The effects of a video-presentation on attitudes towards Mental Health

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Abstract

A cross-sectional and longitudinal design was used in order to establish the effects an intervention in the form of a video presentation may have on attitudes towards mental health. Three variables were combined in order to provide an overall measure of attitudes towards mental health. These measures included attitude towards mental illness, attitude towards seeking professional help and empathy. A total of 74 participants took part in the study. Pre and post-intervention effects were measured in one group (n=37) while a separate control group (n=37) did not engage with the intervention. The repeated measures analysis found that there was no significant difference between pre-intervention scores and post-intervention scores. There was a significant difference between both conditions for each measure when the variables were compared individually. Additionally, the between group analysis indicated that there was a positive significant difference between the post-intervention group and the non-intervention (control) group.
1 Introduction

1.1 Mental Health

The definition of ‘mental health’ may be used to establish a concept which consists primarily of three parts. Firstly, the term may be used in a positive sense in order to indicate the psychological well-being of an individual. On the other hand, the term could be used negatively to describe a person who is suffering from mental health problems. Finally, ‘mental health’ may be used as a much broader term in order to incorporate the facilities used by people suffering from mental health problems (Pilgrim, 2014). Of course, there are a number of definitions which may offer an alternative view on mental health. Jahoda (1958) argues that the term ‘mental health’ is simply too vague a term to adequately summarise such a complex topic.

Jahoda elaborates further on the additional factors which contribute to the difficulties that researchers and clinical professionals face when attempting to conceptualise ‘mental health’. Society’s definition of what is ‘healthy’ or ‘normal’ changes over time. For example, one of the diagnostic criteria published in a manual for psychiatric research in 1972 listed homosexuality and transsexualism as mental disorders (Feighner, Guze, Woodruff, Winokur & Munoz, 1972). A scientifically rigid and clear-cut divide between what is considered normal and abnormal behaviour has proven to be extremely difficult to establish. The issue of simply creating a solid definition for the concept of mental health and mental illness is only scratching the surface of what has become a much more complex and deeply rooted problem in society.

The World Health Organisation (WHO) describes the many areas in which the consequences of mental disorders are felt. Not only does the health of an individual suffer, but the effects are also felt on a social and economic level. The WHO reports on the prevalence of a range of mental disorders. It is estimated that around 400 million people
across all ages suffer from depression, with symptoms being more common in women than in men. Additionally, around 60 million people worldwide suffer from bipolar disorders, 21 million from schizophrenia and 35 million from dementia (WHO, 2014).

The Diagnostics Statistics Manual (DSM) was created in order to aid clinical professionals in the clinical diagnosis of such mental disorders. The DSM is deemed by the American Psychological Association (APA) to be an accepted standard for defining these mental disorders and is currently in its 5th edition, with the first being published in 1952. Alternative resources available for clinical use include the International Classification of Diseases (ICD), which is published by the World Health Organisation (WHO) and is in its 10th edition. After a clinician has performed the necessary psychological tests, a “summary classification” of symptoms experienced by the patient are drawn up. A clinical diagnosis can then be obtained with the help of resources such as the DSM and the ICD. The use of sources such as these provide clinicians with a clearly outlined set of symptoms, which helps aid the validity and diagnosis of mental disorders as it encourages consistent diagnoses across clinical professionals (Butcher, Hooley & Mineka, 2014).

In 2011, the World Health Organisation conducted research using its 184 Member states, which covers approximately 98% of the world’s population. Findings indicated numerous problems with the resources available to treat and prevent mental disorders, with global spending averaging at less than two US dollars per person. This figure drops to just 25 cents per person in countries of lower income. The distribution of these resources was also found to be unevenly spread across the globe, with lower income countries being most affected by a lack of services. Additionally, inefficient utilisation of mental health resources was found to occur globally with 67% of mental health spending allocated to mental hospitals, in which 63% of psychiatric beds are located. Finally, there has been a decrease in mental hospital beds between 2005 and 2011, a statistic found globally and across almost
every income group (WHO, 2011). These trends indicated the urgent need for government agencies across the world to take action in order to ensure the adequate treatment of mental health disorders for citizens in every country and from all income regions.

In response to findings such as these, a strategy was undertaken by the WHO which outlines the necessity to recognise the importance of mental health for the overall health and well-being of people. An action plan was designed and is intended to be implemented from 2013 until 2020. The plan sets out four major objectives. These include the need for government bodies to provide more efficient healthcare systems, more mental health and social care for community-based settings, using various strategies to promote mental health as well as prevent illness and to provide more evidence and research which will enhance understanding of mental illness. The plan also aims to prevent suicide and to protect groups of people, who due to the nature of their environment or situation are particularly vulnerable to mental disorders. Such individuals include, but are not limited to lesbian, gay, bisexual and transgender people (LGBT), people living in poverty, exposed to conflict, disasters and humanitarian emergencies (WHO 2013). It is hoped that these clearly defined objectives will prompt Member States to implement the action plan, as well as provide a basis on which progress and impact can be measured.

1.2 Attitudes, Awareness and Behaviour

An attitude may be defined as an organisation of beliefs, feelings and behavioural tendencies which people hold in relation to other people, objects, symbols or events. A three component attitude model assists researchers in understanding the underlying structure of attitudes. At a basic level, the model consists of a cognitive component, an affective component and a behavioural component. Additionally, attitudes tend to display a number of characteristics. For example, they tend to be relatively enduring and last over long periods of
time. They also appear to be generalizable and quite abstract in nature (Hogg & Vaughan, 2010).

It is proposed that attitudes serve an important social function since they enable people to quickly relate to their surroundings. This means that every experience does not need to be analysed as if it were a new one and in this way, attitudes help save time (Smith, Bruner & White, 1956). Katz (1960) elaborated on the possible functional aspects of attitudes. These include: knowledge, which allows for a consistent environment that enables people to make predictions about the world around them. Expression, since attitudes form a part of our identity. Adaptation, allowing for social acceptance among other people and ego-defensive functioning, which protects an individual's self-esteem and enables them to justify their actions.

Mental health is promoted by many organisations in several different ways, depending on the specific issue that is in question. One general aim that many of these organisations seem to have is to raise awareness. These organisations have certainly had a profound impact in educating the general public on such issues, with a study by Crumpton, Weinstein, Acker & Annis (1967) indicating that words such as “dangerous” and “worthless” were closely affiliated with the topic of mental illness just over 40 years ago. In more modern times, using these derogatory terms to describe someone suffering from a mental illness is generally less heard of.

It was once thought that attitudes were reliable predictors of behaviour, with earlier theorists such as Watson (1925) considering the topic of attitudes to be the central focus of social psychology. However there have been several well-known studies which have demonstrated that attitudes and behaviour are not always as consistent with one another as one might expect. One such study is by LaPiere (1934), in which the researcher travelled around the United States with a Chinese couple visiting numerous restaurants and hotels.
Only one of these establishments refused the couple, despite 91% of the hotels and restaurants stating that they would not serve a Chinese couple when later surveyed. Similar inconsistencies were found by Corey (1937) in which there was no significant correlation between attitudes towards cheating and real life behaviour among a student sample.

1.3 Seeking Professional Help

There are a wide variety of services available for people who are experiencing symptoms of a mental disorder. When an individual begins to display or experience abnormal behaviour, a General Practitioner (GP) is generally their first point of contact. The GP can then decide whether or not they themselves can treat the patient, or whether it would be more appropriate for the patient to be referred to a specialist. The public catchment area system is the main mental health system in Ireland and it aims to provide local access to professional help services. However, many parts of the country still lack such services within the community, which means people must travel further in order to avail of them. In addition to the outlined research regarding stigma values and attitudes towards mental illness, this lack of accessibility to service may further increase the likelihood of an individual delaying seeking help (Barry & Lane, 2006).

The negative consequences of mental health disorders have been irrefutably documented in countless studies across the world. Patel, Flisher, Hetrick & McGregor (2007) highlight the severity of mental health disorders in young people between the ages of 12 and 24. Mental health issues that arise during youth are noted to be strongly related to many other concerns that may carry into adult life. These include substance abuse, violent behaviour and typically lower educational achievements than healthy individuals. Therefore it is vitally important that when symptoms present themselves, particularly at a young age, that the individual seeks the appropriate professional help.
A strong correlation has been established between mental illness and suicide (Harris & Barraclough, 1997). In one study, 100 cases of suicide were reviewed by researchers. It was found that 93% of these cases involved people who were diagnosed as mentally ill, with depression and alcoholism being the largest contributing factors (Barraclough, Bunch, Nelson & Sainsbury, 1974). The central statistics office in Ireland reported worrying findings that indicated a recent spike in suicide cases, particularly among men. In 2011, 554 suicides were recorded in the country, 458 of which were male cases, (Central Statistics Office, 2011).

With this knowledge in mind, early detection and treatment of mental health disorders is vitally important to ensure that an individual develops healthily later in life. However, younger people have been shown to display a strong reluctance towards seeking professional help, with one study indicating that only one third of 15-16 year olds with extremely high levels of anxiety and depression sought help from mental health services (Zachrisson, Rodje & Mykletun, 2006). Wang, Angermeyer, Borges, Bruffaerts, Tat Chiu, De Girolamo & Chatterji (2007) used the World Mental Health (WMH) survey to conduct a study using over 76,000 participants from 15 different countries. The study used the ages at which individuals first started experiencing symptoms of a mental disorder and the age at which they made contact with services in order to receive treatment. This enabled the researchers to identify how long people delayed or failed to seek professional help altogether.

The results differed across various mental health problems. For example, people who were experiencing mood disorders demonstrated a delay in seeking help which lasted from between 1 year to 14 years. Substance abuse disorders showed a slightly longer delay rate, lasting from between 6 to 18 years. However, it was the anxiety disorders that demonstrated the longest duration of delayed help seeking, lasting from between 1 year to 30 years. It is evident from these results that the failure and delay of help seeking differs across various
mental disorders, yet the data led researchers to conclude that this is a consistent problem that can be seen worldwide.

The findings from the aforementioned studies naturally lead researchers to the question as to why people do not seek help, despite the vast array of scientifically validated methods of treatment. There have been many studies which attempt to determine the factors that may discourage an individual from using mental health services, yet there is relatively little research in the field of help seeking behaviour. However, the research that does exist in this area seems to suggest that there are two factors which may influence the likelihood of an individual seeking professional help. The first factor to take into consideration is whether or not the individual has a relationship with someone who has recommended that they seek professional help. This factor accounted for 75% of people who sought help in one study. Another study demonstrated that 94% of participants who had sought help knew of someone who had previously sought help themselves (Pescosolido & Boyer, 1999). It is important that further research is conducted which explores the area of professional help seeking in order to gain a deeper understanding of the complexity of mental health attitudes. Findings from such research could prove to be vitally important for researchers who are designing education and mental health programmes (Vogel, Nathaniel, Wester, Larson & Hackler, 2007).

1.4 Stigma

Unfortunately, the process of attitude formation often facilitates the formation of stereotypes. Stereotypes are usually an overly simplified version of members of from a particular group. The characteristics used to describe these people are often derogatory in nature and usually create a distinct visual description of the group members (Hogg & Vaughan, 2010). It is through the formation of these stereotypes that stigma is created. Stigma was a term coined by the ancient Greeks which was used to identify a person who
posed a risk to society. Such people were generally seen as a highly disliked individual and an overall disgrace (Gregory, Flynn & Slovic, 2013). Stigma is considered to be one of the biggest barriers that prevent people from seeking professional help (Chadwick & Porter, 2014). It is an extremely powerful social phenomenon that carries with it the potential to “destroy the integrity of the ego entirely” (Allport 1979, p.152), as well as create a “grovelling self-image,” (Crocker & Major, 1989). When a person encounters a situation or event that does not match up with their existing stereotypes their expectations are therefore unmet. It is proposed that stigmatisation occurs as a result of this mismatch between expectation and reality.

The effects of the stigmatisation of an individual may vary from person to person. One of the main factors that influence how a person deals with stigma is their identity beliefs. One group that is particularly prone to adverse reactions to stigma are people who are intent on fitting into a specific social category. Should someone fall outside this category for any particular reason, there is likely to be an accompanied sense of shame (Goffman, 2009). This may therefore offer some explanation for the general reluctance to seek professional help for mental health issues, particularly in the younger adolescent demographic, where fitting into a favourable social group is of great concern. Mental illness therefore presents two major problems for sufferers. The first are the actual symptoms themselves which may interfere with many important aspects of an individual's life such as work, education and social abilities (Penn, Corrigan, Bentall & Racenstein, 1997). The second issue that arises with a mental illness is the potential aforementioned stigma that accompanies the diagnosis. Finsen (1996) describes this as a “second illness” which accompanies any mental illness, resulting in further suffering for the individual.

Wahl (1999) described in a study, the effects that stigma had on people suffering from mental health problems. Many participants in the study were particularly concerned about
how others would react to their psychiatric status. This resulted in an array of negative emotions along with an overall lowered sense of self-esteem which inevitably led participants to conceal their mental illness from other people. The study also indicated that sources of stigma included family, co-worker and even the mental health caregivers. One of the most stigmatized mental health illnesses is schizophrenia, while depression, anxiety and eating disorders are garnering public interest in more recent years (Schulze & Angermeyer, 2003).

1.5 Empathy

Human empathy refers to the ability to understand the emotions, thoughts and feelings of another person, while at the same time being able to share emotions with others. Neuroimaging techniques such as the use of fMRI scanners have enabled researchers to localise particular areas of the brain associated with empathetic behaviour. Findings from such research has led to the development of a two-system theory, in which both emotional and cognitive elements play a role in empathetic functioning. The inferior frontal gyrus and the inferior parietal lobe have been identified as key structures involved with emotional responses. Additionally, the ventromedial prefrontal cortex, temporoparietal junction and the medial temporal lobe appear to play an important role in the cognitive system, (Tsoory & Simone, 2011).

These neuroimaging techniques have also enabled researchers within the field of social psychology to investigate the effects that stigma can have on an individual’s empathy on a biological level. One such study exposed participants to two people experiencing pain as a result of an AIDS infection, one of which contracted the virus through intravenous drug use, while the other through an error in blood transfusion. The research rationale was that participants would hold a social stigma for people that engage in drug use and this would affect how empathetic they felt towards them. These empathetic values should therefore be
reflected in results obtained from behavioural and functional neuroimaging techniques. The results confirmed this hypothesis, with the neuroimaging results indicating that most participants experienced heightened activity in areas of the brain such as the right anterior insula and anterior midcingulate cortex. These regions are notably involved with pain processing and were shown to be more active in participants in relation to the transfusion case rather than the intravenous case (Decety, Echols & Correll, 2010). Findings such as these indicate that a relationship may exist between stigma and empathy. In light of this knowledge, it may be useful to therefore take empathy into consideration when attempting to measure stigma.

1.6 Intervention

As previously outlined, healthcare professionals such as caregivers may be just as affected by stigma as the rest of the population and it is important to take these kind of findings into consideration because they show that stigma can be found where it is least expected. This highlights the importance of research that attempts to come up with solutions that may reduce stigmatisation. Chadwick & Porter (2014) designed a study which attempted to determine what kind of an effect a clinical placement in a psychiatric/mental establishment would have on the attitude of the nurses towards people with mental disorders. The findings indicated a positive shift in attitude after the 4 week placement, with more negative attitudes generally recorded prior to the placement. It was concluded that mental health stigma was reduced after experience in such a setting. Of course, not every person has an opportunity to receive such experience. Therefore, it is important that research focuses on alternative ways to reduce stigma in the wider population.

Another reportedly effective method for reducing stigma and raising mental health awareness is through the use of social marketing techniques. This form of marketing aims to
bring about social change, rather than attempt to sell products to the public (Pinfold, Thornicroft, Huxley & Farmer, 2005). The potential benefit of implementing such a marketing strategy is that it could reach a target audience on a national level. Previous strategies have been undertaken in which the media has been utilised to bring about change in health behaviour. Huge amounts of money have been spent by government agencies on advertisements which discourage risky health behaviour such as smoking and alcohol abuse. The effects that these advertisements have had on behaviour appear to be inconsistent across various studies (Wakefield, Lokin & Hornik, 2010).

Despite the varying success rates of media health campaigns, Salter & Byrne (2000) argue that the media may certainly be used as a tool to reduce stigma across large masses of people. It is already apparent that the media plays a large role in how the public engages with the topic of mental health through the portrayal of stereotypical mentally ill patients in the media. It is, however, additionally important for research to consider whether or not these campaigns have the capability of bringing about changes in behaviour, namely actively seeking psychological help. Wimbush, MacGregor & Fraser (1998) reported on the effect a mass media health campaign had on individuals in Scotland. The campaign was aimed at encouraging walking and despite 70% of people surveyed being aware of the campaign, they reported that it had no effect on their behaviour.

One way in which research could build upon findings such as these is by implementing other factors into the campaigns which have demonstrated favourable results in previous studies. As was previously outlined, people appear to be more strongly engaged with individuals who have had first-hand experience with the topic of mental illness. Scollay, Doucett, Perry & Winterbottom (1992) noted in one study that a lecture given to a large school audience on the topic of safe sex from someone known to be HIV positive resulted in higher awareness and positive behavioural attitudes than a lecture given by someone that was
not affected by sexually related illnesses. These findings are consistent with an instructional theory presented by Gagne (1972) which elaborates on the various forms of learning outcomes which should be taken into consideration when attempting to teach a learner certain material. One of the learning outcomes which is discussed is in relation to attitudinal learning. For this particular outcome, Gagne emphasises the importance of involving social contact with a human model in the teaching process.

One study by Pinfold, Stuart, Thornicroft & Arboleda-Florez (2005) sought to establish the effect an intervention had on the mental health attitudes of a younger, school-based population in both the UK and in Canada. The intervention, which featured an educational workshop produced a positive change in the attitudes, which was indicated by a shift in the students understanding of myths and facts surrounding mental health. Further findings indicated that a highly effective method for reducing stigma and raising awareness is through the use of first-hand accounts provided by people who have previously suffered from mental health problems and have made use of professional services. The use of testimonials such as these as an intervention measure have yielded significantly favourable results among different samples including police officers and school students.

Despite the effectiveness of these first-hand testimonial intervention methods, the cost and time consuming factors involved may certainly become barriers to their implementation on a large scale. Media campaigns could perhaps offer a solution to this shortcoming and with the knowledge of first-hand testimonial effectiveness, previous research with regards to media health campaigns could be built and improved upon. This may be particularly relevant to modern society and its technological advances which could provide a medium through which many people can be reached.
1.7 Rationale of Current Study

The current study attempted to measure attitudes towards mental health. This was achieved by measuring three variables which were attitudes towards mental illness, attitudes towards seeking professional help and levels of empathy. As the previously outlined research has shown, attitudes do not always predict behaviour. Attitudes towards seeking professional help was included as a measure since there is currently a lack of research with regards to this topic. Additionally, it was hoped that this would encourage participants to consider how they would actually apply their attitudes to real life situations. It is therefore hoped that through a combination of these three variables, that a richer understanding may be obtained with regards to overall attitudes towards mental health.

An intervention in the form of a short video with a speaker on mental health was shown to participants. Taking the previous research findings into consideration, it was hoped that this video, particularly since the speaker has experienced mental health issues at first hand, would induce a positive change in attitudes among participants on the topic of mental health. While previous research has looked at the effects of testimonial intervention with the speaker present with the participants, this study would differ since the speaker would not be physically present with the participants.

If a significant result did indicate a positive shift in attitudes, then this study may have been beneficial in the sense that future research could focus on ways to best utilise media tools, as well as evaluate its effectiveness in order to provide a cheaper, quicker and a potentially wider reaching intervention. Alternatively, a non-significant finding could have been taken into consideration as it may suggest that further research needs to be undertaken.
in order to identify the optimal ways of reducing stigma and promoting positive mental health attitudes.

1.8 Main Hypotheses

Several hypotheses emerge in light of the previously outlined rationale:

H₁ Stated that scores relating to attitudes towards mental health would be higher post-intervention than pre-intervention.

H₂ Stated that scores relating to attitudes towards mental health would be higher in the post intervention group than the group receiving no intervention.

H₃ Stated that scores for attitudes towards mental illness would be higher post-intervention than pre-intervention.

H₄ Stated that scores for attitudes towards seeking professional help would be higher post-intervention than pre-intervention.

H₅ Stated that scores for empathy would be higher post-intervention than pre-intervention.
2 Methodology

2.1 Participants

Participants (n=74) were selected using two sampling techniques. Firstly, a convenience sample (n=67) was obtained from a college located in Dublin City. This was achieved by presenting the topic of the study to several classes within the college and asking for voluntary participation. Secondly, participants were obtained through word of mouth outside the college (n=7). In this case, people recommended the study to friends and family who in turn volunteered to take part. Such sampling methods were used in order to ensure that there were enough pre and post-intervention participants available for the study. Of these 74 participants, 37 were measured both pre and post intervention. The remaining 37 participants did not engage with the intervention. The sample consisted of both male and female students who were studying psychology, with no particular specification on age range.

2.2 Design

Both a longitudinal and cross-sectional design were used for this study. The independent variable (IV) was the video-intervention, while the dependent variables (DV) were attitudes towards mental health, seeking professional help and measures of empathy. A longitudinal design allowed for analysis of data pre and post-intervention. The cross-sectional
design allowed for statistical comparison between participants who had engaged with the intervention and participants who did not.

2.3 Materials

An information sheet preceded the questionnaire pack. This sheet contained information regarding the study, including the name of the researcher, the purpose of the research and anonymity. Three questionnaires were selected for use in this study and a total of two questionnaire packs were used. In order to facilitate a pre/post intervention sample, while also maintaining participant anonymity, the first set of questionnaires were marked with a number. The second set of questionnaires provided a space in which participants could later indicate their allocated number from the previous questionnaire. Please refer to the appendix for the full copy of information and instruction sheet as well as each questionnaire.

2.3.1 The Attitudes towards Mental Illness Scale

The Attitudes towards Mental Illness Scale (Cates, Burton and Woolley, 2005) was used to measure attitudes towards mental illness. The questionnaire consisted of 11 Likert-type questions, asking candidates to rate their level of agreement on a series of statements. These levels included ‘strongly disagree’, ‘disagree’, ‘agree’ and ‘strongly agree’. Examples of such statements included: “Most patients in mental hospitals are not dangerous” and “Mentally ill people are not intelligent.” Reverse scoring was used for questions 2, 3, 4,
5, 6, 9 and 10. The questionnaire was scored out of 33 and higher scores denoted a positive attitude towards mental illness.

2.3.2 Attitudes toward Seeking Professional Help (short form)

Attitudes towards Seeking Professional Help (short form), (Bacon, Fischer, & Farina, 1995) contained 10 Likert-type questions. This questionnaire measures candidates’ attitudes towards seeking professional help. Candidates were asked to indicate their level of agreement of each statement. This was done by indicating either 0, 1, 2 or 3 beside each statement, which corresponded to ‘disagree’, ‘partly disagree’, ‘partly agree’ and ‘agree’ respectively. Reverse scoring was used for questions 2, 4, 8, 9 and 10. Examples of these statements included “I might want to have psychological counselling in the future” and “If I believed I was having an emotional breakdown, my first inclination would be to get professional help.” The questionnaire was scored out of a maximum score of 30, with higher scores indicating a positive attitude. This questionnaire has been found to have a high internal consistency rating of .84 (Fischer & Farina, 1995).

2.3.3 The Toronto Empathy Questionnaire

The Toronto Empathy Questionnaire (Spreng, McKinnon, Mar & Levine, 2009) included 16 questions which are designed to briefly measure empathy. A five point scale including ‘never’, ‘rarely’, ‘sometimes’, ‘often’ and ‘always’ was used to measure the participants response to each statement. Examples of these statements included “when someone else is feeling excited, I tend to get excited too” and “It upsets me to see someone being treated disrespectfully”. The questionnaire was scored out of 64, with higher scores being indicative of higher levels of empathy. Reverse scoring was used on questions 2, 4, 7,
Spreng, McKinnon, Mar & Levine (2009) have demonstrated a high test-retest reliability, as well as good internal consistency with regards to the questionnaire. Positive correlations between the questionnaire and measures of social decoding, self-report measures of empathy and negative correlations with a measure of autism symptomatology were also found.

2.3.4 What’s so funny about Mental Illness?

A video presentation by Wax (2012) entitled ‘What’s so funny about Mental Illness?’ lasting approximately 8.5 minutes long was used as an intervention measure. The video included a first-hand account of the personal effects of mental illness and stigma, as well as a brief account of relative neurological processes.

2.4 Procedure:

The study began with a brief introduction of the topic the research was concerned with (mental health). The variables which were being measured were also briefly discussed, as well as the approximate length of time that it would take for the participant to complete the study. Participants were also made aware that there would be a second administration of questionnaires at a later stage. Participants were then given a questionnaire pack which with an information and instruction sheet attached. Participants were asked to carefully read through both of these attached sheets before beginning the questionnaire. Participants were also asked to take note of the number indicated on the second page of the pack and to keep a safe record of the number for the second part of the study.

Approximately 15 minutes was allowed for participants to complete the three questionnaires. Once completed, the questionnaires were collected. Participant were then thanked for their participation in the study and their attention was drawn to the various
organisations listed on the last page of the questionnaire pack which contained contact details of various organisations that were available, should the study have had any emotional effect on them.

Participants were then shown a video presentation, which served as the intervention measure. However, participants were not made aware that the video was part of the study. This was done in order to reduce any expectancy effect that may come about if participants knew the video was involved in the study. Approximately 3 weeks was then left between the video presentation and the next questionnaire administration. The previously outlined procedure was carried out once again, with the exception that participants were this time asked to indicate their numbers in a box on the second page of the questionnaire pack. People who were not present for the first half of the experiment were also invited to take part, but were asked to indicate that they had not completed the first survey on the second sheet of the pack.

Once again, the questionnaires were completed and the participants were debriefed. At this point, the purpose of the study was reiterated and the participants were made aware of the fact that the video that they had previously viewed was in fact was used as an intervention measure.

2.5 Ethical Considerations

The sensitive nature of the topic which the study intended to investigate was taken into careful consideration. It was acknowledged that despite being very unlikely, it was possible that some aspects of the study may evoke some negative feelings in the participants. In order to reduce the chances of this occurring, it was ensured that the questionnaires selected did not contain any potentially upsetting material. Additionally, due to the personal nature of the questions being asked, the confidentiality of each participant was respected to
the highest degree, with follow up questionnaire data only being identifiable by number. It was also necessary to inform the participants of the purpose of the video that they were shown and which they were not aware was an element of the study.
Results

3.1 Descriptive Statistics

There were 37 participants present for the intervention. Descriptive statistics were obtained for each of the dependent variables. The mean score for attitudes towards mental illness pre-intervention was 30 (SD=1.76) while the mean score for attitudes towards mental illness post-intervention was 29.3 (SD=1.84). The mean score for attitudes towards seeking professional help pre-intervention was 24.22 (SD=3.06) while the mean score for attitudes towards seeking professional help post-intervention was 24.62 (SD= 2.54). The mean score for empathy pre-intervention was 46.03 (SD= 4.81) while the mean score for empathy post-intervention was 46.51 (SD=3.21).

There were 37 participants present in the non-intervention (control) group. Descriptive statistics were obtained for each of the dependent variables. The mean score for attitudes towards mental illness in the control group was 25.65 (SD= 2.34). The mean score for attitudes towards seeking professional help was 23.24 (SD= 3.74). The mean score for empathy was 44.24 (SD= 4.91) (see fig.1).
Mean differences for Intervention group & Non-intervention group

Fig. 1

Mean score differences for intervention group and non-intervention group

3.2 Normality and Assumption checks

The dependent variables were checked for normal distribution in order to validate the use parametric testing. Empathy pre-intervention and attitudes towards seeking help post-intervention were both slightly negatively skewed. Attitudes towards seeking help with no intervention displayed a slightly platykurtic curve (see appendix H). Q-Q Plot scores did not show any significant deviation from the line and no outliers were present (see appendix I). In light of these checks, parametric testing was carried out.

In order to test for the effects of the intervention on the dependent variables in the intervention group, as well as to test for differences between the intervention and non-intervention group, the assumptions for use of a multivariate analysis of variance were checked. It was found that the assumption of homogeneity of variance-covariance matrices was violated as Box’s M test displayed a significant result (P<0.05). However due to the
conservative nature of this test, since there were equal sample sizes and due to the fact that
significance value was greater than .001, this result was ignored as recommended by

3.3 Inferential Statistics

It was hypothesised that the video intervention would have a positive effect on the
levels of attitude towards mental health, attitude towards seeing professional help and
empathy. A repeated-measures MANOVA found that there was no statistically significant
difference between scores in the pre-intervention stage and the post-intervention stage (F (3,
34) = 2.59, p = .069). Therefore the null hypothesis can be accepted and H1 must be rejected.

A one way multivariate MANOVA found that there was a statistically significant
difference in scores between the intervention group and non-intervention (control) group (F
(3, 70) = 20.63, p < .001). Following a Bonferroni adjustment to .017, there was no
significant difference in attitudes towards seeking professional help (F (1, 72) = 3.44, p =
.068, effect size = .046). However, there were significant differences in attitudes towards
mental illness (F (1, 72) = 55.39, p < .01, effect size = .44) and empathy (F (1, 72) = 5.55, p =
< .05, effect size = .072) (see table 2). Therefore H2 can be accepted and the null hypothesis
rejected (see table 2).
A paired samples T-test was conducted in order to determine if there was a statistically significant difference in scores before and after the intervention for attitudes towards mental illness (see table 3). There was a significant difference between pre-intervention scores (M=30.00, SD = 1.76) and post-intervention (M=29.3, SD =1.84) scores; t(36) = 2.64, p = <.001. It can therefore be said that post-intervention scores were significantly lower than the pre-intervention scores. In light of this, H3 must therefore be rejected, while the null must be accepted.

A paired samples T-test was conducted in order to determine if there was a statistically significant difference in scores before and after the intervention for attitudes
towards seeking professional help (see table 3). There was a significant difference between pre-intervention scores (M=24.22, SD = 3.06) and post-intervention (M=24.62, SD =2.54) scores; t (-.961) = 2.57, p = <.001). It can therefore be said that post-intervention scores were significantly higher than the pre-intervention scores. This means that H4 can be accepted while the null must be rejected.

A paired samples T-test was conducted in order to determine if there was a statistically significant difference in scores before and after the intervention for empathy (see table 3). There was a significant difference between pre-intervention scores (M=24.22, SD = 3.06) and post-intervention (M=46.03, SD =4.81) scores; t (.730) = 4.05, p = <.001). It can therefore be said that post-intervention scores were significantly higher than the pre-intervention scores. Therefore H5 can be accepted, while the null must be rejected.

Table 3

*T-test within-group comparison results*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Groups</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude towards Mental Health</td>
<td>Pre-Intervention</td>
<td>30</td>
<td>1.76</td>
<td>2.639</td>
<td>36</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Post Intervention</td>
<td>29.3</td>
<td>1.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes towards seeking Professional Help</td>
<td>Pre-Intervention</td>
<td>24.2</td>
<td>3.06</td>
<td>-.961</td>
<td>36</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Post Intervention</td>
<td>24.62</td>
<td>2.54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathy</td>
<td>Pre-Intervention</td>
<td>46.03</td>
<td>4.81</td>
<td>-.730</td>
<td>36</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Post Intervention</td>
<td>46.51</td>
<td>3.21</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4 Discussion

4.1 Aim

The aim of the current study was to establish whether or not an intervention in the form of a short video would have a positive effect on attitudes towards mental health. Measures included attitudes towards mental illness, attitudes towards seeking professional help and a measure of empathy. These measures were used in order to establish an overall attitude towards mental health. The dependent variables were measured before and after the intervention in order to establish whether there were any significant differences resulting from the intervention. The variables were compared both individually and as one combined variable. A control group which received no intervention was also compared to the post-intervention group in order facilitate more robust findings.

4.2 Results

Hypothesis one stated that scores relating to attitudes towards mental health would be higher post-intervention than scores pre-intervention. In order to establish this, three measures were combined. These were attitudes towards mental illness, attitudes towards seeking professional help and empathy. In order to measure these variables, three different questionnaires were used. These were The Attitudes towards Mental Illness Scale (Cates, Burton and Woolley, 2005), Attitudes towards Seeking Professional Help (short form), (Bacon, Fischer, & Farina, 1995) and The Toronto Empathy Questionnaire (Spreng, McKinnon, Mar & Levine, 2009). Analysis indicated that there was no significant difference between both conditions and the null hypothesis was accepted.

This study incorporated findings from previous studies in which speakers would discuss their first-hand experience of dealing with mental health issues (Pinfold, Stuart, Thornicroft & Arboleda-Florez, 2005). The objective was to apply such findings to an
intervention design that would portray the same first-hand experience, but without the speaker actually being present in the room with the participants. In this way, the results obtained could possibly stimulate a discussion on whether this method of promoting positive attitudes towards mental health could be explored by future research.

Since there was no significant result found, the findings correspond to those of Gagne (1972), who stipulated that an important factor in attitudinal learning outcomes is social contact with a human model. However, the process of acquiring an individual with the knowledge and experience pertaining to the topic of mental health is a time-consuming and potentially expensive process. The rationale behind this study was that if a positively significant difference was found between the pre and post-intervention stages, then this study may be taken into consideration when planning future interventions. It was proposed that the use of media tools may prove to be a more strategic intervention method in that it could prove to be cheaper, less time-consuming and may have the ability to reach large audiences quickly.

Such a proposal was put forward by Salter & Byrne (2000) who advocate the use of the media in this manner. However the findings from this study would appear to disagree with this view. These findings do bear similarity to data from previous studies pertaining to other health issues such as tobacco and alcohol consumption. These studies have yielded inconsistent results in relation to the effects that media campaigns have had on encouraging more health conscious behaviour (Wakefield, Lokin & Hornik, 2010). The findings from the current study are in alignment with these inconsistent findings, since there was no apparent positive change in participants’ attitudes and empathy, despite the encouragement from the speaker in the video to reduce stigmatisation, encourage understanding and awareness of mental health and mental illness.

Hypothesis two stated that scores relating to attitudes towards mental health would be higher in the post intervention group than the group receiving no intervention. Following
statistical analysis it was determined that there was a significant difference between both groups, with the control group displaying lower scores than the intervention group. Therefore $H_2$ was accepted. These results were particularly surprising in the sense that they contradicted findings for $H_1$. However, they demonstrate that overall, the attitudes towards mental health in the intervention group were significantly higher than those who had not engaged with the intervention at all. These findings would therefore correspond to those from (Scollay, Doucett, Perry & Winterbottom, 1992) & (Pinfold, Stuart, Thornicroft & Arboleda-Florez, 2005) which highlight the effectiveness of first-hand testimonial experience in an intervention. However, Gagne (1972) describes the importance of social contact in attitudinal learning, yet these particular findings suggest that there was a positive shift in attitudes, despite the speaker being physically absent. However, there was no significant difference for in scores for attitudes towards seeking professional help. These contradictions within findings highlight the need for further research. Such research could focus on developing these findings in order to determine whether or not this method of promoting positive attitudes towards mental health is a reliable one.

Hypothesis three stated that scores for attitudes towards mental illness would be higher post-intervention than pre-intervention. Following analysis, it was found that there was a significant difference between both conditions. However, it was found that scores in the post-intervention condition were actually lower than those in the pre-intervention condition. Therefore the null hypothesis was accepted. These findings were surprising since previous research indicated that there would be a positive shift in attitudes given that the participants were listening to first-hand experience, (Scollay, Doucett, Perry & Winterbottom, 1992), (Pinfold, Stuart, Thornicroft & Arboleda-Florez, 2005). However, it is worth noting that these findings did not take into account the effects of first-hand testimonials without the speaker being physically present in the room with the listener. The fact that there was no
positive shift in attitudes towards mental illness tie in somewhat with the work of Gagne (1972), but such research does not account for the negative shift in these attitudes that was observed in this study. Further research is required in order to generate more data and investigate these findings further.

Hypothesis four stated that scores for attitudes towards seeking professional help would be higher post-intervention than pre-intervention. A significant difference was found between both groups, with higher scores being observed in the post-intervention group and thus $H_4$ was accepted. This measure aimed to provide a deeper understanding into overall attitudes towards mental health since participants were required to consider how they would apply their attitude to real life dilemmas. These findings suggest that the intervention had a positive effect on these attitudes. However, they are not consistent with attitudes towards mental illness, as shown by the results pertaining to $H_3$ which indicated a negative shift in attitudes towards mental illness, while in this instance a positive shift was seen in attitudes towards seeking professional help. These findings are in agreement with previous research that highlights the attitude-behaviour gap (LaPiere, 1934) & (Corey, 1937).

Despite this attitude-behaviour gap, these findings may be useful as they may suggest that these participants could be more willing to actually seek psychological help after engaging with the intervention. These findings are in contrast to those of Zachrisson, Rodje & Mykletun (2006) and Wang, Angermeyer, Borges, Bruffaerts, Tat Chiu, De Girolamo & Chatterji (2007) which demonstrate a high level of reluctance or general delay in help seeking behaviour.

$H_5$ stated that scores for empathy will be higher for the post-intervention group than pre-intervention. Since analysis indicated that there was a positive significant difference, this hypothesis was accepted. These findings complement those from Tsoory & Simone (2011) & Decety, Echols & Correll (2010). Through the use of modern neuroimaging techniques, these
researchers were able to localise various structures within the brain such as the ventromedial prefrontal cortex, temporoparietal junction and the medial temporal lobe which may be associated with empathetic behaviour. These findings could then be applied in a social psychology context in order provide an objective measure which could be used to suggest a connection between empathy and stigma. The findings from the current study may provide further evidence of this connection since a positive shift in empathy was observed after an intervention which aimed to reduce stigma and promote positive attitudes towards mental health.

4.3 Strengths & Limitations

Limitations exist with this study as there was no record of the demographics such as the age of each participant. During the design of the study, age was not considered to be an important factor as it was not a variable that was being taken into consideration for analysis. Additionally, the deliberate omission of data relating to age was done in order to preserve the anonymity of participants, particularly since the study required a follow up measure. If age were to be incorporated into further studies, it may provide differences in attitudes towards mental illnesses across different age brackets. This in turn may be useful in designing interventions to suit individual age groups rather than exposing one group containing all ages to an intervention.

Another possible confounding variable evident in this study was the way in which some of the questions were posed in the questionnaires. Several participants expressed confusion in relation to some of the items being asked. An example of such an item was one in which participants were asked how much in agreement they were with the statement “There is nothing about mentally ill people that makes it easy to tell them apart from normal people”. It became apparent that the wording of statements such as these became confusing
for the participants and may have results in a random, rather than clearly thought out response. It may be useful for future researchers to bare this in mind if they were to use the same questionnaires as the current study. Perhaps the use of questionnaires with more clearly defined items would be more appropriate in accurately measuring the dependent variables.

Further problems with the questionnaires may be due to the fact that participants who engaged with the intervention would have been measured using these questionnaires on two occasions in order to determine the effect of the intervention. It may be the case the participants became bored or impatient after receiving the same set of questions. This may be even more relevant with the knowledge that not all of the questions were easy to understand. One improvement that could be made in relation to this study would be to set up a parallel form of testing in which different questionnaires could be used in order to minimise the chances of participants answering questions impatiently.

It would have been ideal to obtain participants through random sampling. However, due to time and accessibility restrictions this was not possible. The study therefore relied on participants that were selected using a convenience and snowball-sampling technique. A large proportion of the participants were sampled from a third level college in Dublin. All of these students were either in their first or second year of a psychology degree course. It may be the case that psychology students were not an optimal sample to obtain, since these participants may have had a previous interest in the topic of mental health and this may have been reflected in their scoring. With this in mind, the generalisation of these findings may prove to be difficult. One remedy to this possible confounding variable would be to include participants from different academic backgrounds within the college. In this way, the researcher may obtain findings that could be more applicable to the wider society.

The convenience sample did not yield a substantial amount of participants whose data could be used for both the pre and post-intervention measure. The reason for this was a high
level of absenteeism of participants during the second administration of questionnaires. The use of a snowball-sampling technique (n=7) was therefore implemented in order to obtain as many candidates as possible in order to enhance the external validity of the study. This meant that friends of the researcher were asked to take part in the study and then to pass this information on to other friends. It is possible that the details of the study were discussed prior to participation which may have had an expectancy effect on the answers of the participant, particularly if they knew the purpose of the intervention prior to debriefing.

One particular strength with this study was that participants were not aware that the video they were watching was part of the study. This reduced chances of researcher expectancy influencing the scores of the participants. However, due to circumstances outside the control of the researcher, a larger gap than had been anticipated was left between the pre-intervention and post-intervention stage. An improvement that could be made here would be to reduce this gap in order to observe more immediate results from the intervention.

4.4 Future Direction

The inconsistency observed among results in the current study highlight the need for future research to continue to investigate reliable methods which will seek to promote positive attitudes towards mental health. One aspect of this study which research could build upon is the positive shift observed in attitudes towards seeking professional help. Future research could look at ways of implementing more accurate ways to measure actual professional help seeking behaviour in a mental health context. This could allow for a more reliable method of establishing whether or not an intervention has had an effect on real life behaviour. These findings have also offered supporting evidence for the role played by empathy in stigmatisation. Further research could explore this relationship between empathy and stigma in order to gain a richer understanding of how empathy may potentially be
incorporated into a measure of attitudes towards mental health. Such findings may contribute overall to the development of effective interventions which will promote positive attitudes towards mental health.

4.5 Conclusion

In conclusion, the results of this study have shown inconsistent findings with regards to the effects of a video intervention on attitudes towards mental health. When scores before the intervention were compared to scores after the intervention, no significant difference was found. However, when cross-sectional scores between a non-intervention group and the post-intervention group were compared a significant difference was found. A significant difference was also found when measures were compared individually before and after the intervention. A negative shift in attitudes towards mental illness was seen, while a positive shift in attitudes towards mental health and empathy scores were observed. Limitations such as sampling methods and the wording of some items on the questionnaires used were discussed in an effort to help explain these inconsistent findings. Despite these limitations, it was proposed that the findings from this study may be useful for future research since some significant differences were observed between certain scores. It was suggested that future studies could incorporate such findings into research that focuses on developing effective interventions which promote positive attitudes towards mental health.
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Appendix A

Participant Information Sheet

**Empathy, attitudes towards mental health and towards seeking professional help.**

My name is Shane Mac Sweeney and I am conducting research in the Department of Psychology that explores empathy, attitudes towards mental health and attitudes towards seeking professional help. This research is being conducted as part of my studies and will be submitted for examination.

You are invited to take part in this study and participation involves completing and returning the attached anonymous survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services are included on the final page.

This is a two-part study in which participants will be asked to complete another survey at a later stage. Participation is completely voluntary and so you are not obliged to take part.

Participation is anonymous and in order to ensure confidentiality, participants will receive an allocated number. These numbers will be distributed in no particular order.

The questionnaires will be securely stored and data from the questionnaires will be transferred from the paper record to electronic format and stored on a password protected computer.

It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.
Should you require any further information about the research, please contact Shane Mac Sweeney,

My supervisor, Rosie Reid, can be contacted at.

Thank you for taking the time to complete this survey.
Appendix B

Instruction sheet contained in first questionnaire pack

Please read the following instructions carefully before beginning the survey:

- Please take note of the number at the top right hand corner of the page. This number will be important when completing a follow up survey at a later stage. It may be useful to record this number into your phone or on a piece of paper to ensure that you remember it.

- Once you have recorded your number, please turn over to the next page and begin filling out the survey. Please do so as honestly as possible and take time to carefully consider each question. This should not take any longer than 10-15 minutes.
Appendix C
Instruction sheet contained within second questionnaire pack

Please read the following instructions carefully before beginning the survey:

• Have you completed this survey before? – Please circle: Yes/No

• yes, please indicate your allocated number:

• Once you completed the previous step, please turn over to the next page and begin filling out the survey. Please do so as honestly as possible and take time to carefully consider each question. This should not take any longer than 10-15 minutes.
Appendix D

The Attitudes towards Mental Illness Scale (Cates, Burton and Woolley, 2005)

Using the scale below, please tick circle relevant answer for each statement

SD = strongly disagree
D = disagree
A = agree
SA = strongly agree

1. Most patients in mental hospitals are not dangerous
   " SD " D " A " SA

2. It is easy to recognise someone who once had a mental illness
   " SD " D " A " SA

3. We cannot expect to understand the bizarre behaviour of mentally ill persons
   " SD " D " A " SA

4. Mentally ill people are not intelligent
   " SD " D " A " SA

5. Most mentally ill persons haven’t the ability to tell right from wrong
   " SD " D " A " SA

6. Most mentally ill people don’t care how they look
   " SD " D " A " SA
7. Most people have mental and emotional problems

8. Mental illness is nothing to be ashamed of

9. Mentally ill people are ruled by their emotions; normal people are ruled by their reason

10. A mentally ill person is in no position to make decisions about even everyday living problems

11. There is nothing about mentally ill people that makes it easy to tell them from normal people
Appendix E

Attitudes towards Seeking Professional Help (short form), (Bacon, Fischer, & Farina, 1995)

Instructions
Read each statement carefully and indicate your degree of agreement using the scale below.

In responding, please be completely candid.

0 = Disagree 1 = Partly disagree 2 = Partly agree 3 = Agree

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention._____

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. _____

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. _____

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. _____

5. I would want to get psychological help if I were worried or upset for a long period of time. _____

6. I might want to have psychological counselling in the future._____
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

9. A person should work out his or her own problems; getting psychological counselling would be a last resort.

10. Personal and emotional troubles, like many things, tend to work out by themselves.
Appendix F

The Toronto Empathy Questionnaire (Spreng, McKinnon, Mar & Levine, 2009)

Below is a list of statements. Please read each statement carefully and rate how frequently you feel or act in the manner described. Circle your answer on the response form. There are no right or wrong answers or trick questions. Please answer each question as honestly as you can.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When someone else is feeling excited, I tend to get excited too</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Other people's misfortunes do not disturb me a great deal</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>It upsets me to see someone being treated disrespectfully</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I remain unaffected when someone close to me is happy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I enjoy making other people feel better</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I have tender, concerned feelings for people less fortunate than me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>When a friend starts to talk about his/her problems, I try to steer the conversation towards something else</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I can tell when others are sad even when they do not say anything</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I find that I am &quot;in tune&quot; with other people's moods</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I do not feel sympathy for people who cause their own serious illnesses</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>I become irritated when someone cries</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>I am not really interested in how other people feel</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>I get a strong urge to help when I see someone who is upset</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
14. When I see someone being treated unfairly, I do not feel very much pity for them 0 1 2 3 4
15. I find it silly for people to cry out of happiness 0 1 2 3 4
16. When I see someone being taken advantage of, I feel kind of protective towards him/her 0 1 2 3 4

Appendix G

Contact Information Sheet

Thank you for taking the time to complete this survey. If any of these questions have raised difficult feelings for you, please consider the following resources which may be of use to you:

- Barnardos, Christchurch Square, Dublin 8.
  Website: www.barnardos.ie E-mail: info@barnardos.ie
  Office: 01-4549699 or Callsave: 1850 222 300

- Samaritans. Website: www.samaritans.org
  E-mail: jo@samaritans.org
  Helpline: 1850 609090 Office: 01-8781822

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Appendix H

Distribution and scores for each variable as shown on histograms.
Histogram for Group= Intervention

Mean = 29.30
Std. Dev. = 1.839
N = 27

Histogram for Group= No Intervention

Mean = 25.85
Std. Dev. = 2.448
N = 27
Appendix I

Distributions and scores of each variable as indicated on Q-Q Plots

Normal Q-Q Plot of Mental_Before

Normal Q-Q Plot of Professional_Before

Normal Q-Q Plot of Mental_After for Group= Intervention
Normal Q-Q Plot of Mental_After
for Group: No Intervention

Normal Q-Q Plot of Professional_After
for Group: No Intervention