

**The Stigma of Mental illness: Generational Differences, Help Seeking Behaviours and Quality of Life**

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**Abstract:**

The aim of the current study was to investigate gender differences in help seeking behaviours for mental illness, age differences in stigmatizing attitudes and quality of life as a predictor for stigmatizing attitudes. This was a quantitative study that investigated the above hypotheses with a questionnaire, given to 136 participants of all ages. The results indicate that there was a significant difference between the ages in relation to stigmatizing attitudes. There was a gender difference between attitudes towards seeking help for psychological illness. Satisfaction with life was a valid predictor for stigmatizing attitudes. This study can therefore conclude that quality of life is important in how a person reacts to a person with mental illness, similarly as is age and gender.

### **Introduction:**

In recent years, much research has been conducted on the stigma of mental illness such as

within the national disability authority, the national suicide research foundation and the health service executive. These studies have primarily focused on identifying the causes and sources of stigma to further deplete these destructive attitudes. There are a large number of studies that have attempted to alienate cultural differences, societal differences and individual differences that characterise the sources of this stigma. 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). The focus of this study is to address the gaps, which were found throughout the review of the literature in regards to the age differences in stigmatization of the mentally ill, and particularly with regard to person’s quality of life and how that affects their attitudes and behaviour towards the mentally ill. This study aims to address these gaps within the literature and to investigate the effect these concepts may have upon the stigma of mentally ill individuals. It was these gaps within the literature that led the researcher to the interests regarding this study.

Mental disorders comprise a broad range of problems, with a catalogue of different symptoms (WHO, 2003). However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others (WHO, 2003). Examples are schizophrenia, depression, mental retardation and disorders due to drug abuse. Most of these disorders can be successfully treated (World Health Organisation, 2012). The stigma of mental illness has detrimental affects on an individual’s everyday living. Stigma is described as “ (A) category of people pejoratively regarded by the broader society and who are devalued, shunned or otherwise lessened in their life chances and in access to the humanizing benefit of free and unfettered social intercourse” ( Alonzo and Reynolds, 1995).

#### *The History of Mental Illness:*

A long extended history leads up to present day society’s attitudes towards mental illness. It is clear that mental illness has existed since ancient times (Porter, 1991). The

understanding of mental illness has advanced enormously since ancient times. In the beginning, it was thought that people with mental illness were infected with evil spirits; often it was the seen practice to drill holes in to the patient's skull to allow the evil spirits escape (Gleitman, Reisberg and Gross, 2007). Alongside this method, mentally ill people were seen to be treated through floggings, starvation, being bathed in boiling water and given potions that would "purge" the spirits. A century later, there was a shift in the understanding of mental illness. Mental illness was then thought of as disease, and it was that kind of thinking that gave rise to institutions where mentally ill people were confined alongside criminals and beggars. They were treated in the same manner as prisoners. Some of these institutions opened up as "human zoos" where people paid to see the patients in these settings. With the French revolution came a change in how these institutions worked. The patients were allowed exercise and freedom of the chains they were forced to wear (Porter, 1991).

Mental illness soon came to be thought of as organic illnesses, which eventually lead to today's understanding that mental illness a psychological illness. With this kind of history, it is not hard to see how a stigma still exists around mental illness. In Ireland alone, there was an outstanding history up to recent times, of severe cases of institutionalisation. Institution's had no segregation between the intellectually disabled and the mentally ill. Many of the admissions were involuntary, and once the patients were admitted they would be unlikely to be allowed discharge themselves. There were strong religious influences in twentieth century Ireland, and this imposed strict controls in how people who were considered socially undesirable were dealt with (Walsh and Daly, 2004).

It is not difficult to explain, with the history of attitudes towards mental illness that has preceded today's generations, how there is an existing stigma surrounding mental illness. This can especially be slightly more understandable in Ireland where as up to recent times that shame hung over the concept of mental illness and tainted the family's who were unfortunate enough to have the experience of it. It is not surprising then that there is a lack of knowledge, and a tension in how a person interacts with a mentally ill

individual.

*The effect of Stigma on Mental Illness:*

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. A study conducted in Australia in 2011 found that those who suffered from chronic schizophrenia were likely to be linked to dangerous and unpredictable behaviour. Participants of the study expressed perseverance for not employing someone with such a problem (Reavley, and Jorm 2011).

Jamaica had a similar institutionalisation as Ireland, due to British colonisation, up until 1962 and had severe cases of asylums and institutions. Hickling, Hickling and Paisley (2011) set up focus groups to attempt to integrate mental health treatment and break down the barriers of stigma by opening it up within the mainstream primary care system. These focus groups found that the negative attitudes were sourced by the method of handling mental health care, which was Bellevue hospital, the institution in the current case. They expressed finality about being treated in an institution for the mentally ill, and perceived it as more serious than if you were offered treatment in a local medical centre. This study supports the notion that by exposing the very nature of what is mental illness, perhaps individuals would be less fearful or avoidant of issues surrounding mental illness. A study in Singapore found that elderly participants who had strong religious beliefs, and met the DSM4 requirements for mental illness, did not report seeking help significantly less than those who reported no religious beliefs. (Ng et al. 2010)

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, 2001). A longitudinal study conducted in Canada sought to source the focus stigmas perceived by gay, lesbian and

transgender individuals who also suffered from mental illness. Although the sample size was small, the stigmatization was adequately explained through a repeat interview process. Many felt they had to constantly conceal part of their identity to be accepted. They felt excluded from multiple communities. They themselves reported misinformation and predominant attitudes as the brunt of the stigma relating to mental illness. They felt the double stigmatized identity affected their ability to form new relationships, and supports. Overall feelings of concealment fear, isolation, shame and difficulty in life surfaced the most because of their double stigmatized identity (Kidd et al 2011).

Self-stigma is the idea that the mentally ill person themselves are the main sources for the perceived stigma. They may feel shame or personal liability for their illness. This stigma can also be associated with the perceptions or ideas an individual has towards mental illness. Whilst it exists it may not be directly linked to individuals with mental illness, but with person's perception of the illness should they be inflicted with it themselves. This was shown in the Mental Health in Ireland, Awareness and Attitudes, (HSE, 2007) report where people of a higher social status showed concerns that they would be viewed differently in their employment and by their peers should they be inflicted with a mental health disorder. Given a case study of a fictitious woman who presented with mental health problems participants recommended that she seek help even though their own rate of help seeking were low. Eighty five percent of individuals who completed this study agreed with the statement that "anybody can be inflicted with a mental illness" but 62% of those would not want anybody to know if they themselves were suffering from a mental illness.

This was particularly evident in a report carried out in America to test how teenagers, and parents of these teenagers (Moses, 2010) felt the illness. The study outlined the embarrassment and shame felt by both the parents and the adolescents. The study essentially looked for the source of the self-stigma that the adolescents felt, based on their mental illness. This investigation used a number of scales to address this issue. They tested the adolescents self-stigma in relations to embarrassment, and anxiety about others responses to the illness. They asked what the teenager themselves thought caused

the illness, their perceived control of the illness, their anticipated levels of persistence, and the teenager's demographic and clinical characteristics. The parent's stigma experiences and the parent's illness perceptions were also taken into account. The results showed that adolescents who perceived less control over their emotions and expressed a lifelong expectancy of mental health problems were more self-stigmatized than those who did not. The parent's thoughts directly affected the adolescent, with parents who were positive about the outcome of the illness and who expressed confidence in their child's ability to express their emotions, resulted in lower levels of self-stigma from the child, and more of a positive outlook towards their illness. It was found that a parent who wished to conceal their child's illness had a detrimental effect on the self-stigma of the teenager (Moses 2010).

Martinez et al (2011) found that where an individual was presented with the concept of mental illness, they ascribed the label of chronic mental illness, with dehumanizing responses. When the researchers had the person in the vignette, express that they had either bi- polar disorder or melanoma, they were ascribed more humanity by the participants. This suggests that the overall label of chronic mental illness may have an effect on the perceived seriousness of the illness, and the perceived effect it has on the individual who has it.

This was also found in a study conducted in 2010, which sought to reach beyond stigma to source the effect of knowing someone, or being inflicted oneself effect on multiple dimensions of attitudes towards mental illness (Boyd et al 2010). The study presented the participants with a vignette of a person with mental health problems. The study revealed interesting results regarding the effect of knowing or having suffered the illness. They found that those who had come into contact with people with mental illness perceived lower stigma, less social distance but more perceived seriousness of the situation, which comes across as interesting as the individuals in this study who had suffered a mental disorder themselves perceived much less seriousness of the situation (Boyd et al, 2010)

The current study seeks to test for a generational difference in the attitudes held by the different aged cohorts. (Aromaa, Tolvanen, Tuulari, Wahlbeck, 2008) found that the higher the age of the person, the more negative attitudes they hold. This study also explored many other misconceptions. They found the higher the level of education the lower the concern over the detriments of mental illness and that woman expressed higher concerns over controllability and fear of the effects of mental illness.

*Gender patterns in Help seeking behaviour for Mental Illness:*

Help seeking is a direct derivative of stigma of mental illness, the stigma held by the individual will directly affect their probability of seeking help (Doherty, O'Doherty, 2010). Of course, there are many sources of help such as professional help, family, friends or elsewhere a person known to the individual that they feel they can confide in. The research in this area suggests a gender divide in the help seeking behaviours for mental illness. Locally this is conclusive. A study conducted in Ireland in 2010 found that 63% of females were willing to discuss problems with their GP compared to just 54% of males (Doherty, O Doherty, 2010). Many factors determine this with men stating that they felt that they would be thought less of if they were to succumb to a mental illness problem (HSE, 2007). This has been replicated in a study in Australia, which directly examined the gender differences in help seeking behaviours and found that men were likely to feel more discredited and were less open to admitting weakness. Females portrayed a stronger openness to seeking help for mental illness (Judd, Komiti, Jackson 2008). Gonzalez et al (2011) studied the gender roles in help seeking behaviours for mental health; in doing this, they found a stark difference in the gender divide between help seeking behaviours. Less than half the men in comparison to the females on the cohort reported a high willingness to seek out help for any mental health difficulties they were having. Vogal et al (2007) in a study of college students found that woman were just over twice as likely to seek help for a mental illness as males.

Begley et al (2002) conducted a large study on the young males of the mid west of Ireland. They tested their experience of psychological problems and their attitudes

towards seeking help for problems among many other things. They found that the participants in this study flagged dislike talking to strangers about problems and the cost as barriers to seeking help. Other problems that these men interestingly flagged were, the embarrassment or the shame and the confidentiality issues, in that they were fearful that people might find out they were seeking help and think less of them as a result. Twelve percent of this sample admitted to having experienced what they considered serious personal or emotional, mental health problems, did not seek help due to the above factors. This accentuates the need for a more open health system as was seen in Hickling, Hickling and Paisleys 2011 study in Jamaica, which was already discussed.

There have been a number of arguments regarding the cause and effect of willingness to seek psychological help one of which has been the effect of social contact with a mentally ill person and how that effects help seeking attitudes. Zartaloudi & Madianos, in 2010 found that those with a family member or friend who have received help for mental health problems were less concerned with the outcomes of seeking help and so were more perceived to be more forthcoming towards help if they were concerned with their own mental health. This strengthens the argument that social contact with the mentally ill reduces help seeking concerns for the individual and in turn reduces their stigma of mental illness. The route and availability of the services could also be an effect of the behaviours towards seeking help. Often in terms of adolescent's friends and family have a primary role in getting adolescents access to professional help for their psychological problems ( Rickwood, Deane, & Wilson 2007). In studies, this proved favourable in terms of seeking out help as was seen in 2005 in a survey of those who were already diagnosed with mental illness admitted to turning to friends or relatives rather than their GP initially (Oliver, Pearson, Coe and Gunnel. 2005).

Vogul, Heimerdinger, Hammer and Hubbard (2001), suggested from the findings of their study, that masculinity has a large part to play in the inhibitors of seeking help for men. Self-stigma was flagged as an inhibitor for men seeking help, as they felt it failed to live up to the internal standards of masculinity. This study took into account racial difference and sexual orientation. This stigma may not be unjustified as Mc Cusker and

Galupo (2011), presented a number of vignettes of a different person's presenting with depression, these people varied in sexual orientation. Participants were asked to rate them on their masculinity and femininity. They found that when the person in the vignette was male, presented with depression and was heterosexual he was rated as significantly less masculine than a male presenting with depression who reported themselves as homosexual who seemed feminine.

Wimer and Levant (2011) found that a male with high conformity level was less likely to seek help in general. This study clearly shows masculinity as a motivator for help seeking attitudes. Younger men in this study reported this to a greater extent than older individuals within this study. Tsan, Day, Schwartz and Kimball (2011), looked at the factor of emotional restrictiveness, and gender role. They found that Gender role has a key role in developing positive attitudes towards psychotherapy. They found that the personality trait, openness to experience, mediated the relationship between restrictive emotionality and attitudes toward psychotherapy. Zawawi (2011) found that the need for education is necessary for males in terms to help develop more positive attitudes, towards help seeking, and perhaps that emphasising the negative consequences for not seeking help would be more effective when educating males about mental illness.

There is again cultural difference in help seeking behaviours as was seen in Loya, Reddy and Hinshaw's study in 2010, which explored the cultural context in which stigma, is affective. Through their comparative study of south Asian students and Caucasian students they found support for much research that has shown that south Asians are more stigmatizing of mental illness. The Asian students tested higher on personal stigma towards mental illness and negative attitudes pertaining to seeking help for psychological problems. Although this directly shows a cultural effect on the attitudes regarding mental illness this study in particular does not reflect the overall cultural flaws in treatment and acceptance of psychological problems. A study of students in Nigeria, found that there was no difference in the patterns of seeking help between males and females in their cohort. They concluded from their results that, perceived control or responsibility over one's health, openness to new experiences, personal growth initiative,

and sense of coherence within the individual were the greatest predictors for help seeking attitudes (Oluyinka, 2011).

In a society where there has been unprecedented rises in suicide rates the need for openness towards mental illness has never been more important. It seems that help seeking behaviours are poor and that directly affects the suicide rates. In a society where more people die by suicide than car accidents mental health promotion has never been more important. These suicides have a ratio of 6:1 males as to females where the suicides of the ages under 35 have been isolated (Begley et al. 2002).

Interventions are needed to change how people think about mental illness. An intervention by the National Suicide Research Foundation (Arensman, 2009) which sought to educate and change attitudes about suicide and seeking help for their problems among Irish secondary school students, found that after the intervention there was a considerable increase in the adolescents who expressed that they would talk to someone should they experience problems, or that if they were worried they would try to focus their attention elsewhere rather than dwell on the problem. The male adolescents who partook in this study measured higher on emotional resilience following this study. It is important to shape the attitudes early within an individual's life, and this intervention helped to shape more positive attitudes toward seeking out help for negative mood's or troubles (Arensman, 2009). Interventions like this will benefit and help to nurture positive attitudes towards mental illness, which will be carried through life then, and passed on to the future generations.

#### *Quality of Life as a predictor for empathising with the mentally ill:*

A person's quality of life will directly affect their outlook on life. If they are happy, they will express that happiness and will be open and upbeat. A person with poorer quality of life will express more negativity and will in turn hold a more negative outlook on life with a more closed of approach to new experiences. Quality of life is often considered to be very low or affected with people who suffer from mental illness.

This is often because the person judging them has misconceptions or misinformation regarding the concept of mental illness. Often mental illness is considered a lifelong disorder and this directly affects how a person thinks this would affect someone who was inflicted with illnesses life or quality of life per se. As was seen in a study conducted by Moses (2010) the parents who perceived the illness as bad directly affected the quality of life of the child inflicted with the illness. The child reflected these bad attitudes and self stigmatized as a result. This study clearly shows how perceived quality of life affects the person's outlook in life and the attitudes they express. An individual's quality of life will directly affect their satisfaction with life.

There are many determinants of quality of life, which will naturally vary from person to person. For some individuals money and careers will be high up in their agenda where as others will be contented with lower income but a more family orientated approach. In the economic society that is Ireland today there has never been such a questioning of roles. There is now more stay at home fathers with the mothers as the breadwinners. In addition, there has been a shift in typical family structure. In this society, there is an increasing amount of sources for stress, which in turn will affect a person's mental health. In the recent Irish Attitudes and Awareness (HSE, 2007) study, the participants were asked to rate their quality of life and eight out of ten rated their quality of life as either good or very good. Quality of life has an even more protruding effect on how a person stigmatizes illnesses. The current study hypothesises that a person with a better quality of life will better empathise with someone with a mental illness. A person's empathy will directly predict their tolerance of a person with mental illness as was shown in Phelan and Basow's (2007) study. It was found that participants in this study who showed greater levels of empathy showed more acceptance of the scenarios they were shown. These scenarios showed someone in a state of stress, depression, and alcohol abuse and gauged the participant's reaction to that situation. This study shows that empathy directly increases a chance of somebody accepting a mentally ill person and stigmatizing them a lot less.

Quality of life will vary from everyone as was said before. The wealthy might

categorise themselves with a good quality of life just the same as a less wealthy person would. A study in America investigating older adults perception of a hypothetical mentally ill older adults, determined the attitudes in relation to depression, schizophrenia, and anxiety. This study found that the older adults with higher amounts of education were more comfortable around those with mental illness than those with lower educational levels (Webb et al, 2009)

Empathy can be seen as early in life in infancy. Baby's can be seen to empathise with other crying baby's. Empathy is directly correlated with observed pro-social behaviour in children (Panfile and Laible, 2012). These findings were resounded in (Perrault et al, 2009), study of the part of the brain that has been recently linked to empathy, the mirror neuron system. They conducted a study through examining the neurobiological development of children as well as the behavioural development of the child. They found that more securely attached children showed higher levels of empathy than those who were not securely attached (Perrault et al, 2009). Vygotsky proposed the theory of proximal development. In this theory, Vygotsky proposes that "scaffolds" are put in place for a child and it is through these scaffolds that a child reaches their maximum potential, due to guided learning. This theory has strong environmental influences and supports the idea that the environment a child is reared in has a direct and strong effect on the child's development and beliefs (Miller, 2011).

Erickson (1968) also put forward a theory of psychosocial development, the stages represents important points in the development of an individual. According to this theory adolescents are going through the developmental stage of identity and role confusion. This then would be a priority period for the solidifying of their attitudes and outlook on life, as they tend to be more impressionable. The environment one grows up in, not only has an impact on how satisfied one is with their lives as a whole. An individual who has been reared in a negative un-stimulating environment will be more negative and less empathetic to the less fortunate, they will view themselves as having a low quality of life and hence project this negative, begrudging attitude, onto society, and to those who are less fortunate (Corso et al, 2008) conducted a study with participants,

who were maltreated as children, and how they reported quality of life as adults. Those who were maltreated as children reported poorer health related quality of life than those who were not maltreated as a child. This kind of outlook showed negative attitudes that still simmered due to their neglecting past.

Carr et al, (2009) supports the notion that attachment styles impact on a person's quality of life. This study found that those survivors of institutional abuse in Ireland with strong attachment types had more positive quality of life compared to that of those who showed the fearful avoidant attachment styles. Through the harshest of circumstances, these individuals showed better and more stable characteristics for dealing and moving on with their lives. This promotes the view that the parental and early postnatal influences will set up a level of resilience and strength in an individual's personality.

*Aim of the Current Study:*

The aim of this study is to investigate the generational differences in the stigma of mental illness, the gender difference in seeking help for mental illness and ones quality of life and how that influences the empathy expressed for those who are mentally ill and in turn their stigma of the mentally ill. A cross sectional survey design will be utilised to attain results to advance the understanding of the phenomenon that is the attitudes towards mental illness. The literature regarding the stigma of mental illness seems to support the concept that males are less forthcoming with mental illness problems, than females. The literature in this area has been sparse, especially in relation to the stigmatizing attitudes towards mentally ill individuals, and how stigmatizing different age groups are. There is also very little research regarding how an individuals satisfaction with their life could effect their attitudes towards others, especially those who are already vulnerable to society. Thus the purpose of this investigation is to investigate the relatively under addressed ages difference's and satisfaction with life and their effects on an individuals attitude's towards others. It is anticipated that the results of this study will contribute to the literature that exists already and may contribute to the mental health awareness schemes that currently exist in Ireland. The Results may provide valuable data

to further inform mental health awareness schemes that currently exist in Ireland of generational difference in relation to stigma. Such results may suggest effective ways of further engaging people in these scheme due to the particular focus on generational differences within this particular study. This could be more so related to the paucity of research related to rural Ireland and attitudes towards mental illness.

*Hypotheses:*

Hypothesis 1: Older participants in this study will be significantly more stigmatizing of people with mental illness than the younger participants in this study.

Hypothesis 2: Females will express more willingness towards seeking help for mental health problems, compared to that of the male sample.

Hypothesis 3: The participant's satisfaction with their lives will have an effect on the stigmatizing attitudes they hold towards mental illness.

## **Method**

### *Design*

The current study was a cross correlation, between subjects, qualitative design. The hypotheses of this study were that there would be a generational difference in the stigmatization of those with mental illness. The second hypothesis is that males will be less forthcoming for seeking help for mental health problems compared to that of females. The final hypothesis is that participants who report lower satisfaction with their life will hold more positive attitudes towards people who have mental health problems. The predictor variables were the age, gender and quality of life, the criterion variables were the stigmatizing attitudes, and the attitudes towards help seeking. The only demographic variables that were used were age and gender.

### *Participants:*

There were 136 participants in total for this study. All the participants were Irish in nationality and were from a number of rural parish's in South Tipperary, Ireland. There were seventy-one females (52.2%) in this study and sixty-five males (47.8%). The participants varied in age. For respecting the participant's privacy, the ages were categorised into five distinct categories. These categories were as follows, sixteen to eighteen, nineteen to twenty five, twenty-six - forty, forty one to sixty and the sixty plus

category. In total the response rates were as follows, for the sixteen to nineteen age bracket there was 39 (28.7%) respondents, of that 39 there was 14 females and 25 males. For the nineteen to twenty five categories, there were 23 participants (16.9%) of which fourteen were female and nine were male. There was twenty participants (14.7%) aged between twenty-six and forty, of this group there was ten females and ten males. Twenty-six (19.1%) respondents were between the ages of forty-one and sixty, of those 16 were female and ten were male. Finally, there were 28 (20.6%) participants aged over sixty seven of which were female and eleven who were male. The under eighteen sample was approached through a local secondary school. The only other club that was contacted was the local active retirement club where the over sixty sample was achieved. All permissions were granted.

*Materials:*

This study involved paper and pen questionnaires, and a statistical package for the social sciences, Version 18, was used to input data and carry out statistical tests on the data. The following measures were used to test the hypothesis.

Willingness to seek psychological help questionnaire, by Mackenzie, Knox, Gekoski and MaCauley 2004. This is a commonly used questionnaire, which seeks to investigate the participant's attitude towards seeking help for mental illness. This questionnaire does the above by testing three concepts, Psychological Openness, Help Seeking Propensity, and Indifference to stigma. This questionnaire included demographic questions about the participant's exposure to persons who are mentally ill, including if they had family, a colleague, or a neighbour who had a mental illness. The questionnaire then had a 24 item section where the participants were asked about their willingness to seek help for mental health problems, how they viewed seeking help for such problems and how open they would be to making themselves available for such help. For these items participants were asked to indicate their agreement to each item on a 5 point scale, ranging from the points of one (Strongly Disagree) to five (Strongly Agree), in the direction of positive attitudes towards seeking help for mental illness. Scores for all the items were summed, to give a total score, and the higher the score the higher the level of agreement with seeking help.

The individual concepts within the questionnaire were also summed to find a total, the higher the score again the higher the level of agreement with the concept.

The second measure used in this study was the Cates, Burton, and Woolley (2005) Attitudes towards mental illness scale. This seeks to measure a person's attitude towards those with mental illness. This measure seeks to investigate a person's belief about mental illness and their stigmatizing attitudes towards it. The questionnaire had eleven items. The subjects were asked to respond to statements such as "people in mental hospitals are not dangerous" on a four point scale from one (strongly Disagree) to four (Strongly Agree). These answers were summed, and a higher score on this questionnaire reflected a more positive attitude towards mental illness.

The final measure that was used in this study was the satisfaction with life scale. This questionnaire was designed to test a person's perceived satisfaction with their lives. The participants were asked to respond to statements such as if I were to live my life over I would change almost nothing. The participants were to respond on a 7 point scale with 1 being strongly disagree and 7 being strongly agree, the higher the total the more the individual was considered satisfied with their life. While quality of life was the desired variable that the researcher wished to test, a satisfaction with life scale was used instead due to the length of the quality of life questionnaires. The researcher felt that the questionnaire needed to be kept as short as was possible given the collection method that was to be employed.

#### *Procedure:*

#### Ethical Considerations

Ethical considerations were considered pertinent to this study from the design stage of the research process. Prior to commencing this research project permission to carry out this study was sought from the ethics committee at DBS. A detailed research proposal was submitted to the committee. Following which ethical approval was granted.

#### Protecting Individual Participants:

Participants were made aware that their participation in the study was voluntary and that they were free to withdraw from the study at any time. A questionnaire (Appendix A) accompanied by a cover letter (Appendix B) outlined contact details of the researcher for those who had questions or who sought further information. This allowed the participants to make an informed decision regarding completion of the questionnaire. A consent form was also made up for the parents of the under eighteens (Appendix C).

### Confidentiality and Anonymity

Research participants were assured that the confidentiality of material would be maintained and that the anonymities of individual participants would be protected and disguised in any subsequent reporting of the data. All questionnaires were stored in a locked drawer in the researcher's home and only members of the main researcher had access to them, the supervisor on request had access to them. Data will be destroyed on completion of the study.

The participants were informed based on keeping the questionnaire confidential, they were not to write their name on any part of the questionnaire. As the focus was on a rural population all the participants were sourced from in total three rural parishes in South Tipperary. The local Active retirement leader was approached and asked for permission to give out questionnaires at one of their monthly meetings. Upon consent, a date was set and the questionnaires were given out at the monthly meeting. The local secondary school was contacted and when consent was given there, individual parental consent forms were prepared and were handed out to 6th Year students. The response rate was 35 and when they were all back a date was arranged and the questionnaire was given out. As for the rest of the questionnaires, they were given out through convenience and snowball sampling methods. People were asked to fill out the questionnaires through meeting with them personally.

The Questionnaire consisted of 49 items all together. The questionnaire also contained demographic questions such as age and employment and gender, alongside these were questions regarding any relations that the participant might have with persons with mental illness. Such as a family member, neighbour, or colleague. There was an opened

ended question for participants to include any additional information that they felt would be appropriate to include regarding mental illness. The participants filled out the demographic and situational questions, followed by the attitudes towards help seeking questionnaire. They then came to fill out the satisfaction with life questions, and finally the attitudes towards mental illness questionnaire. The Questionnaire took approximately eight minutes to complete. There were no incentives for completing this study.

### **Results:**

The hypotheses of the current study were as follows, that the older participants in this study would be significantly more stigmatizing of people with mental illness than the younger participants in this study. Females will express more willingness towards seeking help for mental health problems, compared to that of the male sample. It was hypothesised that the participant's satisfaction with their lives will have an effect on the stigmatizing attitudes they hold towards mental illness.

In total, there was 136 participant's, 71 of which were female and 65 of which were male. A number of Crosstabs were conducted to analyze the relationships to gauge what exposure or experience they had of them. Regarding this study, questions were asked of the participants to determine whether they had any family or professional colleagues with mental illness, mainly to gauge their exposure to it. The results tallied at ten participants in total reporting to have an immediate family member with mental illness. Of that 10, 6 were female, 12 reported to have a close friend with mental illness of those who reported this 5 were female and 7 were male. 22 reported that they had relative who had mental health problem, in which case 11 of both genders reported this fact. 65 participants admitted to having a neighbour who suffered from mental illness, 27 females reported this finding and 38 males. 43 participants recalled having worked professionally with someone who suffered from mental health problems, 24 of those who reported this were female and 19 were male.

*The effect of Age on stigmatizing attitudes towards the mentally ill:*

In relation to the first hypothesis, that the older participants in this study will be significantly more stigmatizing of people with mental illness than the younger participants in this study. A one way ANOVA was conducted, to compare the effect of age on the stigma of mental illness. There was a significant (0.001) effect of age on stigma, at the  $p < 0.05$  level at the different categories of age ( $F(4, 131) = 5.122, P=0.01$ ). Post Hoc comparisons were conducted to analyse the source of significance. Post Hoc comparisons using the Tukey's HSD test indicated that the mean score, for the 19- 25 year olds ( $M= 3.87, SD= 1.20$ ) was significantly different to the 60+ age group ( $M= -3.87, SD=1.20$ ). The mean score for 26-40 year olds ( $M= 3.61, SD= 1.25$ ) was significantly different to the 60+ age group ( $M= -3.61 SD= 1.25$ ). The mean score for the 41- 60 age group ( $M= 4.34 SD= 1.17$ ) was significantly different to the 60+ age group ( $M= -4.34 SD= 1.17$ ). The 16 - 18 year olds, ( $M= 1.40 SD= 1.06$ ) was not significantly different from the 60+ age group ( $M= 1.40, SD= 1.06$ ).

Table 1:

*Descriptive statistics of the stigma level across all age groups.*

Age	N	Mean	SD
16- 18	39	30.4359	3.50034
19- 25	23	32.9130	4.34755
26-40	20	32.6500	4.56848
41-60	26	33.3846	5.86568
60+	28	29.0357	3.23731

The results clearly show that there was a difference within the different age groups in stigmatizing attitudes towards individuals with mental illness. These results do not reflect

the hypothesised results, in that the younger 16-18 years olds had a similar low level of stigma as the over sixty's. There was stigma there but the two latter age groups on either side reflected more positive attitudes towards the mentally ill.

*Quality of Life as a predictor of Stigmatizing attitudes towards the mentally ill:*

In relation to the third hypothesis, that a participant who reports lower quality of life will have more stigmatizing attitudes towards mentally ill individuals, 75% of females reported a positive satisfaction with their life (reporting an overall total equivalent of either extremely satisfied, satisfied, or slightly satisfied). 69% of males reported the same. Across the participants, there was a relatively positive satisfaction with their lives. 69% of 16- 18 year olds reported that they were satisfied with their life. Similarly, 69% of 19-25 olds, 75% of 26- 40 year olds, 69% of 41-60 year olds, and 88% of 60+ year olds reported a satisfaction with their life.

A Pearson's R correlation was produced to test the strength of the relationship between the stigma and the participant's satisfaction with their life. It was found that there was a strong negative correlation between stigma and satisfaction with life, ( $R = -.101$ ,  $N = 135$ ,  $P = .244$ ). This supports that as the stigma increases, the participant's satisfaction with life decreases. This is further supported with the findings from the age category tests on the stigma attitudes, where the 60+ age group produced the lowest mean in relation to stigmatizing attitudes towards mental illness. It is clear that there is a definite link between higher satisfaction with life and negative attitudes toward the mentally ill.

*Help Seeking Behaviours and the effect of gender on these behaviours:*

The second hypothesis was then, that there would be a gender difference in seeking help for psychological illnesses. To test this hypothesis an independent samples T-test was conducted, to compare help seeking behaviours of males and females. There was a significant difference in the scores, for males ( $M = 79.6$ ,  $SD = 13.72$ ) and females ( $M = 84.54$ ,  $SD = 12.86$ ),  $T(134) = 2.170$ ,  $P = (.032)$ .

The three subcategories of the help seeking questionnaire were broken down to reveal where the significant difference within gender lay. Independent Samples T- tests were conducted on each variable and the following results were achieved.

An independent samples T test was conducted to test for difference between males and females in their response's to the psychological openness questions. There was a significant difference found between males (M= 23.47, SD= 5.35) and females (M= 25.56, SD= 6.40) in their psychological openness (T (134) = 2.052, P= (.042)).

An independent samples t test was conducted to expose any differences that may be existent between males and females on their help seeking propensity. Males (M= 29.38, SD= 6.10) were not significantly different to females (M= 31.29, SD= 5.45) in their willingness to seeking psychological help, (T (134) = 1.928, P= 0.57).

An independent samples t test was conducted to expose any differences that may be between males and females in their indifference to stigma. No significant difference was shown between males (M= 26.73, SD= 6.39) and females (M= 27.69, SD= 6.53) in their indifference to stigmatising attitudes towards persons with mental illness, (T (134) = .857, P =.393).

A one way ANOVA was also conducted, to compare the effect of age on help seeking attitudes towards mental illness. There was a significant (.001) effect of age on help seeking, at the  $p < 0.05$  level at the different categories of age (F (4, 131) = 4.997, P = 0.001). Post Hoc analysis with a Tukey's HSD was conducted and indicated, that there was a significant difference between the mean of 16-18 year olds (M= -10.96, SD= 3.34) and the 19- 25 year olds (M= 10.96, SD= 3.34). There was a significant difference in means between 16-18 year olds (M= -10.48, SD= 3.50) and 26-40 year olds (M= 10.48, SD= 3.50). There was also a significant difference between the means of 16-18 year olds (M= -12.23, SD= 3.22) and the 41-60 year olds (M= 12.23, SD= 3.22). There was not a significant difference between 16-18 year olds (M= -8.15 SD= 3.15) and the 60+ year

olds (M= 8.15 SD= 3.15).

A Pearson's R correlation showed that there was a weak positive correlation between age and help seeking propensity (R=.475 N=136 P = .000). This shows that as the age decreases the help seeking propensity increases. The above research shows a definite link between gender and help seeking. There was a significant difference between males and females in their psychological openness.

A One way ANOVA found that there was a significant result between age and help seeking propensity. There was a significant (.000) effect of age on help seeking propensity, at the P< .05 level (F (24, 111) = 2.461 P= .001). The mean's of the different age groups were compared and it was found that the 16- 18 year olds (M=25.8205, SD=4.84970) had a significantly lower score on help seeking propensity than the other age categories.

Table 2:

*Descriptive statistic's for the age differences between help seeking propensity*

Age	N	Mean	SD
16-18	39	25.8205	4.84970
19-25	23	31.0000	5.06324
26-40	20	30.9000	5.07730
41-60	26	33.3462	5.00354
60+	28	33.1071	5.29388

There was no significant difference between those who knew a person suffering from mental illness than those who did not know anybody suffering from a mental illness.

## **Discussion:**

The aims of the current study were based around three hypotheses. The hypotheses were that the older participants in this study would be significantly more stigmatizing of people with mental illness than the younger participants in this study. Females will express more willingness towards seeking help for mental health problems, compared to that of the male sample.

It was hypothesised that the participant's satisfaction with their lives will have an effect on the stigmatizing attitudes they hold towards mental illness.

The above hypotheses went through a series of analysis to statistically test for the accuracy of the above hypotheses. The results of this study, partially agree with the above predictions. In relation to the first hypotheses, the hypothesis was partially supported. While it was expected that as the age increased the stigma would likewise increase, it was however found that the youngest 16-18 year olds and the 60+ year olds, had less stigma than the rest of the age categories. The 60+ year olds in this study had the least amount of stigma, closely followed by the 19-25's. The ones that expressed the most amount of stigma were the 26-40 year olds, followed by the 19-25's and the 41-60's had the third highest mean stigmatizing attitudes towards the mentally ill. This was an unexpected result regarding the over 60's. Even though the literature has lacked in this area, this study did not agree with Aromaa, Tolvanen, Tuulari and Wahlbeck's (2008) study, which found that the older the age of the participant the more negative attitude they held towards mental illness.

There was a strong response towards knowing someone with mental illness within this study and this did not influence the results significantly. This contrasts with Boyd, Katz,

Link and Phelan (2010) study, as there was no significant effect of knowing someone on the participant's responses within this sample. The stigma of mental illness varied in all aspects to the previous literature within this sample.

Quality of life was seen to have a negative effect on the stigmatizing attitudes towards the mentally ill. It was seen through a correlation that as the individuals satisfaction with their lives increased, their stigmatizing attitudes increased. This could be connected to the low levels of stigma within this subject sample however. There was not a large difference between the age categories in the satisfaction with their lives that they expressed, which may have been due to the fact that all of the participants knew the experimenter personally and they may have felt a certain tendency to report more satisfaction than they actually perceived. This agrees with Phelan and Basow's (2005) research in that this study implicated results that could have related to empathy levels, in the individuals who completed this questionnaire.

The results with respect to help seeking behaviour's and gender, were significantly different but only in respect to psychological openness. Females did report to be more psychologically open than males. This was in line with previous findings (Doherty, O Doherty, 2010; Judd, Komiti, Jackson 2008; Vogal et al 2007). In relation to the help-seeking propensity, males and females were not significant but were very close to statistical difference with a value of (.057). The males and females were apparently far apart with their mean but not far enough to heed a significant difference, this could down to the factor of such a large sample size. The final subcategory of the help seeking questionnaire was the indifference to stigma, and there was no significant result pertaining to gender with indifference to stigma. There was low level of stigma reported throughout the questionnaires, which would have affected a person's indifference to stigma.

The current study also found lower levels of help seeking propensity among 16-18 year olds. This could be due to independence. In rural areas, there is less independence at this age as resources and services are not local and help is not as close by as might be desired.

The more obstacles a person has to overcome the more likely it will be that they will not receive psychological help. This type of finding was replicated within the Wimer and Levant (2010) study, where conformity was ever important. Begley et al's (2002) study accentuated the obstacles than young men in seeking help for their emotional problems, and the different obstacles that stood in their way. With this study as a reference to the young male population above 18, it is not difficult to see how problems may arise within the younger males who would be less independent and more restricted in the methods of reaching out for help. Rickwood, Deane and Wilson (2007) study is agreed with then in that younger males have lower ability to seek help than older males.

There was certain weaknesses attached to this study which could have had implicated in the results that were achieved. The study was carried out in small rural community, which left the study open to cross contamination, fear of anonymity and confidentiality. There could have also been aspects of nervousness, not completely understanding the questions, elements of boredom, due to repetitive questions or the questionnaire being too long.

Within this study all the above factors were extremely relevant, within the factor of nervousness, the over sixty category expressed particular concern over the content and phrasing of the questions within the questionnaire's. This could have directly affected how they answered the questions, as they may have felt overwhelmed by the process. Many participants expressed impatience with the length of the questionnaire and the repetitiveness of the questions within the questionnaire; many expressed a certain level of boredom. There was of course the issue of concerns that the participant might have had regarding confidentiality. In knowing, the participants personally there might have been a certain fear of judgment. There was the obvious problem of cross contamination within the sample, even though there was no control condition within this study. The cross contamination could have occurred due to the limited location of the rural setting, where many local parishioners would have parents in the active retirement club or children in the local school who may have told them the content of the questionnaire. This was aggravated by the fact that time was limited and it took some time to get the questionnaires out to all of the participants.

Future studies could be carried out based on this study. As was said previously there is a gap in the literature regarding rural populations and this could be addressed. This study did not include an empathy scale, which could have advanced the understanding of the link between positive attitudes, satisfaction with life and empathy within an individual. There needs greater exploration between these variables in how they interconnect and effect each other. The possibility of a quality of life scale could also be explored as a more unbiased measurement of one's actual life happiness.

A larger study may be required to further analyse the relationship between age and the stigma of mental illness, honing in on the factors that may affect stigma of mental illness, such as fear, empathy, and personality. Such a study may provide a more comprehensive explanation as to why the different age groups perceive mental illness differently.

The practical implications of this study, is that it provides a more unique view point as to the different age aspects related to the stigma of mental illness. Many interventions exist in modern day society, regarding positive mental health; these are regularly aimed at teenagers and the elderly. A study such as the current one suggests that those promotions for positive mental health could perhaps become more focused towards the middle-aged groups.

In terms of help seeking, the results of this study implicate that there needs to be greater resources placed in more rural locations. While there are many promotions regarding positive mental health, the services are far sparser in rural locations, leading to greater difficulty in accessing these types of services. This was especially implicated in these results where 16- 18 year olds rated significantly lower in help seeking propensity than any other group of individuals. The limited access to services may directly hinge on the younger participants mobility or independence in seeking help for deep psychological troubles. These resources need to be a lot more accessible for under eighteen's.

Also in relation to help seeking there is still a gap regarding a certain male reluctance

towards seeking help for psychological problems, and while much work has been done around this topic, much has yet to be done to bridge the gap between males and females within their psychological openness. This is needed, as the rate of male suicide is still extremely high and if anything on the increase. It is important to reach out to males and try to change the societal norms of keeping one's problems to oneself.

In conclusion, this study found that there was difference in the stigma held by different age groups but that this stigma was concentrated towards the middle-aged groups. This was partially in fitting with the literature. There was a help seeking difference between males and females. This difference was observed within their psychological openness. There was a difference in the help seeking propensity of the different age groups and this could be due to the younger participants being less independent than the other groups. Finally, there was a relationship found between a person's satisfaction with their lives and their stigmatizing attitudes. This study's results partially agreed with the previous literature, but there needs to be a greater exploration amongst the rural populations regarding mental illness, help seeking behaviours and their quality of life.

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**Appendix A:**

Questionnaire that the participants completed:

Please print responses to the following items

\_Your Age: (Please Circle)



For each item, use the following scale to indicate your level of agreement to each statement.  
Insert your answer in the blank box to the right of the question.

- 1 = Strongly Disagree
- 2= Partially Disagree
- 3= Neither Agree or Disagree
- 4= Partially Agree
- 5= Strongly Agree

1. There a certain problems which should not be discussed outside of one's immediate family	
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems	
3. I would not want my significant other ( spouse, Partner etc.) to know if I were suffering from psychological problems	
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns	
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional	

6. Having been mentally ill carries a burden of shame	
7. It is probably best not to know everything about oneself	
8. If i were experiencing a serious psychological problem at this point in my life, I would be confident that i could seek relief in psychotherapy.	
9. People should work out their own problems, getting professional help should be a last resort	
10. If i were to experience a psychological problem, I could get psychological help if i wanted to.	
11. Important people in my life would think less of me if they were to find out that in was experiencing psychological problems	
12. Psychological problems, like many things tend to work out by themselves	
13. It would be relatively easy for me to find the time to see a professional for psychological problems	
14. There are experiences in my life that i would not discuss with anyone	
15. I would want to get professional help if I was worried or upset for a long period of time	
16. I would be uncomfortable seeking professional help for psychological problems because people in my business or social circles might find out about it	
17. Having been diagnosed with a mental disorder is a blot on a person's life	
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fear without resorting to professional help.	
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention	
20. I would feel uneasy going to a professional because of what some people would think	
21. People with strong characteristics can get over psychological problems by themselves and would have little need for psychological help	
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family	
23. Had I received treatment for a psychological problems. I would not feel that it ought to be covered up	
24. I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems.	

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree

- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

\_\_\_\_ In most ways my life is close to my ideal.

\_\_\_\_ The conditions of my life are excellent.

\_\_\_\_ I am satisfied with my life.

\_\_\_\_ So far I have gotten the important things I want in life.

\_\_\_\_ If I could live my life over, I would change almost nothing.

### Section C

Using the scale below, please circle the relevant answer beside 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

SD            D            A            SA

8. Mental illness is nothing to be ashamed of

SD            D            A            SA

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

SD                      D                      A                      SA

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

SD                      D                      A                      SA

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

SD                      D                      A                      SA

**Appendix B:**

This the consent form that was displayed as the front cover of the questionnaire:

Dear Participant,

I am conducting research on Attitudes. Please take the time to answer the questions.

There is no right or wrong answer and complete anonymity is guaranteed. Your

questionnaire answers will be merged with those from other people and we will not be able to trace your answers back to you, and we will not ask you to give your name or identification details. Do not write your name on this questionnaire. You have the right to withdraw at any stage during the completion of this survey.

All you have to do is complete the questionnaire, which will take about 8 -10 minutes and just work through the questions, in each case indicating to the extent to which you feel about each of the statements.

Do not write your name anywhere on the questionnaire.

Thank you for your interest in attitudinal research.

**Appendix C:**

This is the consent form that was sent home to the parent of the under eighteens:

Dear Parents/ Guardians,

My name is Geraldine Brett and I am a 3rd year psychology student of Dublin Business School. As a part of my final year I am conducting a survey on Attitudes. Your child will be asked to complete a questionnaire, the questionnaire

consists of 35 questions and will take approximately 10 minutes.

All information provided will remain confidential and will only be reported as group data with no identifying information. All data, including questionnaires will be kept in a secure location and only those directly involved with the research will have access to them. After the research is completed, the questionnaires will be destroyed.

Participation in this research study is voluntary. Your child will have the right to withdraw at anytime or refuse to participate entirely without Prejudice or discrimination.

If you have questions regarding this study, you may contact myself at 0877867074 or 1568511@mydbs.ie or my supervisor Mr Cathal O Keeffe at cathal.okeeffe@dbs.ie

I the undersigned approve/give permission for my son or daughter to take part in this study

Signature: \_\_\_\_\_ Date\_\_\_\_\_

Childs Name \_\_\_\_\_

