven diseases investigated, six yielded a significant yet mild increase in positive perceptions with the new nomenclature. These diseases included schizophrenia (integrated score difference: +0.158, P<0.001), neurasthenia (integrated score difference: +0.117, P<0.001), paranoia (integrated score difference: +0.209, P<0.001), personality disorder (integrated score difference: +0.282, P<0.001), attention deficit hyperactivity disorder (integrated score difference: +0.086, P=0.005), and bipolar disorder (integrated score difference: +0.154, P<0.001). Epilepsy showed a negative perception with its new nomenclature (integrated score difference: -0.119, P<0.001).

Conclusions The new nomenclature system for psychiatric diseases achieves more positive perceptions among the university students than the old nomenclature. Epilepsy was the exception for which the old nomenclature conferred a more positive perception. Further studies on this topic involving a more general population should be advocated to confirm the improvements in perception with the new naming system for psychiatric diseases.

New knowledge added by this study

- Most of the new Chinese translations of psychiatric diseases resulted in improved perception.

Implications for clinical practice or policy

- This finding supports the implementation of the new Chinese translation of psychiatric diseases, provided further larger and more general studies are also supportive.

Key words
Hong Kong; Psychotic disorders; Stereotyping; Terminology as topic; Translating

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Introduction

Many citizens continue to exhibit significant stigmatisation and discrimination of patients with neuropsychiatric illness. Previous studies showed that to be labelled with such an illness could lead to bias in interpreting behaviour, discrimination in job applications, negative emotional responses, and rejection, all of which were associated with a damaged sense of self.[1]

To help these patients, it is essential to eliminate this stigma. Throughout the years, modified terminologies and new translations for different psychiatric illnesses have been made more popular by different authorities, probably in an attempt to reduce the labelling effect of older 'politically inappropriate' terms. However, the effectiveness of such measures has not been clearly observed or documented.

利用問卷形式探討精神病的不同命名對於大學生對精神病的看法的影響：前瞻性橫斷面研究

目的 探討精神病的不同命名對於大學生對精神病的看法的影響。

設計 橫斷面研究。

安排 香港其中的三間大學。

參與者 利用問卷訪問了201名大學生（本科生或研究生）。

主要結果測量 用李克特五點尺度量表及綜合分數差異，來計算每條問題所使用的新命名和舊命名的分數差異。

結果 研究的七種精神病中，有六種在使用新命名的情況下，受訪者對其觀感有輕微但顯著的改善。這六種病包括：思覺失調（綜合分數差異：+0.158，P<0.001）、情緒病（綜合分數差異：+0.117，P<0.001）、偏執症（綜合分數差異：+0.209，P<0.001）、解離性人格（綜合分數差異：+0.282，P<0.001）、專注力失調（綜合分數差異：+0.086，P=0.005）、和雙極性情感疾病（綜合分數差異：+0.154，P<0.001）。而腦癇症則在使用新命名的情況下產生較為負面的看法（綜合分數差異：-0.119，P<0.001）。

結論 與精神病的舊命名比較，大學生對於其新命名產生較為正面的看法。唯一的例外是腦癇症，大學生對於腦癇症的舊命名（癲癇症）有較為正面的看法。應把類似的研究推廣至一般市民，讓精神病的新命名能改善人們對精神病的看法得到確認。

Among relevant articles published, a few of them related directly to this locality,[2,3] while most were from the US.[4-7] Even the locally published articles presented little numerical data for interpretation, and very limited details concerning their settings and the interventions undertaken. One of them carried out by the Department of Psychiatry, The University of Hong Kong detailed information on perception, with their target population comprising mainly secondary school students.[2] It claimed that there have not been any attitudinal changes upon utilisation of the new term for schizophrenia. On the whole, however, most articles suggested that renaming of psychiatric disorders could have a positive effect on relieving social stigmatisation and labelling, as well as a possible reduction in the severity of patient stress related to discrimination.

This study aimed to assess the effectiveness of the new Chinese translation of psychiatric illnesses on public perceptions, so as to provide empirical data for further investigation (Table 1). We compared opinions and reactions to fictional situations involving psychiatric patients with regard to the traditional and new terminologies of these neuropsychiatric illnesses. We examined current university students because there have been little data on their attitudes towards individuals with neuropsychiatric illnesses. Moreover, neuropsychiatric illness starting in young adulthood is not uncommon. The new nomenclature often uses longer and more complicated terminology, which can be difficult for the general public to comprehend. To deal with this challenge, we targeted university students as they are expected to have a relatively higher level of education than the general public and more likely to comprehend the wording of the new nomenclature. Outcomes from this study were therefore expected to provide a rationale to either support or contest the value of the new nomenclature of psychiatric illness as a means of reducing social stigma towards patients.

Methods

Subjects

In the first half of 2011, students from three local universities (The University of Hong Kong, The Chinese University of Hong Kong, and The Hong Kong University of Science and Technology) were asked to respond to a questionnaire. Recruitment was by convenience sampling and entailed distributing the questionnaires in canteens, outside libraries, and other public areas. The subjects included undergraduates and postgraduates from all faculties. All of these voluntary participants signed an informed consent form. The sample size was not estimated prior to conducting the study. Data from all 201 participating university students were used in the analysis. The

TABLE 1. Terminologies investigated

Disease entity	Old nomenclature	New nomenclature
Schizophrenia	精神分裂 Jing Shen Fen Lie	思覺失調 Si Jue Shi Tiao
Neurasthenia	神經衰弱 Shen Jing Shuai Ruo	情緒病 Qing Xu Bing
Epilepsy	癲癇症 Dian Xian Zheng	腦癇症 Nao Xian Zheng
Paranoia	妄想症 Wang Xiang Zheng	偏執症 Pian Zhi Zheng
Personality disorder	人格分裂 Ren Ge Fen Lie	解離性人格 Jie Li Xing Ren Ge
Attention deficit hyperactivity disorder	過度活躍症 Guo Do Huo Yue Zheng	專注力失調 Zhuan Zhu Li Shi Tiao
Bipolar disorder	躁狂抑鬱症 Cao Kuang Yi Yu Zheng	雙極性情感疾病 Shuang Ji Xing Qing Gan Ji Bing

only inclusion criterion was that the subject had to be a current university student. Inability to comprehend written or spoken Cantonese, Mandarin, or English was the only exclusion criterion.

Procedures

We made clear that the participation was voluntary and anonymous, and irrespective of whether they might or might not have had prior formal teaching on mental health. We explained that the purpose of this study was to assess the effectiveness of a new Chinese translation of psychiatric illnesses on public perception. All subjects were tested separately and individually in their respective campuses. We allowed adequate time for completion of the questionnaire (Appendix) without any information or comments on individual mental illnesses. Respondents were asked to provide their gender, age, faculty, whether they were local or overseas students, and religion. The questionnaire asked if the respondents had been diagnosed with any types of mental disorders, whether they had family or peers who had been exposed to any specified or unspecified psychiatric illness. The subjects were also asked about any prior formal introduction and understanding of psychiatric diseases. All of the participants filled in the same bilingual (Chinese and English) questionnaire; no explanation of the terms used was given on the questionnaire.

Dependent measures

We used the following dependent measures: overall impression; acceptance in peer group or neighbourhood and in workplace; perception of mental illnesses in terms of being easy to get along with; predictability; tendency to harm others; likelihood of symptom control by treatment; and the chance of a full recovery. The participants used a 5-point Likert scale, with 1 being 'very negative' and 5 being 'very positive'. Scores in questions 5 to 7 (Appendix) were reversed to reflect the Likert scale, and indicated attitudes towards various mental and neuropsychiatric illnesses named with new and old terms mixed randomly by means of a random number table. Greater acceptance (less stigmatisation) in a peer group or neighbourhood and in the workplace was indicated by a more positive overall impression, greater acceptance, and more positive perceptions towards a named disease in terms of ease of getting along with, predictability, tendency to harm others, control of symptoms by treatment, and the likelihood of a full recovery. In each question, the difference in scores between the new and the old term for each disease was calculated for each subject. The differences in scores of questions in the same category (overall impression, stigmatisation and social distance, and attitudes and thoughts) were averaged for each disease. The higher the positive score, the better the impression towards the new term, while a negative value indicated that the old term received a more positive impression.

An integrated score for each disease was derived by averaging the score differences for all questions on each disease to give a general impression on the effect of the new term on the perception of the respective disease.

We categorised the diseases into two large groups, namely: behavioural (including attention deficit hyperactivity disorder [ADHD], epilepsy, and personality disorders) and psychological (including schizophrenia, neurasthenia, paranoia, and bipolar disorders). The basis of such a classification was that for behavioural diseases, the symptoms are enacted out externally in a prominent feature. On the other hand, psychological diseases tend to feature the mind and thinking disturbance. For the two disease categories, the differences between the final score of in each group were also calculated by averaging the integrated individual scores.

The influence of demographic factors (including gender, whether participants were local students, and had relatives or friends with psychiatric diseases) on the scores was also examined.

Statistical analysis

All statistical analysis was performed using the Statistical Package for the Social Sciences (Windows version 20.0; SPSS Inc, Chicago [IL], US). We used paired *t* tests to compare the differences in: (1) scores for each disease in each category (overall impression, stigmatisation and social distance, and attitudes and thoughts), and (2) integrated scores of each disease. For the final scores in the two disease categories (behavioural and psychological), paired *t* tests were used. Independent sample *t* tests were used to examine differences with respect to demographic factors, namely: gender, local versus overseas, and family and peer exposures to psychiatric illnesses. Results were considered significant if the P value was less than 0.05.

Results

The demographics of the respondents are shown in Table 2. The overall impression of the persons with these psychiatric diseases improved using the new terms. This was indicated by the significant positive mean difference in scores in six out of the seven diseases (Table 3a). Yet for epilepsy, there was a negative mean difference in score (-0.080), meaning that the overall impression of people with epilepsy was more negative using the new term. That result, however, did not attain statistical significance (P=0.167).

TABLE 2. Subject demographics (n=201)

Demographics*	No. (%) of patients†
Mean age ± standard deviation (range) in years (n=198)	21.1 ± 2.1 (17-31)
Gender (n=200)	
Male	122 (61.0)
Female	78 (39.0)
Faculty (n=197)	
Architecture	9 (4.6)
Arts	39 (19.8)
Business	39 (19.8)
Dentistry	6 (3.0)
Education	5 (2.5)
Engineering	23 (11.7)
Law	11 (5.6)
Medicine and nursing	11 (5.6)
Science	32 (16.2)
Social work	20 (10.2)
Others	2 (1.0)
Local student or not (n=166)	
Local	139 (83.7)
Non-local	27 (16.3)
Religion (n=200)	
Yes	92 (46.0)
Christianity	51 (25.5)
Catholic	14 (7.0)
Buddhism	3 (1.5)
Others, not specified	24 (12.0)
No	98 (49.0)
Not sure	10 (5.0)
History of psychiatric or mental disease(s) [n=201]	
Yes	1 (0.5)
No	199 (99.5)
Family members, relatives or friends having psychiatric or mental disease(s) [n=201]	
Yes	58 (28.9)
No	143 (71.1)
Frequency of attending information sessions about psychiatric diseases (n=201)	
Quite often	14 (7.0)
Sometimes	18 (9.0)
Occasionally	10 (5.0)
Nearly never	53 (26.5)
Never	105 (52.5)
Self-perception of knowledge about psychiatric diseases (n=201)	
Very good	9 (4.5)
Good	26 (12.9)
Satisfactory	60 (29.9)
Not quite	72 (35.8)
Poor	34 (16.9)

* Differences in numbers of patients reflect missing data
† Unless otherwise indicated

Concerning stigmatisation and social distance, the results for schizophrenia and ADHD did not attain significance (Table 3b). There were mean score increases (0.106 to 0.294) which were significant for most of the diseases mentioned, meaning that using the new terms made people more willing to interact and work with patients who had recovered from the stipulated diseases. However, there was a significant negative mean difference noted for epilepsy (-0.137; P=0.001), meaning that using the new term made people less willing to interact and work with persons suffering from or who previously suffered from epilepsy.

Concerning attitudes and thoughts towards

these patients, all the results showed a significant P value, with an overall positive mean difference ranging from 0.094 to 0.279, except for epilepsy, which showed a negative mean difference of -0.110 (Table 3c). Thus, in general, the new terms caused people to have a more positive attitude towards persons diagnosed with or who had recovered from these psychiatric diseases.

According to Table 4, the overall results showed a significant positive mean difference in score for the majority of diseases, ranging from 0.086 to 0.282. Specifically, the least improvement in the integrated mean difference score of the new as opposed to the old term was for ADHD (0.086), while the most improvement was for personality disorder, with an average difference of 0.282 across all three aspects investigated (Table 4). Again, epilepsy was the only entity with a significant negative score for the new term (-0.119).

When comparing the difference in integrated scores in the two categories of psychiatric diseases, there was a significant mean score difference of -0.059 (95% confidence interval [CI], -0.098 to -0.020; P=0.003), indicating that the new terms used in the behavioural group had attained less gain in terms of positive perceptions compared to the psychological group (Table 5).

We found that male respondents had a larger mean score difference with respect to the personality disorder term than female interviewees; the net difference was 0.148 (95% CI, 0.023-0.273; P=0.02), meaning a better gain in positive perceptions with the new terms in males than females. Local students also manifested a better increase in perceptions than the non-local students with the new nomenclature on personality disorder, with a mean score difference of 0.324 (95% CI, 0.136-0.512; P=0.001); the magnitude of the difference was large since the mean score of the former was 0.355 while that among non-local students was 0.031. For all other diseases, male and local students tended to have higher mean score differences than the females and non-local students, indicated by positive values, though such differences were not statistically significant.

There was no significant difference in mean scores in subjects having relatives or friends with psychiatric diseases, compared to those who did not.

Discussion

Previous studies mainly compared old and new terms for schizophrenia, and indicated that there was no significant difference in attitudes after renaming the old term.[2,6] In our study, however, there was significant improvement in impressions and attitudes towards patients described with the new term "Si Jue

TABLE 3. (a) Overall impression (Q 5). (b) Stigmatisation and social distance (Q 6, 7). (c) Attitudes and thoughts (Q 8a-e)

The choices are transformed into a numerical score for data interpretation, ranging from score 1 to 5; higher scores indicate better overall impressions. The mean values of new terms were subtracted from the old term mean score to achieve a final score difference. The higher the positive difference, the better the impression towards the new term. The range of this value was -4 to 4.

(a)

Disease	Mean difference in score	95% Confidence interval	P value (paired *t* test)
Schizophrenia	0.134	0.019 to 0.250	0.023
Neurasthenia	0.149	0.031 to 0.267	0.013
Epilepsy	-0.080	-0.195 to 0.034	0.167
Paranoia	0.209	0.095 to 0.323	<0.001
Personality disorder	0.250	0.126 to 0.374	<0.001
ADHD*	0.214	0.097 to 0.331	<0.001
Bipolar	0.230	0.108 to 0.352	<0.001

(b)

Disease	Mean difference in score	95% Confidence interval	P value (paired *t* test)
Schizophrenia	0.063	-0.017 to 0.142	0.121
Neurasthenia	0.106	0.016 to 0.196	0.021
Epilepsy	-0.137	-0.221 to -0.053	0.001
Paranoia	0.221	0.138 to 0.304	<0.001
Personality disorder	0.294	0.211 to 0.377	<0.001
ADHD*	0.028	-0.063 to 0.118	0.549
Bipolar	0.229	0.140 to 0.317	<0.001

(c)

Disease	Mean difference in score	95% Confidence interval	P value (paired *t* test)
Schizophrenia	0.202	0.136 to 0.268	<0.001
Neurasthenia	0.107	0.039 to 0.175	0.002
Epilepsy	-0.110	-0.170 to -0.051	<0.001
Paranoia	0.200	0.129 to 0.271	<0.001
Personality disorder	0.279	0.205 to 0.353	<0.001
ADHD*	0.094	0.022 to 0.165	0.011
Bipolar	0.111	0.050 to 0.172	<0.001

* ADHD denotes attention deficit hyperactivity disorder

TABLE 4. Integrated score difference between new term versus old term

Disease	Mean difference in score	95% Confidence interval	P value (paired *t* test)
Schizophrenia	0.158	0.101 to 0.215	<0.001
Neurasthenia	0.117	0.056 to 0.177	<0.001
Epilepsy	-0.119	-0.168 to -0.070	<0.001
Paranoia	0.209	0.151 to 0.268	<0.001
Personality disorder	0.282	0.220 to 0.344	<0.001
ADHD*	0.086	0.026 to 0.145	0.005
Bipolar	0.154	0.096 to 0.212	<0.001

* ADHD denotes attention deficit hyperactivity disorder

TABLE 5. Comparison of differences between two disease categories: behavioural (attention deficit hyperactivity disorder, epilepsy, and personality disorder) and psychological (schizophrenia, neurasthenia, bipolar, and paranoia) for the final mean score difference between the new and old terms (n=166)

Disease category	Mean gain in score	Standard deviation	
Behavioural group (new minus old)	0.104	0.221	
Psychological group (new minus old)	0.163	0.233	
	Mean score difference*	**95% CI**	**P value**
Difference in mean total score between the behavioural and psychological diseases group	-0.059	-0.098 to -0.020	0.003

* The score difference is calculated by using the mean gain in score of the behavioural group diseases to subtract the mean value in the psychological group. A positive value indicates that the new term in behavioural group is achieving a greater gain of positive impression than the psychological group. However, the score only evaluates the difference in new term versus old term, but not representing the true impression to the disease itself. A higher score did not indicate a final better impression

Shi Tiao" (思覺失調). This was consistent with other publications,[3,5] which also supported renaming of the nomenclature, although most of them lacked numerical comparisons. This result was consistent with our hypothesis, that newer and more neutral terms can reduce negative public perceptions, although our study failed to prove that it can reduce stigmatisation and social distancing. This may be due to our small sample size, but could also indicate that improved perception does not necessarily result in a reduced stigmatisation. Another example was ADHD, for which there was a very high score in overall impression using the new terminology, but no significant difference in stigmatisation. This was probably because the overall impression included much more than just stigmatisation. Overall impressions may be worse if the patients are perceived to do harm to the public and obviously, ADHD patients are very unlikely to jeopardise the safety of others. 'Difference' is the key for stigmatisation to arise, and inevitably, interviewees recognise the difference between ADHD patients and the general public.

A new Chinese term for epilepsy "Nao Xian Zheng" (腦癇症) was recently adopted in the year 2010 to substitute for the old term "Dian Xian Zheng" (癲癇症),[8] with a view to reduce patient stigmatisation by the public. This was because many people misinterpreted the psychiatric disease due to the word "Dian" (癲), which carries a meaning akin to psychosis or craziness in Chinese. In our study, however, the new nomenclature was associated with significantly more stigmatisation and negative attitudes than the old term. The overall impression was also poorer although the difference was not statistically significant. This was an unexpected finding, and not documented before. One possible explanation was that most university students were familiar with the old term for epilepsy, and more importantly, their impression of the old term was sympathetic compared to that for other diseases. Moreover, they might not have noticed or heard of the new term. Uncertainty due to the new term might have caused a less desirable response.

There was also a significant negative mean difference in scores for epilepsy in the area of stigmatisation and social distance (Table 3b) and attitudes and thoughts (Table 3c), which suggests the new term may cause more stigmatisation and negative perceptions in the public. However, the score for overall impression was not conclusive enough to show a disadvantage with the new term. Nevertheless, by looking at the integrated score, it supports a weakness in the new term for epilepsy.

Notably, ADHD also attained lower mean difference scores in the other two aspects when compared to the score for overall impression (Table 3a). This suggests possible improvement with the new term in other areas of perception not investigated in this study.

Concerning our secondary objectives, we found a significantly better score difference for the psychological than the behavioural disease categories. However, this finding might not be applicable to diseases outside our study that also belonged to the latter group, since the phenomenon may be partly due to the effect on epilepsy (the only disease with a negative score difference among behavioural diseases). On the other hand, personality disorder, with the highest mean score, was also classified as behavioural disorder. With few sample diseases in each group, and large score discrepancies between individual diseases, it appears inappropriate to infer that psychological disorders benefit more than behavioural disorder from the new nomenclature.

Other independent variables were originally included for comparison, based on the hypothesis that they could potentially affect the results. For example, female gender may be more sensitive to wordings, non-local students could be less welcoming or accepting of unfamiliar or new terminologies, or that subjects with relatives or friends with psychiatric disease might have a stronger reaction to re-nomenclature aimed at making the disease sound more neutral. In our study, we found that male students had insignificantly

better acceptance towards the new terms than their female counterparts, which was only significant for personality disorder. This may be due to the small sample size. The isolated significant difference of the term personality disorder could also be explained by its high baseline score difference (as shown in Table 3) causing the gender difference to be more easily detected. This may also explain the results for local versus non-local students. Non-local students may be less familiar with the psychiatric terms currently used in Hong Kong, causing a generally less marked impact (difference). Further study with a larger sample may confirm this hypothesis. That males tended to have better perception of changes in the new terms than females should also be investigated further in a larger study. Students having relatives or friends with psychiatric diseases showed no difference towards the new terms compared to those who did not. Thus, knowing someone with such a disease may not necessarily alter perception of the name of the disease, but a larger sample size may be needed to resolve this issue.

One limitation of this study was that our subjects consisted solely of university students recruited by convenience sampling. It was also difficult to include a more random sample, as there was no practical way to gain access to all students. The demographics in our study population of students from each faculty or their religious beliefs may not reflect the situation in society as a whole, and thus our findings may not be applicable to the general public. Another limitation was that responding to the questionnaire was in public areas, where candidates may not give their true answers to some of the questions, especially those on personal history of psychiatric diseases. Ideally, candidates should answer the questionnaire in private, but due to limited resources, this could not be achieved. While filling in the questionnaire, our staff tried to ensure that the environment was reasonably comfortable for the candidates. Other limitations included the persistence of stigmatisation after the new terms were implemented. This study only compared the effect of a single new term with the old term of each disease. Although the new terms may be better than the old terms as shown in most parts of this study, there may still be misunderstandings and stigmatisation. Other new terms for these diseases, which were not fully explored in this study, might have resulted in different perceptions.

That some terms were appeared to be better than the old terminology may also have been due to their novelty. Diseases like schizophrenia get stigmatised not because of the particular name given, but because of the behaviour of those who get stigmatised. Changing a name may work for a short period, once people notice that the new term "Shi Jue Shi Tiao" (思覺失調) is implying the disease 'schizophrenia', they may revert to former expectations.

Conclusions

With the new naming system, this study found statistically significant improved perception of a number of diseases, namely: schizophrenia, neurasthenia, paranoia, personality disorder, ADHD, and bipolar disorder. Aspects of improvement included the overall impression, stigmatisation and social distancing, and attitudes and thoughts. On the other hand, epilepsy was the only entity that showed a poorer response. In general, this study favours changing the nomenclature of psychiatric diseases to the new system. However, its results may not be clinically significant and should not be used as the sole reason to support or deny the name changes. In this regard, influence by the media and the selective nature of our subjects must be appreciated. Possible improved perception associated with the new nomenclatures should be further investigated by recruiting subjects from the general public.

Appendix

Additional material related to this article can be found on the HKMJ website. Please go to <http://www.hkmj.org>, search for the appropriate article, and click on **Full Article in PDF** following the title.

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APPENDIX

Questionnaire on the perception of University Students towards different nomenclature of Psychiatric or related illness
問卷調查：有關大學生對不同精神科疾病名稱的看法

We are a group of HKU year 3 medical students working on a health research project on university students' perception of different nomenclatures of psychiatric or their related illness. You are being invited to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

We would like to ask you a few questions on the topic, and would like you to give your response according to your direct perception and impression on just the name of the psychiatric diseases (in which only the Chinese terminology is given). As we are assessing the effects of nomenclatures, no details or explanation of the stated terms will be given.

The questionnaire is anonymous and all information collected will only be used in this study, be kept confidential and be destroyed afterwards.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form, which will be collected separately form the questionnaire. If you decide to take part you are still free to withdraw at any time during the interview or refuse to answer any question without giving a reason, if you find it uncomfortable. If you decide to take part in this study, please kindly answer the following questions. Thank you very much.

我們是香港大學三年級醫學生，正在進行一項有關大學生對不同精神科或相關疾病名稱看法的健康研究計劃。在訪問進行之前，希望你先瞭解一下本次調查的目的。請仔細考慮是否答應參與是次訪問。如想瞭解更多資料，請隨時發問。

我們希望能夠借用你幾分鐘的時間進行訪問，瞭解你對不同精神疾病的印象和看法。由於是次訪問旨在研究各位對不同精神病名的直接印象，因此只會列出不同精神病的名稱，不會提供解釋或詳請。

是次問卷是匿名的，所有收集的資料將只用於在此研究中，絕對保密，並於完成研究後予以銷毀。

問卷調查完全屬於自願性質。如果你決定參加，請簽署同意書，同意書會和問卷分開收集，確保問卷不記名。即使您決定參加，你仍然可以不需提供任何理由的情況下，隨時退出或拒絕回答任何問題。如果你同意接受任何訪問，請回答下列問題，感謝您的參與！

Contact information:
Jerome Lau
Email: lauj@hku.hk

Date: 22 – 02 - 2011
Before the interview, make sure the patient fulfill the criteria of

- Aged 18 or above
- University students in Hong Kong
- Able to understand and comprehend written or oral Chinese/Mandarin

(People with insufficient knowledge in Chinese to properly understand the questionnaire will be excluded from the study)

(Demographic factors:)

Gender 性別	Male ☐ Female ☐
Age 年齡	_____
Faculty: 學系	Architecture ☐ Arts ☐ Business & Economics ☐ Dentistry ☐ Education ☐ Engineering ☐ Law ☐ Medicine and Nursing ☐ Science ☐ Social Sciences ☐ Others _____
	Yes ☐ No ☐
Local Student 是否本地學生	Yes ☐ No ☐ Not sure ☐
Religion 宗教	**If yes:** Christianity基督教 ☐ Catholic 天主教 ☐ Buddhism 佛教 ☐ Others: _____ (Specify)

APPENDIX (Cont'd)

- The following is the list of nomenclature corresponding to different psychiatric / related disorder that will include in the questionnaire.
- The order of the list is randomised, and during the interview, attempts will be made not to let the interviewees to know that we include both the new terms and old nomenclature, which represent the same disease. We will also avoid giving any hints to the nomenclature in order to minimise bias and to better assess the direct perception and impression of the terminology.
- Discussion was held and consensus was reached among investigators beforehand to ensure the style is uniform and standardised.
- The terms used are shown below, with the new nomenclatures shown in bold.
  精神分裂=**思覺失調**，神經衰弱=**情緒病**，妄想症=**偏執症**，人格分裂=**解離性人格**，癲癇症=**腦癇症**，躁狂抑鬱症=**雙極性情感疾病**，過度活躍症=**專注力失調**

1. Have you ever diagnosed with any types of mental disorder or psychiatric disease?
   你是否曾確診患有任何情緒或精神病？
   Yes 有 ☐ No 沒有 ☐
2. Do you know any family member, relative or friends having psychiatric disease?
   你所認識的家人，親戚或朋友當中，有沒有曾經被診斷患有精神病？
   Yes 有 ☐ No 沒有 ☐
3. Have you ever attended any talks, lecture or demonstration (such as Mental Health First Aid class) that help you to have a better understanding of different psychiatric disease?
   你曾否上過有關介紹精神病的課程，講座或展覽？例如精神健康急救課程？
   Quite often 時常 ☐ Sometimes 有時 ☐ Occasionally 間中 ☐ Nearly never 幾乎沒有 ☐ Never 從來沒有 ☐
4. How much do you rate yourself on your knowledge about different mental or psychiatric disorder?
   你認為自己對不同情緒或精神病的認識有多少？
   Very good十分認識 ☐ Good 認識 ☐ Satisfactory 可接受 ☐ not quite 很少 ☐ poor 差 ☐

Assessing the overall impression

5. If you know someone diagnosed with the following diseases, what will be your impression to them?
   假如你所認識的人患有以下疾病，你會對他們有什麼印象？

	1 **非常正面** **Very positive**	**2** **正面** **Positive**	**3** **中立** **Neutral**	**4** **負面** **Negative**	**5** **十分負** **Very negative**
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

APPENDIX (Cont'd)

(Assessing the level of stigmatisation and social distance)

6. How likely would you make friends/be neighbours with someone diagnosed to have the following diseases/recovered from these diseases?
   你會願意和以下病患者/康復者做朋友/鄰居嗎？

	1 十分願意 Very likely	2 願意 Likely	3 可能 Maybe	4 不願意 Unlikely	5 十分不願意 Very unlikely
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

7. If you are the employee, and if someone, who is eligible to your post, diagnosed to have following diseases/recovered from these diseases, how likely would you like to employ him/her?
   假如你是顧主，而以下病患者/康復者符合職位的要求，你會樂意聘用他們嗎？

	1 十分願意 Very likely	2 願意 Likely	3 可能 Maybe	4 不願意 Unlikely	5 十分不願意 Very unlikely
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

APPENDIX (Cont'd)

(Assessing the attitudes and thoughts)

8. Will you have the following ideas/attitudes towards someone diagnosed with the following diseases?
   你會對下列的病患者抱有以下感覺嗎？
   a. Difficult to get along with 難以相處

	1 絕對同意 Absolutely agree	2 同意 Agree	3 中立 Neutral	4 不同意 Disagree	5 絕對不同意 Absolutely disagree
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

   b. Unpredictable 難以預測

	1 絕對同意 Absolutely agree	2 同意 Agree	3 中立 Neutral	4 不同意 Disagree	5 絕對不同意 Absolutely disagree
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

APPENDIX (Cont'd)

c. Can harm others 對大眾安全構成危險

	1 絕對同意 Absolutely agree	2 同意 Agree	3 中立 Neutral	4 不同意 Disagree	5 絕對不同意 Absolutely disagree
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

d. Symptoms cannot be improved/controlled with treatment
治療不能改善/控制病情

	1 絕對同意 Absolutely agree	2 同意 Agree	3 中立 Neutral	4 不同意 Disagree	5 絕對不同意 Absolutely disagree
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

APPENDIX (Cont'd)

e. Can never recover fully 不能完全治癒

	1 絕對同意 Absolutely agree	2 同意 Agree	3 中立 Neutral	4 不同意 Disagree	5 絕對不同意 Absolutely disagree
精神分裂	☐	☐	☐	☐	☐
情緒病	☐	☐	☐	☐	☐
妄想症	☐	☐	☐	☐	☐
人格分裂	☐	☐	☐	☐	☐
腦癇症	☐	☐	☐	☐	☐
偏執症	☐	☐	☐	☐	☐
思覺失調	☐	☐	☐	☐	☐
雙極性情感疾病	☐	☐	☐	☐	☐
專注力失調	☐	☐	☐	☐	☐
躁狂抑鬱症	☐	☐	☐	☐	☐
神經衰弱	☐	☐	☐	☐	☐
過度活躍症	☐	☐	☐	☐	☐
解離性人格	☐	☐	☐	☐	☐
癲癇症	☐	☐	☐	☐	☐

END OF QUESTIONNAIRE

THANKS FOR YOUR KIND RESPONSE!