Psychology Students Attitudes towards Mental Illness In relation to Stress, Coping Styles, Optimism and Mental Well-Being.

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Abstract

The research literature concerning psychologists attitudes towards mental illness, are fuelled by conflicting results. According to Nordt, rossier and lauber (2006) mental health professionals are found to have an increased stigma toward mental patients. However, The Royal College of Psychiatrists' anti-stigma campaign, Changing Minds: Every Family in the Land; reported the attitudes of psychiatrists towards people with mental illness, especially schizophrenia, are generally positive compared with those of the general population. This study provided a review of the relationships between attitudes towards Mental Illness and that of gender, stress, coping styles, optimism and general health among psychology students (n=68) and general population (n=83). No significant differences were observed for male and female participants or between the two groups in relation to their attitudes towards the mentally ill. No significant results were found in relation to over mental well-being between the two groups however a correlation was examined between some of the factors in relation to psychological distress. Findings and limitations of this research are discussed with suggestions for future research.

1. Introduction

1.1 Mental Illness

First, it is important to differentiate terms commonly misused by the general public in relation to mental illness. Mental health and mental ill health do not constitute the label of mental illness. Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his or her own community (Who, 2007). Mental ill health refers to the kind of general mental health problems we can all experience in certain stressful circumstances; for example, wok pressure can cause us to experience; poor concentration, mood swings and sleep disturbance. Such problems are usually of temporary nature, are relative to the demands a particular situation makes on us, and generally respond to support and reassurance. Everybody is susceptible to mental illness and the incidence of mental illness within the population is increasing. Estimates indicate that one in four people will experience a mental health problem in their lifetime (WHO, 2007). However, temporary problems that we all experience, at times, does not necessarily lead to mental illness but prolonged mental illness limits our potential as human beings and may lead to more serious problems.

According to Stein et el (2010), a “mental disorder” may be defined as a “behavioral or psychological syndrome or pattern that occurs in an individual”. Following this, the National Alliance on Mental Illness (NAMI) describes mental illness as a “medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others, and daily functioning”. The diagnosis of mental disorders and mental illness is "fundamental to any science" (Manning, 2001), although there is much controversy in establishing a universal definition for mental illness or mental disorder. As a result, many mental health professionals often distinguish between "severe mental illness" and other milder forms of mental illness. For example, people with schizophrenia and manic depressive disorder experience psychotic symptoms and those who suffer from stress, anxiety and mild forms of depression experience neurotic symptoms.

1.2 Stigma and Labelling of Mental Illness

Stigma is the negative evaluation of a person as tainted or discredited on the basis of attributes such as mental disorder, ethnicity, drug misuse or physical disability (Goffman, 1963). There is no doubt that such prejudice has substantial negative social, political, economic and psychological consequences for stigmatised people (Dovidio et al, 2000). They may feel unsure of how `normal' people will identify or receive them (Goffman, 1963) and become constantly self-conscious and calculating about what impression they are making (Rush, 1998).

Negative attitudes to people with mental illness start at playschool and endure into early adulthood: one cohort confirmed the same prejudices on re-examination eight years later (Weiss, 1994). Knowing someone who has a mental illness is not associated with more enlightened attitudes (Wolff et al, 1996a), but Huxley (1993) identifies that the key factor is direct contact with people who have had "helpful treatment for episodes of mental illness". Mental illness, despite centuries of learning and the 'Decade of the Brain', is still perceived as an indulgence, a sign of weakness. Self-stigmatisation has been described, and there are numerous personal accounts of psychiatric illness, where shame overrides even the most extreme of symptoms (Byrne, 2000). In two identical UK public opinion surveys, little change was recorded over 10 years, with over 80% endorsing the statement that "most people are embarrassed by mentally ill people", and about 30% agreeing "I am embarrassed by mentally ill persons" (Huxley, 1993).

Studies have shown that stigma can have an adverse effect on people with mental health problems. For instance, the World Health Organisation indicates that the myths and misconceptions associated with mental disorders negatively affect the day-to-day lives of sufferers, leading to discrimination and the denial of even the most basic human rights." (WHO, 2003). Localised reports in Ireland suggest that there is an existing stigma. The Mental Health in Ireland report, Awareness and Attitudes (HSE, 2007), found that one third of their participants would find it difficult to talk to somebody who suffered from mental illness. They also found mixed reviews for a question pertaining to the segregation of those with mental illness

1.3 Statistics from Irish Studies

See Change is Ireland's national programme working to change minds about mental health problems in Ireland. In 2012, See Change commissioned Millward Brown Lansdowne to conduct a nationally representative survey of Irish attitudes towards mental health problems to build on baseline research conducted for the campaign in 2010. The 2012 research reported an increased number of Irish people claim to have some experience a mental health problem, either themselves or through others, up from 39% in 2010 to 55%. There was increased awareness and understanding of mental health, mental health problems, stigma and support services. There are increased levels of recognition that people with mental health problems experience high levels of prejudice and discrimination, up from 73% in 2010 to 77% in 2012. On a very positive note there was increased willingness to seek professional help for a mental health problem, risen from 88% in 2012 to 91% in 2012. However, on the negative, the survey highlights that since 2010, an increased number would not want others to know about their mental health problem, up from 50% in 2010 to 56% in 2012. It also reported 28% of people would delay seeking treatment for fear of someone else knowing about their mental health problem, up from 18%in 2010 and 41% would hide a mental health from friends, up from 32% in 2010. 24% would conceal a mental health problem from family, up from 13% in 2010.

There is an increased belief that family would want to conceal a diagnosis from others, up from 32% in 2010 to 42% in 2012. 57% believe that being open about a mental health problem at work would have a negative impact on job and career prospects, up from 48% in 2010. 47% believe that being open about a mental health problem at work would have a negative effect on a person's relationship with colleagues, up from 36% in 2010.

These research statistics thus, provide another basis for this study which intends to focus on general population and psychology student's attitudes towards mental illness. Furthermore, prominent figures within the field of mental health frequently state that in order for there to be a decline in the negative attitudes held towards those who suffer from a mental health disorder the general public must receive more in depth knowledge and education regarding the spectrum of mental illness. Research conducted by Corrigan and Penn (1999)

shows that individuals who possess more information about mental illness are less stigmatizing than individuals who are misinformed about mental illness.

1.4 Psychology Professionals Attitudes Mental Illness

The research literature concerning psychologists attitudes towards mental illness, are fuelled by conflicting results. According to Nordt, rossier and lauber (2006) mental health professionals are found to have an increased stigma toward mental patients concluding that better knowledge of mental health resulted in more negative ratings when compared to the public. Similarly, Hasson et el (2011) investigated mental health staff's attitudes towards mental illness and again found that negative attitudes were prevalent. However, The Royal College of Psychiatrists' anti-stigma campaign, Changing Minds: Every Family in the Land; reported the attitudes of psychiatrists towards people with mental illness, especially schizophrenia, are generally positive compared with those of the general population and state psychiatrists do seem to generally hold non-stigmatising views. Most psychiatrists do not agree that a man or woman would be foolish to marry someone with mental illness but the longer qualified; the less likely is an opinion on this to be offered. In considering 'someone with schizophrenia', most psychiatrists thought that they were not likely to be dangerous to others, but might be hard to talk to and unpredictable. This latter view was less likely where caseload of people with schizophrenia was higher; suggesting that direct personal experience improves understanding. Psychiatrists are more optimistic about recovery than the public. Eighty per cent of psychiatrists disagree with the statement that there is something about people with mental illness that makes it easy to tell them from normal people compared with 64% of the general population. Psychiatrists were more likely to believe that people with schizophrenia were not to blame for their illness, and would improve if given treatment. Finally, and fortunately, they reported an overwhelming majority of psychiatrists working with people with schizophrenia enjoy doing so.

1.5 Measuring Mental Illness

The topic of mental illness has always been an important area to investigate among mental health professionals as every society holds its own unique perception of mental illness. It is clear that mental illness has existed since ancient times (Porter, 1991) and many major studies have been carried out, with the knowledge that the public do not view mental illness as an illness like any other. Nunnally (1961) began an extensive 6 year investigation to see what the public knew and felt about mental illness. Nunnally reported that "as is commonly suspected, the mentally ill are regarded with fear, distrust, and dislike by the general public". It was noted that these "bad" attitudes were not held because of existing information but because of the lack of information, even the younger and better educated held slightly less derogatory attitudes but essentially the attitudes were negative. Nunnally's study reveals that the negative attitudes regarding mental illness appear to be passed down from one generation to the next. This study further reiterates the point of needing to educate the public.

The field of mental health has some of the oldest instruments available for measuring stigma related attitudes; these assessments have emphasis on general public attitudes towards those with mental illness. Furthermore, one of the earliest scales includes the Opinions about Mental Illness (OMI) questionnaire (Cohen & Struening 1962; Struening & Cohen 1963). This 51-item questionnaire had good construct validity and internal consistency to which Taylor and Dear further developed the OMI. They added a subscale to measure Community Mental Health Ideology and created the "Community Attitudes to Mental Illness" (CAMI) scale. Taylor & Dear (1981) tested the CAMI scale on a neighborhood in Toronto, Canada, assessing the community's attitudes towards mental health facilities. The Toronto study demonstrates the strength, direction, and consistency of the four scales and provides strong evidence for the predictive validity of all four scales.

1.6 Variables and Studies related to Mental Illness

Optimism:

Optimism and pessimism may be described as psychological dimensions in which optimism represents a bias in perceptions and expectations in favor of positive features in life and pessimism represents a negative bias (Peterson and Bossio, 1991). Optimistic individuals

believe that the future holds positive opportunities with successful outcomes. People that hold an optimistic outlook in life have demonstrated higher levels of motivation, persistence, and performance (Carver et el, 1979; Taylor and Brown, 1988). On the other hand pessimistic individuals tend to look at the world and future experiences in a negative fashion pessimistic people view the world as a place of bad experiences and events. Recently, optimism and pessimism have been associated with several points of interest within clinical and health psychology (Lewis et el, 1995). Natail-Alemany (1991) found optimism to be positively associated with adaptive coping skills, while Weintruab, Carver and Scheier (1986) have found pessimism to be associated with maladaptive coping strategies. Optimism and pessimism have also been shown to relate to different patterns of preferred defense mechanisms (Dember et el, 1989). Specifically, Dispositional optimism, typically measured by the life orientation test (LOT-R; Scheier et el, 1994), has been tied to a broad array of mental and physical heal benefits, including greater psychological well-being (e.g. Kubzansky et el, 2002), and faster recovery from illness (Scheier et el, 1989).

Optimism has been shown to mitigate the effects of stressors on psychological functioning. Dispositional optimism (who hold generalized positive outcome expectancies) have shown less mood disturbance in response to a number of different stressors, including adaptation to college (Aspinwall & Tayloy, 1992: Scheier & Carver, 1992), breast cancer biopsy (Stanton & Sinder, 1993), and breast cancer surgery (Carver et el, 1993). These findings may be attributed to optimists' belief that discrepancies between their goals and their current attainment will be resolved, minimizing defeat-related moods such as shame, depression, and anger (Carver & Scheier, 1985). In a study by Segerstrom et el it was found that as predicted optimism was associated with better mood. One explanation for the associations that have been found is that optimists cope more effectively with their stressors than do pessimists. There is substantial evidence that optimists use different strategies to cope than do pessimists and that these coping differences contribute to the positive associations between optimism and better adjustment (carver, Scheier & Weintraub, 1989, Scheier, Weintraub, & Carver, 1986; Stantion & Snider, 1993). On a basic cognitive level, optimists are observed to use adaptive, encouraging strategies when dealing with stress and goal obstruction, as opposed to the

avoidant strategies of their less hopeful acquaintances (Lai & Wan, 1996). In the event that its strategies do not facilitate a successful outcome, optimism has also been demonstrated to lend itself to the maintenance of self-esteem (Cantor & Norem, 1989). Optimism also has a positive influence upon psychological well-being; it has been demonstrated to partially mitigate both the distress commonly associated with the transition to college (Scheier & Carver, 1993). Pessimism is the tendency to take worst views or expect the worst outcome and the belief that the actual world is the worst possible one or that all things tend to be evil (Scheier, Carver & Bridges 2001:191). Pessimists give up more easily, think that bad events will last a long time and believe the worst about people around them. They are less likely to persevere, and they exhibit higher rates of stress, depression and anxiety (O'Gorman & Baxter, 2000:536).

Stress:

Stress has been defined as "the negative feelings that occurs when an individual feels unable to cope with the demands placed upon them by their environment" (Lazarus and Folkman, 1984). It is a natural reaction that everyone experiences at one time or the other. It is a part of human nature. Stress is the body's response to danger or perceived threat. Many things in life can bring us stress. Adrenalin is released through our body, causing our body pressure to rise and the outward muscles to tighten. Elevated levels of stress can put a toll on our system but we can develop ways to cope with stress or to make attempts in our lives to avoid it. A particular stress will not hold the same importance for everybody—for example, an examination is likely to be viewed less severely by someone who is well prepared or to whom the result matters little (Fisher & Reason, 1988). Some people characteristically handle stress as a challenge to be overcome; others are overwhelmed. Some have friends that they can talk to, or who can give advice or support; others do not. As the stress continues, its importance may change as people gather resources, recruit help, or perceive the effectiveness (or otherwise) of their attempts to deal with it (Appley & Trumbull, 1986).

The difference between a stressor (that is, the environmental event) and the response to it is critical for understanding the role of stress in mental illness. Some separate "stress" (the event) from "strain" (the response); this is a useful distinction, and it is a pity that it is little used

in clinical contexts (Herbert, 1997). Psychological stress has an important role in both the onset and course of mental illness, including schizophrenia, anxiety disorders, and depression. Life events have been most studied. These are occurrences that most people would recognise as emotionally important—for example, bereavement, loss of a job, marital separation, as well as lesser events such as moving house. The recognition that these events play a prognostic role in illness first came from the work of Rahe (Holmes & Rahe, 1967). In addition to the common stressors experienced by the general population, college students encounter an additional range of stressors (Archer and Lamin, 1985). Although an optimal level of stress can enhance learning ability, too much stress can cause physical and mental health problems and may affect the academic achievement of students. Sax (1997) states a disturbing trend in college student health is the reported increase in student stress nationwide. This is evident in Hirsch and Keniston (1970) study, which looked at the dropout rate of students in university. They estimated that fifty percent of entering students do not finish college four years later.

Many studies have researched what the primary sources of stress are among college students. A study in a university in the united states found that the five highest stressors among the student population were a change in sleeping habits, a change in breaks, a change in eating habits, new responsibilities and increased work load. (Ross, Neilbling and Hecket, 1999). According to Hirsch and Ellis (1966) the pressure to earn good grades and to earn a degree is a very high source of stress among students. Taylor (2009) states that overloaded people who have more tasks in their lives report higher levels of stress than do those who have fewer tasks, which would apply to college students especially around exam time. Sgan-Cohen and Lowental (1988) indicated that time pressures and interaction with faculty members were common stressors. It is clear from these studies that college students are particularly prone to stress. Acute and chronic stress has been linked to psychological and emotional problems such as anxiety, depression, irritability, frustration, anger, worrying, uncertainty, and lack of confidence.

Coping styles:

Coping is the process of attempting to manage the demands created by stressful events that are appraised as taxing or exceeding a person's resources (Lazarus & Folkman, 1984). It is one of the factors which has a proven track record in mitigating the relationship between life stress and physical and psychological functioning (Lazarus, 1999). Lazarus and Folkman (1984) indicate that coping styles can affect how a stressful event is perceived and how it is managed. It has long been known that people with a diverse array of mental disorders, including depression, schizophrenia, anxiety disorders and autism lack coping resources for managing the challenges of daily living. Likewise chronic psychological distress, which is related to lack of coping resources (Repetti et el, 2002), is implicated in more than half of the DMS-IV axis I disorders and in almost all of the axis II psychiatric disorders (Am. Psychiatry. Assoc. 1994). For example depression is marked by pessimism, low- self-esteem, a low sense of social relationships (Beck, 1967). In a study Aldwin et el reported those in poorer mental health and under greater stress used less adaptive coping strategies, but coping efforts still affected mental health independent of prior symptom levels and degree of stress (Taylor & Stanton, 2007).

Most Coping responses are considered to broadly encompass problem, or emotion-focused coping (Carver & Scheier, 1994; Folkman & Lazarus, 1985). Problem focused coping is generally viewed as an adaptive mode of coping that involves actively planning or engaging in a specific behavior to overcome the problem causing distress (Folkman & Lazarus, 1985). Emotion-focused coping involves attempts to regulate one's emotions, and can be considered active or avoidant (Holahan & Moos, 1987). Active emotional coping, such accepting the situation or cognitively reframing a stressor's impact, is typically viewed as an adaptive emotion-regulation strategy (Folkman &Lazarus, 1985). Avoidant emotional coping is viewed as maladaptive, for example, using self-distraction to avoid the source of distress (without engaging in problem-focused behavior) (Holahan & Moos, 1987). Although avoidant coping may help individuals manage their day-to-day activities soon after a crisis, reliance on this coping style over time can lead to mental health problems (Holahan & Moos, 1987); Similarly, problem-focused coping in the absence of active emotional coping may be

problematic. Studies have found that emotion-focused coping, specifically an avoidant strategy, is generally related to worse overall mental health outcomes (Coyne & Racioppo, 2000).

1.7 Mental Well-Being

Health is regarded as a positive and balanced state characterized by the best achievable physical, psychological, emotional, social, spiritual and intellectual levels of functioning at a given time, the absence of disease or the optimal management of chronic disease, and the control of both internal and external risk factors for both diseases and negative health conditions. Wellness is a way of life, a lifestyle a person designs to achieve his/her highest potential for wellness. Wellness is a process, a developing awareness that there is no end point, but that health and happiness are possible in each moment, here and now (Durkin & Paxton, 2002).

Diener, Suh, Lucas and Smith (1999) state that wellness is multidimensional and encompasses the six dimensions: one of which is the emotional dimension. The emotional dimension emphasizes an awareness and acceptance of one's feelings. Emotional wellness includes the degree to which one feels positive and enthusiastic about oneself and life. It includes the capacity to manage one's feelings and related behaviors, including the realistic assessment of one's limitations, development of autonomy and ability to cope effectively with stress. The emotionally well person maintains satisfying relationships with others (Zauszniewski & Rong, 1999). Blanton, Axsom, Mc Clive and Price (2001) found that as an emotionally well person, one would be aware of and accept a wide range of feelings in oneself and others. One will be able to express feelings freely and manage feelings effectively. On the wellness path, one will live and work independently while realizing the importance of seeking and appreciating the support and assistance of others. One will be able to form interdependent relationships with others, based upon a foundation of mutual commitment, trust and respect. One will take on challenges, take risks and recognize conflict as being potentially healthy. Managing one's life in personally rewarding ways, and taking responsibility for one's actions, will help one to see life as an exciting, hopeful adventure (Oishi, Wyer & Colombe, 2000).

1.8 Psychology Profession and Mental Well-Being

Psychologists, it appears, don't always get the mental health care they need, according to a new study published online in February in Professional Psychology: Research and Practice. In an analysis of 260 APA members who had been surveyed about their experiences with psychotherapy, researchers at George Fox University found that although 86 percent reported they'd had psychotherapy at some point in their lives, 59 percent said there were times when they could have benefited from therapy but didn't seek it. The team also found that, unlike the general population, psychologists don't appear to be inhibited much by stigma when it comes to seeking mental health care. Yet the study found that psychologists still face many of the same barriers to seeking mental health care the general population faces: not enough time, not enough money and trouble admitting distress. The biggest barrier to seeking therapy, according to the study, was the selection process — finding a therapist who's neither a colleague nor a mentor, who works nearby and who provides care that lives up to psychologists' own high expectations. Bearse and her team also found that burnout, countertransference and vicarious traumatization were all rated by study participants as top stressors that affect their therapeutic effectiveness. Moreover, 61 percent of those surveyed listed additional stressors that interfere with their jobs, including personal losses, problems with insurance companies and conflicts with co-workers.

1.9 Objective of This Study

The aforementioned literature and research demonstrates mixed attitudes and opinions towards those with mental illness which stems back over a long period of time. Furthermore, most research supports a lack of education about the various aspects of mental illness with a strong emphasis placed on educating the younger generations in order to alleviate negativity and pessimism associated with mental health disorders. There is much research on the topics of mental disorders, mental illness and stigma related to mental illness. However, there is little research on either college students attitudes towards mental illness or in fact psychologists attitudes towards mental illness. Hence the purpose of this study. The field of psychology has been chose as a representative group in this study based on the above mentioned need for education in relation to mental illness. Therefore, this study will examine if there is a difference

in attitudes towards mental illness among psychology students and the general population.

The community attitudes towards mental illness scale (CAMI) was used to measure the opinions of willing participants from both the general population and the academic field of psychology. Leading on from this, a vital purpose of this study is to examine if psychology students will have better mental well-being than the general population. From the information that is available it is clear that psychologists and psychology professionals have just as much is not more stress to deal with than the general population.. A further aim of this study is to examine if there is any predictor association between a person's own mental well-being and their levels of stress, optimism and their use of different coping techniques. The overall goal of the study is to provide a further insight into the attitudes held among individuals within a field that has relevance to mental health welfare.

The results and findings from this investigation should contribute to the literature within all respective fields. The main research hypothesis for this study are

1. The first research objective hypothesis is to first explore the difference between the criterion variable, attitudes towards mental illness and the two groups, psychology students and the general population. It is hypothesised that there will be a significant difference in the attitudes towards mental illness held among psychology students and the general population with respect to the subscales of the Community Attitudes Towards Mental Illness scale.

2. The second research objective hypothesis is to investigate the difference in the mental well-being (using the 4 indicators) held among psychology students and the general population. It is hypothesised that there will be a significant difference among psychology students and the general population in terms of the 4 indicators of mental well-being (stress, coping styles, general health and optimism).

3. The third research objective hypothesis is to investigate if perceived stress, coping styles, and optimism will significantly predict psychological well-being. It is hypothesised that there will be a signification prediction in psychological distress in respect of the five indicators, Perceived stress scale, The Brief Cope (sub-divided by category) and The Life OrientationTest-revised.

2. METHOD

The present study intends to investigate a sample group (N = 151) consisting of participants from the academic field of psychology and a sample from the general population. Participants are to be obtained through means of convenience in Dublin Business School and the general population. The willing participants will be administered a questionnaire investigating their attitudes towards the mentally ill. The procedures and results accumulated from this study will be reported accordingly.

2.1 Participants

A sample population of 151 participants were obtained for this study. The participants consisted of psychology students (n=68) and general population (n=83). Psychology students accounted for 45% of the data collected along with the general population accounting for 55% of the data collected. In relation to gender, the female participants accounted for 59.6% of the sample while male participants accounted for 40.4% of the sample.

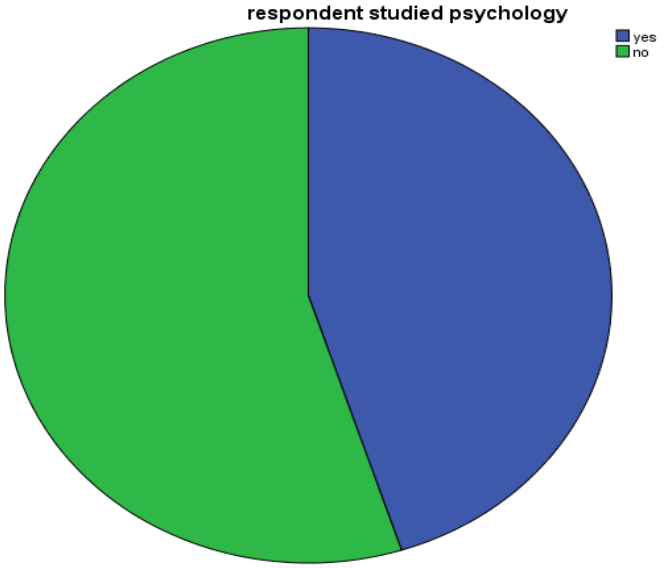

Figure 1.Participant population percentage in terms studying Psychology.

2.2 Materials

A short demographic questionnaire was devised to obtain the participants gender and academic field of study if relevant (see Appendix B). Also included are the standardised questionnaires used; The Community Attitudes towards Mental Illness scale (Taylor & Dear, 1981) (see Appendix C), perceived stress Scale (Cohen et el, 1983) (see Appendix E), The Brief COPE (Carver, 1997) (see Appendix D), The Life Orientation Test-Revised (Scheier et al. 1994) (see Appendix F), and The General health questionnaire GHQ12 (Goldberg & Williams, 1988) (see Appendix G). Participants also signed a consent form (see Appendix A).

The "Community Attitudes to Mental Illness" (CAMI) has 40 items covering 4 subscales with factor A- Authoritarianism: this is the belief that persons with mental illness are different, inferior, and requires coercive authoritarian handling, higher scores for Authoritarianism scale denotes more coercive attitudes towards mental health consumers. An example would be 'Mental patients need the same kind of control and discipline as a young child'. Factor B- Benevolence: this represents a more moral paternalistic attitude towards persons with mental illness, who are viewed as childlike in nature; higher scores on the Benevolence scale indicate an optimistic view towards those with mental illness. The item 'Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for' suggests benevolence. Factor C- Social Restrictiveness: this signifies a belief that persons with mental illness are a threat to the community and must have restrictions placed on them; high scores on the Social Restrictiveness scale reflect fear of the mentally ill. The statement 'Anyone with a history of mental problems should be excluded from taking public office' suggests social restrictiveness. Factor D- Community Mental Health Ideology: which look at individual and community responses to mental health facilities, high scores on the Community Mental Health Ideology indicate an accepting attitude towards mental health clients. A statement related to this factor is 'The best therapy for many mental patients is to be part of a normal community'. The participants response is indicated on the CAMI 5-point likert scale ranging from "strongly disagree" (scored as 1) to "strongly agree" (scored as 5). The reliability of this scale ranges from .68 Authoritarianism to .88 Community Mental Health Ideology (Taylor and Dear, 1981).

Psychological stress was assessed using the 10-item perceived stress Scale (PSS; Cohen et el, 1983). The PSS is the most widely used psychological instrument for measuring the perception of stress. Cohen et al. (1983) found the PSS to provide better predictions of psychological symptoms, physical symptoms and utilization of health services than other instruments which measure specific life events (Hamarat et al., 2001). The instrument, which was designed for use in the community samples with at least a junior high school education, consists of 10 items designed to measure how unpredictable, uncontrollable and overloaded respondents find their lives to be. Items include statements such as; in the past month, how often have you felt your difficulties were piling up so high you could not overcome them? Participants rated each of the 10 items on a 5-point response scale ranging from 0 (never) to 4 (very often). PSS scores are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1 & 4 = 0) to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items. The higher the overall score the greater amount of perceived stress. Coefficient alpha reliabilities for the PSS range between .84 and .86, and the measure correlates with physical and depressive symptomatology measures between.52 and .70, and .65 and .76 respectively (Hamarat et al.,2001).

The Brief COPE (Carver, 1997) is a 28-item measure of coping style use derived from the longer COPE inventory (Carver, Scheier, & Weintraub, 1989). The brief COPE uses a 4-point likert scale (I haven't been doing this at all to I've been doing this a lot), querying a variety of different coping methods such as praying or meditating, receiving emotional support, substance abuse, self blame, self criticism, planning, acceptance, venting and positive reframing etc. it consists of 14 subscales containing two items each (Schnider, Elhai and Gray,2007, p346). Based on conceptive and empirical literature describing the three coping strategies summarized above (Carver & Scheier, 1994; Folkman & Lazarus, 1985; Holahan & Moos, 1987) and previous research by Schnider & Elhai (2007) the 14 subscales will be grouped into the three categories by summing items accordingly (see Table1), with higher scores indicating greater intensity of use of the coping strategy (Schnider, Elhai and Gray,2007, p346). The stress coping strategies and the associated subscales were problem-focused coping (active coping, planning,

instrumental support, and religion scales); active emotional coping, venting, positive reframing, humor, and emotional support scales); and avoidant emotional coping (self-distraction, denial, behavioral disengagement, self-blame, and substance use scales).

The Life Orientation Test-Revised (LOT-R) is a 6-item inventory that measures general optimism vs. pessimism (Scheier et al. 1994). The LOT-R is a revised, refined, but shorter version of LOT, which was later developed with the omission of items that could confuse optimism as a personality feature with coping mechanisms. Participants were asked to respond to items on a five-point scale indicating their agreement with statements ranging from "strongly disagree" to "strongly agree." A sample item is, "In uncertain times, I usually expect the best." Negatively worded items are reverse coded and scores equal the mean across all items. Higher scores indicate higher levels of optimism. There are 10 questions overall but questions 2, 5, 6 and 8 are just fillers and are not used in analyzing data. The LOT-R has also been extensively tested for reliability and validity. Scheier, Carver and Bridges (1994) found a Cronbach's alpha coefficient score of 0.78 for the LOT-R. The researchers also found a strong correlation between the revised life orientation test, the original life orientation test and a number of related scales, confirming the validity of the LOT-R as a measure of dispositional optimism.

The General health questionnaire GHQ12 (Goldberg & Williams, 1988) is a measure of current mental health by screening for the detection of minor psychiatric disorders (i.e non-psychotic psychological impairment) in community and non-psychiatric settings. It is sensitive to changes in normal functioning 'over the past few weeks' and has the ability to differentiate between 'cases' (i.e., the probability that the individual has a minor psychiatric disorder) and 'non-cases'. It focuses on two major areas – the inability to carry out normal functions and the appearance of new and distressing experiences. Originally developed as a 60-item instrument, a range of shortened versions of the questionnaire including the GHQ-30, GHQ-28, GHQ-20 and GHQ-12 are now available. Although shorter the GHQ-12 is deemed as valid and reliable. The questionnaire asks whether the respondent has experienced a particular symptom or behavior recently. Each item is rated on a four-point scale; not at all, no more than

usual, more than usual, much more than usual, for statements: 1, 2, 7, 10, 11 and 12, whereas, for the rest of the statements the responses were; more than usual, no more than usual, less than usual, and much less than usual. GHQ-12 has a good internal consistency, Cronbach's Alpha ranged from 0.82 to 0.90 in a series of studies and the retest reliability was 0.73. Cronbach's Alpha is an estimate of the reliability of a test for a sample of participants. High scores on this measure represented poorer psychological health, while lower scores more favourable levels of psychological health.

Table 1. Categories, subscales and questions for Brief Cope Scale

	SUBSCALE	ITEMS
Problem focused coping	Active Coping	2 + 7
	Planning	14 + 25
	Instrumental support	10 + 23
	Religion scales	22 + 27
Active emotional coping	Positive reframing	12 + 17
	Venting	9 + 21
	Humour	18 + 28
	Acceptance	20 + 24
	Emotional Support	5 + 15
Avoidant emotional coping	Self-distraction	1 + 19
	Denial	3 + 8
	Behavioural disengagement	6 + 16
	Self-blame	13 + 26
	Substance use	4 + 11

Note- items corresponds to question number.

2.3 Design

This study will be a quantitative, cross-sectional questionnaire design study, which is descriptive in nature. As this study involves two independent groups it is a between groups study. A causational analysis of data will be used to compute whether stress, optimism and coping strategies are predictors of Psychological distress. Differences between male and female

participants will also be looked at as an exploratory investigation.

2.4 Procedure

Approval for the study was obtained from the Ethics Committee Board consisting of both internal and external examiners. I approached Psychology lecturers from numerous classes within Dublin business school and obtained permission to distribute the questionnaires amongst the students prior to the start of their lecture. Participants were recruited with a standard informed consent form, all responses were confidential and anonymous. All willing participants who met the inclusion criteria; over 18 years of age and do not suffer from severe learning difficulties. I informed participants about the nature of the study and each group of participants were administered the questionnaire which took an average of 10-15 minutes to complete. Once all respondents had completed the questionnaire they received debriefing, a time to ask any questions or express opinions about the study. It was taken into consideration that due to the sensitive nature of the topic of mental illness, there may have been individuals who were uncomfortable to ask a question and so information to contact Samaritans or AWARE were provided on the very last page of the questionnaire. All Questionnaires will be destroyed 1 year after collection The statistical package for SPSS/PASW software, was used for analysis of the data and to test the null hypothesis.

3. Results

3.1 Sample

The present investigation obtained a sample of 151 participants. Given the analysis of multiple regression we needed enough participants in each group to perform this test. 40.4% of the participants were male (n=61) the remaining 59.6& of participants were female (n=90). 45% of the respondents had studied psychology (n=68) and 55% were from the general population (n=8.). Table 2 (below) shows this demographic results and related data.

Table 2. Demographic information obtained in research

Gender,	**%**
Male	40.4%
Female	59.6%
Studies Psychology	
Yes	45%
No	55%

3.2 Hypothesis 1:

Will psychology students, and the general population have different mental health attitudes? There will be a significant difference in the attitudes towards mental illness between psychology students and the general population with respect to the subscales of the Community Attitudes towards Mental Illness (CAMI) scale.

In regards to the first aim of the study, a two-tailed Independent samples t-test was used. Normal distribution was checked as part of the preliminary analysis. The results of the t-test analyses found that psychology and the general population were not observed to significantly differ with respect to the CAMI subscales of Authoritarianism ($t = 1.04$; $df = 149$; $p>.05$, 2-tailed), Benevolence ($t = 1.54$; $df = 149$; $p>.05$, 2-tailed) and Social Restrictiveness ($t = 1.04$; $df = 149$; $p>.05$, 2-tailed). The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -0.74 and 2.39 for Authoritarianism, between -0.43 and 3.49 for Benevolence and between -0.83 and 2.67 for social restrictiveness. This result suggests that both psychology students and the general population do not see the need for social distance to be put between the public and the mentally ill. It indicates that psychology participants and the general population maintain a similar belief in the intuitionalism of the mentally ill. However significant differences were observed for the

Community Mental Health Ideology subscale (t = -2.06; df 149; p<.05, 2-tailed), The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -4.53 and -0.92 for Community mental health ideology. Examination of the means shows that the general population displayed significantly higher levels of Community Mental Health Ideology. This result indicates that psychology students endorse the belief of deinstitutionalisation of the mentally ill for integrative community support. Therefore, the t-test partially accepts the null hypothesis. As no significant differences were observed for psychology students and the general population with respect to the CAMI subscales of Authoritarianism, Benevolence and Social Restrictiveness. The t-test confirms that the two group differ with respect to the CAMI subscales of Community Mental Health Ideology.

Table 3. *An Independent Samples T-test table, displaying the differences two groups, Psychology students and the general population, in relation to the CAMI scale.*

Variables	Studied Psychology	Mean	SD	t	df	p
Authoritarianism	Yes	41.84	4.50	1.04	149	.30
	No	41.01	5.11			
Benevolence	Yes	42.87	6.96	1.54	149	.12
	No	41.34	5.20			
Social Restrictiveness	Yes	18.22	5.78	1.03	149	.30
	No	17.30	5.11			
Community Ideology	Yes	19.81	6.79	-2.05	149	.41
	No	22.12	6.93			

3.3 Hypothesis 2:

Will psychology students and the population have different levels of mental wellbeing? There will be a significant difference in the levels of mental wellbeing between psychology students and the general population with respect to the four indicators of mental

well being: Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983), Brief Cope Scale (Carver, 1997), Life Orientation Scale (Carver, Scheier & Segerstrom, 2010) and General Health Questionnaire (Goldbery & Williams, 1988).

In regards to the second aim of this study a two-tailed Independent Samples T-Test was used and, again, normal distribution was checked as part of the preliminary analysis. The bonferronni adjustment was used in order to prevent increased likelihood of type 1 error. In this case a p value of (0.05/4) 0.013 will be used to determine statistical difference. The results of the T-Test found that there was no significance difference between psychology students and the general population in regards to 3 of the indicators of mental health well-being. In regards to Perceived stress ($t = 0.26$; df 149; $p>.013$, 2-tailed), Optimism ($t = -1.90$; df 149; $p>.013$, 2-tailed), and General Health ($t = 0.81$; df 149; $p>.013$, 2-tailed). Further analysis showed no significant difference in relation to pessimism subscale (as part of life orientation scale) showing results of ($t = -1.04$; df 149; $p>.013$, 2-tailed). When we examined the 2 groups in relation to coping skills this section of results had be sub-divided into 3 categories. The results indicate that there was no significant difference in relation to avoidant emotional coping between the groups ($t = -0.51$; df 148; $p>.013$, 2-tailed). However the t-test revealed that there was a significant difference between psychology students and the general population in the categories problem focused coping ($t = -4.69$; df 148; $p<.013$, 2-tailed) and active emotional coping ($t = 4.26$; df 148; $p<.013$, 2-tailed). Psychology students (mean=22.33, SD= 7.306) exhibited greater use of problem focused coping than the general population (mean=17.18, SD= 6.11). Psychology students also showed greater use of active emotional coping (mean=26.27, SD =5.81) than the general population (mean=21.63, SD=7.22). While there was no significant between the two groups, psychology students (mean= 6.21, SD= .75) and the general population (mean= 6.18, SD= .67) in terms of using avoidant emotional coping. Therefore, the t-test partially accepts the null hypothesis. As no significant differences were observed for psychology participants and the general population with respect to indicators of stress, optimism, pessimism, general health and in one sub-division (avoidant emotional) in the coping

scale. The t-test confirms that the two groups differ with respect to the brief cope sub-divisions for problem focused coping and active emotional focused coping.

3.4 Hypothesis 3:

Will scores on perceived stress, coping styles and optimism predict a person's mental well-being? There will be a significant positive prediction in participants mental well-being, based on the General Health questionnaire, in relation to stress, coping styles and optimism.

In regards to the third aim of this study a standard multiple regression will be used to determine if Perceived stress, coping styles (sub divided into three categories as previous tests) and optimism will predict a person's mental well-being by scoring their level of psychological distress on the General Health Questionnaire. The results of the regression indicated that five predictors explained 62% of the variance (R^2 = .62, $F(5,142) = 48.05$, $p < .001$). All correlations, except for optimism, were statically significant. It was found that Perceived stress significantly psychological distress (β = .69, p = .00, 95% CI = .40 - .64) as did problem focused coping (β = .07, p = .001, 95% CI = .10 – .36), as did active emotional coping (β = .07, p = .02, 95% CI = -.37 – .-84), and avoidant focused coping (β = .08, p = .006, 95% CI = .00 – .31). Optimism did not significantly predict psychology distress (β = .01, p = .086, 95% CI = -.14– .16). As the 95% confident level is quite narrow we can be confident with our result. Based on these results we can reject the null hypothesis as the indicators did significantly predict psychological distress in participants.

3.5 Hypothesis 4:

Will there be a difference in the attitudes held among male and female students in relation to the CAMI scale? There will be a significant difference in the attitudes held among male and female participants in relation to the subscales of the Community Attitudes towards Mental Illness (CAMI) scale.

It was hypothesised that there would be a significant difference between the predictive variable gender and the criterion variable attitudes towards mental illness. For this, a two-tailed independent samples t-test was conducted in order to determine any significant gender differences. The results of the t-test analyses found that males and females were not observed to significantly differ with respect to the CAMI subscales of Benevolence (t = -1.25; df = 149; p>.05, 2-tailed), Social Restrictiveness (t = .99; df = 149; p>.05, 2-tailed) and Community Mental Health Ideology (t = .15; df = 149; p>.05, 2-tailed). However there was significant difference in the subscale of Authoritarianism (t = -2.23; df = 149; p.<.05, 2-tailed). Therefore, the t-test accepts the null hypothesis of no significant differences between male and female participants although there was partial significance for one subscale.

Table 4. *An Independent Samples T-test table, displaying the differences in gender, in relation to the CAMI scale.*

Variables	Gender	Mean	SD	t	df	p
Authoritarianism	Male	40.33	5.41	-2.23	149	.02
	Female	42.10	4.31			
Benevolence	Male	41.28	5.44	-1.24	149	.21
	Female	42.53	6.47			
Social Restrictiveness	Male	18.25	5.37	0.99	149	.32
	Female	17.36	5.46			
Community Ideology	Male	21.18	7.33	0.14	149	.88
	Female	21.01	6.70			

4. Discussion

4.1 Results

The purpose of this was to investigate the attitudes held among psychology students and the general population towards those with mental illness. This was to be achieved by providing a quantitative review of the relationship among measures of Community Attitudes Towards Mental Illness (CAMI: Taylor & Dear, 1981), Perceived Stress scale (PSS0; Cohen et el, 1983), The Brief Cope Scale (COPE; Carver, 1997), The Life Orientation Test-revised (LOT-R; Scheier et al. 1994) and The General Health Questionnaire (GHQ; Goldberg & Williams, 1988). Furthermore, there is an abundance of research available which links each of the variables that provided a foundation for the hypothesis that have been adopted in this study. Following this, the other demographic variables employed for this study included gender and whether the participant has studied psychology. In examining these variables we were able to examine if studying psychology and gaining knowledge about mental illness made a significant difference towards people's attitudes towards mental illness. By using the four indicator of mental well-being we assessed whether this knowledge and understanding obtained studying psychology would equip those participants with the skills and ability to have better copping skills, less perceived stress, be more optimistic and overall have better mental well-being.

The first research objective was to first explore the difference between the criterion variable, attitudes towards mental illness and the two sample groups psychology students and the general population. A two-tailed independent samples t-test was used to explore the differences in attitudes to mental health with regard to the CAMI subscales. A significant difference was observed for the Community Mental Health Ideology subscale ($t = -2.06$; df 149; $p<.05$, 2-tailed), examination of means shows that the general population ($M= 22.12$, $SD=6.92$) displayed significantly higher levels of community mental health ideology. However no significant different was observed for Authoritarianism ($t = 1.04$; $df = 149$; $p>.05$, 2-tailed), Benevolence ($t = 1.54$; $df = 149$; $p>.05$, 2-tailed) and Social Restrictiveness ($t = 1.04$; $df = 149$; $p>.05$, 2-tailed).

The findings for the first hypothesis which relate to the difference in mental health attitudes among the two sample groups were partially accepted and consistent with the literature. Research has suggested that individuals who are more informed about the area of mental health and who are more exposed to the field have been shown to have higher scores on the Community Mental Health Ideology subscales of the Community Attitudes Towards Mental Illness (Pandey et el, 2008). The subscale Community Mental Health Ideology looks at individual and community responses to mental health facilities and high scores indicate an accepting attitude towards mental health clients (Taylor & Dear 1981; Taylor, Dear, & Hall, 1979). This provides positive information that psychology students have a more accepting attitude towards mental health clients. However there are also inconsistencies with literature, Keane's 1991 study found a significant improvement in the opinions of medical students and nursing students on the OMI (Cohen & Streuning, 1962) subscales Authoritarianism and Benevolence after a 8-week course in general psychiatry. These result are not consistent with the current study. Other inconsistencies lie with Pandey's (2008) study which found differences on the Social restrictiveness subscale. This would suggest that the general population hold an optimistic view towards the mentally ill and do not feel the need for the mentally ill to be isolated from the rest of society. It shows that the general population may be as well informed and understanding of mental illness as those students who have studied psychology. This is consistent with the results from Ireland's see change campaign which found there was increased awareness and understanding of mental health, mental health problems, stigma and support services.

The second hypothesis explored the difference in mental well-being among psychology students and the general population. A two-tailed independent samples t-test revealed that there was no significant difference between psychology students and the general population in regards to 3 of the indicators of mental health well-being in regards to Perceived stress ($t = 0.26$; df 149; $p > .013$, 2-tailed), Optimism ($t = -1.90$; df 149; $p > .013$, 2-tailed), and General Health ($t = 0.81$; df 149; $p > .013$, 2-tailed). Further analysis showed no significant difference in relation to pessimism subscale showing results of ($t = -1.04$; df 149; $p > .013$, 2-tailed). Previous literature on Stress has shown that psychological stress has an important role in both the onset and course

of mental illness, including schizophrenia, anxiety disorders, and depression. Life events have been most studied. In our research Psychology students (M=18.2, SD=9.04) showed to score higher on levels of Perceived stress. This is not consistent with our hypothesis that psychology students would be better educated and therefore better prepared to deal with stressful events within their lives. However the results are consistent with Archer & Lalmin (1985), who reported that college students encounter an additional range of stressors and Sax (1997) who states a disturbing trend in college student health is the reported increase in student stress nationwide. This is evident in Hirsch and Keniston (1970) study, which looked at the dropout rate of students in university. They estimated that fifty percent of entering students do not finish college four years later. According to Hirsch and Ellis (1966) the pressure to earn good grades and to earn a degree is a very high source of stress among students. It is clear from these studies that college students are particularly prone to stress and psychology students are no different. This research is useful as it may highlight the need to education college students and ensure their mental well-being is being looked after. Methods to reduce stress by students often include effective time management, social support, positive reappraisal, and engagement in leisure pursuits (Blake and Vandiver, 1988; Mattlin et el, 1990) and college should ensure that these approaches are implemented.

Psychology students also significantly differed from the general population in relation to optimism (M=8.04, SD=5.45) and General Health (M=13.53, SD=7.16). People that hold an optimistic outlook in life have demonstrated higher levels of motivation, persistence, and performance. This is consistent with our finding and follow the hypothesis that psychology students would score higher in the optimism indicator of mental well-being. Natail-Alemany (1991) found optimism to be positively associated with adaptive coping skills, while Weintruab, Carver and Scheier (1986) have found pessimism to be associated with maladaptive coping strategies. This is consistent with our finding and follows our hypothesis that psychology students' higher levels of optimism which in turn, if following the above research, may positively associate with better coping skills.

However, the results for the general Health questionnaire are higher for psychology students (M=13.53, SD=7.16) than the general population which shows that these individuals may be in some psychological distress. This is consistent with researchers at George Fox University who found that although 86 percent of psychologist professionals reported they'd had psychotherapy at some point in their lives, 59 percent said there were times when they could have benefited from therapy but didn't seek it. This shows that although professional in the area are educated and skilled within the area's of mental illness they too may suffer from psychological stress and as stated above may not seek help during these times of distress. Furthermore, the study found that psychologists still face many of the same barriers to seeking mental health care the general population faces: not enough time, not enough money and trouble admitting distress. Moreover, the study found that 61 percent of those surveyed listed additional stressors that interfere with their jobs, including personal losses, problems with insurance companies and conflicts with co-workers. This is consistent with our finding that psychology students showed more psychological distress at the time of data collection despite all the knowledge and skills they learn about coping styles.

When we examined the 2 groups in relation to coping skills this section of results had be sub-divided into 3 subscales. The results indicate that there was no significant difference in relation to avoidant emotional coping between the groups ($t = -0.51$; df 148; $p>.013$, 2-tailed). Psychology students (mean, 6.21. SD, .75) and the general population (mean, 6.18. SD, .67) Avoidant emotional coping is viewed as maladaptive, for example, using self-distraction to avoid the source of distress (without engaging in problem-focused behavior). Although avoidant coping may help individuals manage their day-to-day activities soon after a crisis, reliance on this coping style over time can lead to mental health problems (Holahan & Moos, 1987). This result does not give a clear indication if psychology students are better equip with coping skills. Although the two groups did not differ significantly, avoidant coping as stated above is a form of self-distracting oneself from the problem and it not necessarily a healthy form of coping as overtime it may lead to mental health problems.However the two-tailed independent samples t-test revealed that there was a significant difference between psychology students and the general population in the subscales problem focused coping ($t = -4.69$; df 148; $p<.013$, 2-tailed)

and active emotional coping (t = 4.26; df 148; p<.013, 2-tailed). Psychology students (mean, 22.33. SD, 7.306) exhibited greater use of problem focused coping than the general population (mean, 17.18. SD, 6.11). Problem focused coping is generally viewed as an adaptive mode of coping that involves actively planning or engaging in a specific behavior to overcome the problem causing distress using techniques such as active coping, planning, instrumental support, and religion scales (Folkman & Lazarus, 1985). Examples of this is getting advice from other people, praying or meditating and taking action to try and make the situation better. Results were consistent with our hypothesis that psychology students would display healthier coping skills. Psychology students also showed greater use of active emotional coping (mean, 26.27. SD, 5.81) than the general population (mean, 21.63. SD, 7.22). Active emotional coping, such accepting the situation or cognitively reframing a stressor's impact, is typically viewed as an adaptive emotion-regulation strategy. It includes examples like relying on others for emotional support, venting, accepting what is happening all of which are positive coping mechanisms. This result was consistent with our hypothesis that psychology students have better coping skills.

The third hypothesis explored the hypothesis that perceived stress, optimism and coping styles would significantly predict a person's psychological distress. A multiple regression analysis revealed that there was a significant prediction (R^2 = .62, $F(5,142) = 48.05$, $p < .001$), which further indicated that the five predictors explained 62% of the variance. This is consistent with earlier literature stating that psychological stress (β = .69, p = .00) has an important role in both the onset and course of mental illness, including schizophrenia, anxiety disorders, and depression. Life events have been most studied. The recognition that these events play a prognostic role in illness first came from the work of Rahe and our findings supports this previous research (Holmes & Rahe, 1967). Lazarus and Folkman (1984) indicate that coping styles can affect how a stressful event is perceived and how it is managed. And in relation to our results it was found that all three categories of coping styles positively predicted psychological distress, problem focused coping (β = .07, p = .001), active emotional coping (β = .07, p = .02), and avoidant focused coping (β = .08, p = .006). These result also correlate with

earlier literature which stated that It has long been known that people with a diverse array of mental disorders, including depression, schizophrenia, anxiety disorders and autism lack coping resources for managing the challenges of daily living. Likewise chronic psychological distress, which is related to lack of coping resources (Repetti et el, 2002), is implicated in more than half of the DMS-IV axis I disorders and in almost all of the axis II psychiatric disorders (Am. Psychiatry. Assoc. 1994). However, optimism did not significantly predict psychology distress (β = .01, p = .086). This correlates with Natail-Alemany's (1991) study which found optimism to be positively associated with adaptive coping skills. Specifically, Dispositional optimism has been tied to a broad array of mental and physical heal benefits, including greater psychological well-being (e.g. Kubzansky et el, 2002), and faster recovery from illness (Scheier et el, 1989). Previous research has also shown that optimism has been shown to mitigate the effects of stressors on psychological functioning which would correlate with our finding in this study.

The forth hypothesis explored if there would be a significant difference between males and females in relation to attitudes towards mental illness using the CAMI subscale. For this, a two-tailed independent samples t-test was conducted in order to determine any significant gender differences. The results of the t-test analyses found that males and females were not observed to significantly differ with respect to the CAMI subscales of Benevolence (t = -1.25; df = 149; p>.05, 2-tailed), Social Restrictiveness (t = .99; df = 149; p>.05, 2-tailed) and Community Mental Health Ideology (t = .15; df = 149; p>.05, 2-tailed). However there was significant difference in the subscale of Authoritarianism (t = -2.23; df = 149; p.<.05, 2-tailed). Females (M=42.11, SD=4.31) were observed to maintain slightly stronger beliefs in the institutionalism of the mentally ill. This is of interest as it has been stated that Females have been found to make up a substantial percentage of psychology graduate students with nearly 72% of new Psychology doctorates being women (Cynkar 2007).

4.2 Limitations

Future studies may test if the relationships found here are replicable in different cultural contexts. Furthermore future studies may also include a brief talk or lecture as it has been continuously noted that more education leads to more favourable attitudes regarding mental health. Future studies may also consider focusing on interaction and personal knowledge of someone affected by mental illness, asking questions about their working life and if they come into contact with people affect by mental illness on a regular basis. The added option of an open ended question for people to give a description of what they see mental illness as may bring more insight to any future studies.

4.3 Conclusion

In conclusion, this study found that there was no significant difference in attitudes towards mental illness between the two groups, psychology students and the general population. This provides valuable information that the general population sample used were equally informed about mental health awareness and attitudes towards mental illness. Campaigns such as the see change Ireland compaign strive to provide information to the public and our research corresponds with their increase in positive attitudes towards mental illness as seen in their repeated survey in 2012. The general population were not only found to have favourable attitudes towards the mentally ill but also did not support the idea of isolating the mentally ill form society. Psychology students were found to be more open to the idea of having mental health facilities within their neighbourhood and would not object to having someone with mental illness as their neighbour. Furthermore, it was found that psychology students and the general population did not significantly differ in relation to stress levels, optimism and general psychological distress. However there was some differences in the style of coping used, no significance was determined when using avoidant emotional coping but there was a significant difference in problem focused and active emotional coping techniques with psychology students using these techniques more often. This information could prove valuable in terms of treatment and therapy as poor coping skills have been linked to the development of mental disorders such as anxiety and depression. Furthermore it was determined that stress and

coping styles have a positive association with psychological distress, this along with the other finding of other research has provided information is which may help to improve current anti-stigma campaigns or in the development of new interventions. With more research conducted within the area's of mental illness the greater the chance for these interventions to succeed and the greater the chance of reducing stigma and stereotyping attitudes towards those with a mental illness. In closing increasing psychological well-being of those with a mental illness and producing less stigamatising and more favourable attitudes towards the mentally ill does seem to be improving in Ireland and more research is needed to further this development.

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Appendix

Appendix A: Consent sheet.

Survey Information Consent Form

My name is Sarah Boyle and I am conducting psychological research that explores attitudes towards mental illness. This research is being conducted as part of my final year studies and will be submitted for examination.

The questionnaire will require you to give your opinion on the statements relating to mental illness. It will take 10-15 minutes to complete and you must be over 18 years old to participate. Your answers will be kept anonymous, and your name is NOT required to be put on the questionnaire.

Only group answers will be documented on, not individual answers. For this reason it will not be possible to withdraw from participation after the questionnaire has been collected/submitted.

However, you have the right to withdraw at any time before submitting your questionnaire. It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.

If you are in agreement to fill out the questionnaire, please answer the questions below, as accurately as possible by ticking the box beside the answer that best represents your opinion.

Please note this questionnaire is double-sided. Should you require any further information about the research, please contact me at

Many thanks for taking the time to complete this questionnaire.

Appendix B: Demographic Questionnaire

I am over the age of 18 and understand that by completing and submitting this questionnaire I am consenting to participate in the study.

☐ Yes

☐ No

Gender

☐ Male

☐ Female

Have you studied psychology at college?

☐ Yes

☐ No

Appendix C: Community Attitudes towards Mental Health (Taylor and Dear, 1981).

The questions in this scale ask you about your attitudes towards mental illness. Please choose the answer that best represents your opinion using the following responses:

1) Strongly agree 2) Agree 3) Neutral 4) Disagree 5) Strongly Disagree

	1	**2**	**3**	**4**	**5**
1. The mentally ill should not be given any responsibility					
2. The mentally ill should be isolated from the rest of the community					
3. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered					
4. I would not want to live next door to someone who has been mentally ill					
5. Anyone with a history of mental problems should be excluded from taking public office					
6. The mentally ill should not be denied their individual rights					
7. Mental patients should be encouraged to assume the responsibilities of normal life					
8. No one has the right to exclude the mentally ill from their neighbourhood					
9. The mentally ill are far less of a danger than most people expect					

10. Most women who were once patients in a mental hospital can be trusted as babysitters						
11. One of the main causes of mental illness is a lack of self-discipline and will power						
12. The best way to handle the mentally ill is to keep them behind locked doors						
13. There is something about the mentally ill that makes it easy to tell them from normal people						
14. As soon as a person shows signs of mental disturbance, he should be hospitalised						
15. Mental patients need the same kind of control and discipline as a young child						
16. Mental illness is an illness like any other						
17. The mentally ill should not be treated as outcasts from society						
18. Less emphasis should be placed on protecting the public from the mentally ill						
19. Mental hospitals are an out-dated means of treating the mentally ill						
20. Virtually anyone can become mentally ill						
21. The mentally ill have for too long been the subject of ridicule						
22. More tax money should be spent on the care and treatment of the mentally ill						
23. We need to adopt a far more tolerant attitude toward the mentally ill in our society						
24. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for						
25. We have a responsibility to provide the best possible care for the mentally ill						
26. The mentally ill don't deserve our sympathy						
27. The mentally ill are a burden on society						
28. Increased spending on mental health services is a waste of tax euro's						
29. There are sufficient existing services for the mentally ill						
30. It is best to avoid anyone who has mental problems						
31. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community						
32. The best therapy for many mental patients is to be part of a normal community						

33. As far as possible, mental health services should be provided through community based facilities					
34. Locating mental health services in residential neighbourhoods does not endanger local residents					
35. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services					
36. Mental health facilities should be kept out of residential neighbourhoods					
37. Local residents have good reason to resist the location of mental health services in their neighbourhood					
38. Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great					
39. It is frightening to think of people with mental health problems living in residential neighbourhoods					
40. Locating mental health facilities in a residential area downgrades the neighbourhood					

Appendix D: The Brief COPE Scale, (Carver, 1997)

These items deal with ways you've been coping with stress in your life. There are many ways to try to deal with problems. These items ask what you've been doing in general to cope with stressful events. Obviously, different people deal with things in different ways, but think about what you usually do when you are under a lot of stress. Please choose the answer as true FOR YOU as possible form the responses below;

1) I haven't been doing this at all
2) I've been doing this a medium amount
3) I've been doing this a little bit
4) I've been doing this a lot

	1	**2**	**3**	**4**
1. I've been turning to work or other activities to take my mind off things				
2. I've been concentrating my efforts on doing something about the situation I'm in				
3. I've been saying to myself "this isn't real"				
4. I've been using alcohol or other drugs to make myself feel better				
5. I've been getting emotional support from others				

1) I haven't been doing this at all **2) I've been doing this a medium amount**
3) I've been doing this a little bit **4) I've been doing this a lot**

8. I've been refusing to believe that it has happened				
9. I've been saying things to let my unpleasant feelings escape				
10. I've been getting help and advice from other people				
11. I've been using alcohol or other drugs to help me get through it				
12. I've been trying to see it in a different light, to make it seem more positive				
13. I've been criticizing myself				
14. I've been trying to come up with a strategy about what to do				
15. I've been getting comfort and understanding from someone				
16. I've been giving up the attempt to cope				
17. I've been looking for something good in what is happening				
18. I've been making jokes about it				
19. I've been doing something to think about it less, such as going to movies, watching TV ,reading, daydreaming, sleeping or shopping				
20. I've been accepting the reality of the fact that it has happened				
21. I've been expressing my negative feelings				
22. I've been trying to find comfort in my religion or spiritual beliefs				
23. I've been trying to get advice or help form other people about what to do				
24. I've been learning to live with it				
25. I've been thinking hard about what steps to take				
26. I've been blaming myself for things that happened				
27. I've been praying or meditating				
28. I've been making fun of the situation				

Appendix E: Perceived Stress Scale, (Cohen et el, 1983)

The questions in this scale ask you about how your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way

0) Never 1) Almost Never 2) Sometimes 3) Fairly often 4) Very Often

	0	**1**	**2**	**3**	**4**
1) In the last month, how often have you been upset because something unexpectedly happened?					
2) In the last month, how often have you felt that you were unable to control the important things in your life?					
3) In the last month, how often have you felt nervous and "stressed"?					
4) In the last month, how often have you felt confident about your ability to handle your personal problems?					
5) In the last month, how often have you felt that things were going your way?					
6) In the last month, how often have you found that you could not cope with all the things that you had to do?					
7) In the last month, how often have you been able to control irritations in your life?					
8) In the last month, how often have you felt you were on top of things?					
9) In the last month, how often have you been angered because of things that were outside of your control?					
10) In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?					

Appendix F: Life Orientation Test-revised, (Scheier et al. 1994)

For the following statements please choose an answer according to your own feelings from the responses below;

0) I agree a lot 1) I agree a little 2) Neither agree or disagree 3)I disagree a little 4) I disagree a lot

	0	**1**	**2**	**3**	**4**
1) In uncertain times, I usually expect the best					
2) It's easy for me to relax					
3) If something can go wrong for me, it will					
4) I'm always optimistic about my future					
5) I enjoy my friends a lot					
6) It's important for me to keep busy					
7) I hardly ever expect things to go my way					
8) I don't get upset too easily					
9) I rarely count on good things happening to me					
10) Overall, I expect more good things to happen to me than bad					

Appendix G: The General Health Questionnaire, (Goldberg & Williams, 1988)

These questions relate to how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Please circle the response that best applies to you.

Have you recently:

Been able to concentrate on what you're doing?

0)Better than usual 1) Same as usual 2) Less than usual 3) Much less than usual

Lost much sleep over worry?

0)Not at all 1) No more than usual 2) Rather more than usual 3) Much more than usual

Felt that you are playing a useful part in things?

0)More so than usual 1) Same as usual 2) Less than usual 3) Much less than usual

Felt capable of making decisions about things?

0)More so than usual 1) Same as usual 2) Less than usual 3) Much less than usual

Felt constantly under strain?

0)Not at all 1) No more than usual 2) Rather more than 3) Much more than usual

Felt you couldn't overcome your difficulties?
0)
Not at all 1) No more than usual 2) Rather more than usual 3) Much more than usual

Been able to enjoy your normal day to day activities?

0)More so than usual 1) Same as usual 2) Less so than usual 3) Much less than usual

Been able to face up to your problems

0)More so than usual 1) Same as usual 2) Less than usual 3) Much less than usual

Been feeling unhappy or depressed?

0)Not at all 1) No more than usual 2) Rather more than usual 3) Much more than usual

Been losing confidence in yourself?

0)Not at all 1) No more than usual 2) Rather more than usual 3) Much more than usual

Been thinking of yourself as a worthless person

0)Not at all 1) No more than usual 2) Rather more than usual 3) Much less than usual

Have you recently:

Been feeling reasonably happy, all things considered?

0)More so than usual 1) Same as usual 2) Less so than usual 3) Much less than usual