Adult Mental Health Literacy, Attitudes & Help-Seek Behaviour:
An Irish Context

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Abstract

This study was conducted to examine mental health literacy, attitudes & beliefs, and help-seeking behaviour across gender, age, education level and history of mental health among the adult population aged 18-65-years-old who were residing in Ireland. The research was conducted to establish a body of knowledge in the area of mental health literacy since no previous studies had been conducted within an Irish context. The aim of the research was to establish the level of mental health literacy, attitudes and help-seeking behaviour while ascertaining the level of stigma in Irish society across different socio-demographic factors. The study involved a mixed methods design, employing a quantitative questionnaires consisting of 123 participants with 69 females and 54 males; & qualitative interviews with 9 participants, 5 females & 4 males. The age range was 18-65-years-old. Purposive sampling and a snowball technique was utilised to gather the sample. Statistical analyses were conducted to interpret the quantitative data, and transcripts and themes were created for the qualitative data. The results indicate that women stigmatise more than men and younger groups are more prone to depression, while those with severe mental illnesses experience more discrimination. Self-help and counselling services are the most utilised methods as treatment options. There needs to be more emphasis on education, personal well-being and media promotion in order to change individual’s perspectives on mental health issues. Future research could employ an adolescent sample; examining depression in relation to mental health literacy.
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Chapter 1
Introduction

1.1 Introduction to Mental Health

Mental health is more than the mere lack of mental disorders, and concerns everyone. Mental health problems affect society as a whole, and not just a small, isolated segment. It affects our ability to cope with and manage change, life events and transitions such as bereavement or retirement. Psychological distress is to some extent necessary for people to function; without the heightened awareness and sensitivity that psychological distress brings to social situations and life experiences individuals may end up risking their lives at one extreme and under performing at the other. As such, mental health can be thought of as a continuum, with people positioned at various points depending on life events (external factors), genetic inheritance and stages of development (internal factors) (WHO, 2004b).

There are many terms synonymous with mental health, the most common ones being ‘mental ill health’, ‘mental illness’, ‘mental problems’ and ‘mental disorders’; some of which have been deemed too simplistic, partial or subjective to define. The Diagnostic and Statistical Manual of Mental Disorders (DMS-IV) (American Psychiatric Association, 1994) argued that the term ‘mental disorder’ is an outdate terms associated with mental asylum (Kendall, 1996). The World Health Organisation suggests that ‘mental health’ itself is “…a state of complete physical, mental and social well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004b, p. 9). Meanwhile, Gow et al (2004) argues that it is more helpful to think in terms of concepts of mental health. This idea was first adopted by Wallach (2004) who identified categories within which concepts of mental health could be represented. He described these as follows:

- Mental health is indicated by the attitudes of the individual towards themselves
- Mental health is expressed in the individual’s style and degree of growth, development or self-actualisation
- Mental health is based on the individual’s relation to reality in terms of autonomy, perception of reality, environmental mastery
- Mental health is the ability of the individual to integrate developing and differing aspects of themself over time

In terms of ‘normal’ and ‘abnormal’, or, as most commonly referred to, sane and the insane, it is not easy to distinguish the normal from the abnormal. There is a great deal of conflicting evidence relating to the use of such terms as ‘sanity, insanity, mental illness and
schizophrenia’ (Weiss, 2001). Furthermore, it is open to question as to whether the diagnoses of mental illness reside in the patients themselves or in the environment - Rosenhan says: ‘We might like to believe that we can tell the normal from the abnormal, but the evidence is not compelling . . . there is a great deal of conflicting data on the reliability, utility and meaning of such terms as “sanity”, “insanity”, “mental illness”, and “schizophrenia”’ (Weiss, 2001).

1.2 The Irish Context

While there has been a small amount of research conducted on attitudes and perspectives in Ireland there has been no substantial research carried in the area of mental health literacy in conjunction with attitudes and help-seeking behaviour. Most of the research in Ireland tended to focuses on what the public perceives mental health to be, as opposed to understand why people hold these beliefs. Nonetheless the HSE published a report “Mental Health in Ireland: Awareness & Attitudes” which has established a foundation of research which shows that while the Irish public have a fair understanding of mental health issues, stigmatising attitudes are prevalent which can act as a barrier for individuals to seek help. The Royal College of Surgeon in Ireland also conducted a public health survey ‘SLÁN’ in 2007, and found stigma associated with mental health as an important finding. These surveys highlight that Ireland is moving in the right direction in terms of establishing a body of public health perspectives and will hopefully influence the development of primary care services, while targeting specific groups for health promotion.

1.3 The Present Study

As mentioned while a great deal of research has been carried out internationally concerning mental health literacy, little has been seen within an Irish context. Previous studies in Ireland focused on general health and well-being indicators as opposed to specific mental health concerns. In addition, only a small number of reports have been complied concerning mental health perspectives, but no specific data on mental health literacy in greater detail has been collated in Ireland.

Two key concepts in the approach of this study are Mental Health Literacy and Help-Seeking. The term ‘Mental Health Literacy’ was coined in 1997 by Jorm et al. It refers to knowledge, beliefs and abilities that support the recognition, management or prevention of mental health problems. In 1997 Jorm suggested that a high public level of mental health literacy would improve early recognition in these disorders.

Heginbotham (1998) defined help-seeking as seeking help from any source either informal: peers, parents, family members or formal sources such as counsellors, psychologists and psychiatrists. Help-seeking is an important means of ensuring that individuals obtain appropriate supports and interventions yet there are indications that it is an area in which
people are especially weak. Byrne (2001) state that help-seeking cannot occur until a problem or mental health issue is identified and it is possible that individuals may not look for help because of their lack of awareness of the extent of their difficulties. However there is also a lot of evidence to suggest that because of individuals’ negative perceptions and attitudes surrounding mental health they are less likely to tell anyone about their problems (Miraudo and Pettigrew, 2002, Gould et al, 2004). Consequently they do not look for help and so their illness or disorder is not recognised as such and they receive no treatment.

A recent study by Jorm et al (2007) looked at people’s mental health literacy, taking depression as an example and help-seeking behaviour. One of their findings was that people do not consider doctors appropriate helpers for depressed friends or colleagues. They were far more inclined to recommend counsellors, friends or family and this could suggest that they see doctors as a place to go for physical health needs but not for mental health concerns. It was felt that a similar study with a cohort of Irish adults would be useful starting point to give some indication of the current state of their mental health literacy and help seeking behaviour. As noted above there is a lack of specific research in the area yet other related research suggests that the prevalence of mental health problems in Ireland is similar to that found in other countries highlighting a significant burden of disease in Irish people.

1.4 Research Aims & Objectives

The main focus of the current research is to promote and encourage change within the Ireland with regard to how mental health is perceived. The research attempts identify barriers which prevent individuals seeking treatment, while attempting to highlight risk and cause factors that lead to mental health problems. In addition the research wishes to establish the level of stigma which exists in Ireland or experienced by those with mental health issues

International studies aimed at mental health promotion and prevention have identified many strategies to maximise the public’s mental health, such as increasing public awareness, improving public knowledge about mental health problems, reducing the stigmatisation and discrimination while enhancing public attitudes towards seeking help from mental health professionals. However, any strategy intended to initiate change will have to take into consideration the range of people’s knowledge, attitudes and perceptions.

Based on the latter recommendations for influencing mental health promotion the main research objectives of the present study are to establish:

- The level of mental health literacy in Ireland
- Understand what attitudes and beliefs exist with regard to mental health
- Ascertain what methods of help-seeking behaviours are utilised
- Determine the level of stigma or perceived stigma associated with mental health
A secondary aim of the research is to establish if any differences exist among socio-demographic cohorts in relation to mental health issue within Ireland by:

• Gender
• Age
• Education
• History of mental health

In conclusion, the present study will examine adult’s knowledge of mental health, attitudes towards mental illnesses and towards those with mental health issues, while ascertaining the level of stigma within Ireland. Furthermore attitudes towards mental health interventions and treatment methods will be establishing by examining what level of help-seeking behaviour exists.
Chapter 2
Literature Research

2.1 Mental Health Issues

Mental health problems range from mild to severe and they are characterised by specific signs and symptoms. Mental disorders are especially distinguishable and without intervention tend to follow a predictable course (WHO, 2001). The diagnostic criteria for these disorders have been standardised internationally and are now seen as reliable and accurate as those for physical disorders (WHO, 2001). While there is continued debate about the influence of biological and psychosocial factors over the onset of mental illnesses (Arben, 1996; Harris, 2001), it is not considered an *either-or* question (WHO, 2001). Exactly what route leads to the onset of mental illnesses is still being assessed, but it is likely that mental disorders may be influenced by a combination of biological, psychological and social factors (WHO, 2001; WHO, 2004).

Mental health and mental illness are determined by multiple socioeconomic and environmental factors, as are physical health and physical illness (WHO, 2004b). Mental illness is an enormous and growing worldwide problem (WHO, 2001; WHO, 2004a). The World Health Organization estimates that 450 million people suffer from a mental or behavioural disorder, yet only a small proportion of these are in receipt of treatment. While prevalence rates vary from country to country, mental disorders are highly prevalent and often go untreated (WHO, 2004a).

The global burden of mental health problems is considerable; currently mental disorders represent 4 of the 10 leading causes of disability and the percentage of sufferers is expected to increase (WHO, 2001). While the specific causal mechanisms responsible for mental disorders remain unclear, there is a higher prevalence of certain mental disorders among specific demographic groups. For example, depression is more common in females and all mental disorders show higher prevalence rates among people from lower social classes (Harris, 2001; WHO, 2001; WHO, 2004b). Interestingly, older people are not more likely to be depressed than younger age groups, as commonly assumed (Goldney and Fisher, 2005). However depression in among older groups of people often goes undetected and depression is two to three times more common than dementia among this group (Anderson, 2001). As illustrated, mental health problems are universal and affect people across every domain of life, culture and socioeconomic level; are consistent throughout the life span and illustrate similar prevalence rates for men and women (WHO, 2001).

2.2 Prevalence

Globally, about 450 million people suffer from a mental or behavioural disorder (WHO, 2001). No group is immune to mental disorders, but the risk is higher among the poor,
homeless, the unemployed, individuals with low education, victims of violence, migrants and
refugees, indigenous populations, children and adolescents, abused women and the neglected
elderly. The level to which mental illness has permeated Irish society is illuminated by
organisations such as Amnesty International Ireland, the National Disability Authority, The
Royal College of Surgeons Ireland, and the Health Service Executive. The number of people
directly affected by mental illness in Ireland is estimated as 1 in 4 personally suffering from a
mental illness, with an additional 1 in 5 individuals currently caring for, or related to
someone with a mental illness (Health Service Executive, 2007).

Across gender, men and women experience broadly similar levels of mental health problems
and disorders but sometimes present with different symptoms and respond differently to those
symptoms. For example, men are much more prone to suicide, alcohol and substance abuse
while women are more prone to depression. Similarly, although the prevalence of certain
conditions such as schizophrenia is similar among men and women, the experience is that
men tend to have more enduring and intense symptoms. In addition, men tend to be more
reluctant to seek help and support for their health problems, including mental health problems
(WHO, 2001).

2.3 Health Literacy

*Health literacy* initially operated in a functional capacity, seen as a basic literacy tool which
influenced people to access and benefit from health information and services. Black (2002)
cites the National Library of Medicine definition of health literacy as “the degree to which
people can obtain process and understand basic health information and services they need to
make acceptable decisions.” This includes the ability to read and understand printed health-
related information and documents, such as prescription instructions or clinical appointment
letters (Hixon, 2004). Low levels of health literacy are correlated with low levels of general
literacy, and as such act as a barrier for individuals to seek out health service providers or
utilise appropriate medical and non-medical remedies.

The level of health literacy among people and the problems associated with it are thought to
be substantial. For example, Rootman (2004) cites the Institute of Medicine which reports as
many as 90 million Americans lack the literacy. This highlights the fact that people with
limited health literacy skills could not use a health system effectively. Most of these
individuals would therefore have poorer health, would be less likely to use preventative
services, have less understanding of health promoting behaviours, and are less able to manage
disease. With regard to the older populations, the progression of depression to more serious
form has been associated with lower levels of mental health literacy, leading to poor overall
health status. (Gazmararian et al, 2000). In recent years, researchers have reconstructed the
definition of health literacy to include more complex, higher order cognitive and social
capacities that support empowerment as opposed to a generic *functional* concept.

The WHO health promotion glossary defines this complex health literacy system as “the
cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health” (Kickbush, 2001; Rootman, 2002). In addition, Nutbeam (2000) established 3 levels of health literacy: (1) functional, (2) interactive and (3) critical. The last two levels develops the concept of health literacy beyond basic reading and writing skills to a more superior cognitive and social skills that allow people at level 2 to “…extract information and derive meaning from different forms of communication and to apply new information to changing circumstances” and, at level 3, “to critically analyse information and to use this information to exert greater control over life events and situations.” In practice this definition of health literacy allows for interactive skills, which relates to personal and collective empowerment for appropriate choice on the aspects of health behaviour. By expanding the concept of health literacy to include skills and abilities, people can create meaning from and maintain control over health behaviour. Thus, these reviewed definitions bring health literacy into the domain of health promotion (Rootman, 2002; Tones, 2002). As a result, health literacy may be considered as a major outcome of health promotion that reflects health education and social policy (Nutbeam, 2000; Ratzan, 2001).

A Health Literacy Workshop at ‘The Fifth WHO Global Conference on Health Promotion’ illustrated that health literacy concerns “dimensions of community development and health related skills beyond health promotion…not only as a personal characteristic, but also as a key determinant of population health.” (Kickbusch, 2001 p.12). It has been critically suggested that with this definition, health literacy has now been extended beyond the original meaning of health literacy and has become a general category for concepts already better defined within other health related disciplines (Tones, 2002). However this expanded definition of health literacy is in line with the field of literacy studies, which is moving toward a broader conceptualisation of general literacy as a variety of skill sets (e.g. scientific literacy, cultural literacy) ranging from basic reading and writing to critical analysis. (Nutbeam, 2000; Kickbush, 2001; Rootman, 2002). In addition it supports a focus on the broader social and environmental elements of health, leading to social and individual benefits such as the development of social capital and social and economic development (Kickbush, 2002). In this context, enhancing health literacy is expected to improve population health outcomes, just as improving education and general literacy influences the overall health and well-being of populations (Nutbeam, 2000; Kickbush, 2002).

2.4 Mental Health Literacy

The principles outlined in health literacy have been adopted recently to construct similar concepts for mental health literacy, with an emphasis on mental health knowledge and recognition. The term mental health literacy is relatively new and was first introduced in Australia, by Anthony Jorm in 1997. In 2006 he reported that “since then [1997] the term has come into widespread use in Australia and it has appeared as a national goal in a number of policy documents”. The term refers to the knowledge, beliefs and abilities that support the recognition, management or prevention of mental health problems and it consists of several
components:

- the ability to recognise specific disorders or different types of psychological distress;
- knowledge and beliefs about risk factors and causes;
- attitudes which facilitate recognition and appropriate help-seeking;
- knowledge and beliefs about self-help interventions;
- Knowledge of how to seek mental health information.
- knowledge and beliefs about professional help available;

Activities designed to improve mental health literacy are a significant component of mental health promotion. Strategies for improving mental health literacy generally consist of educational and communication approaches. These activities may be classified in a number of different ways, and can be considered in terms of:

- **mode of delivery** – e.g. mass media, brochures, oral presentations by experts and/or community leaders etc., and whether these modes are used in isolation or in combination;
- **Setting** – e.g. whole communities, hospitals, schools etc.
- **scope** – universal preventive measures (i.e. targeting the whole population or population groups), or selective preventive measures (i.e. aimed at particular subgroups of the population);
- **Scale** – e.g. local or national.

It has been demonstrated that these activities, scope, mode of delivery, setting and scale can all be beneficial in their own right. For example, mental health literacy campaigns in the mass media (mode of delivery) have indicated that there is potential for such campaigns to have an impact at community level, but also on individual knowledge and behavioural intentions. A series of studies from the U.K. by Wolff et al (1996a; 1996b; 1996c) investigated the impact of a localised public education campaign on community attitudes to people with mental illness. Overall, the public education campaign was associated with an improvement in overall attitudes and behaviour towards people with a mental illness, with a modest effect on knowledge. The authors stated that higher levels of contact with patients, rather than the education campaign per-se, resulted in less fearful attitudes in the experimental area. It was recommended that future education campaigns should be targeted more specifically towards those with the most negative attitudes to people with a mental illness.

The impact of educational program within universities (setting) was evaluated by Holmes et al (1999). The aim of this study was to measure the effects of an educational program on attitudes to mental illness, and to determine whether the impact of the program was modified by pre-existing knowledge and experience. The course was two-fold in that it was designed to provide accurate information and dispel misconceptions about schizophrenia, while allowing participants make contact with a relative of someone who had schizophrenia. Two groups
were recruited to participate; a control group (psychology students) and intervention group (general public). The authors concluded that the education course had improved attitudes to mental illness. In particular, it was found that benevolence and social restrictiveness attitudes improved throughout the education program. A change in benevolence attitudes was also found in the control group during the study; however this was smaller in magnitude than that of the intervention group. The authors stated that pre-education knowledge and making contact with a relative of someone with mental illness mediated the effects of the educational program. Ultimately, prior knowledge and contact were found to augment improvements in benevolence attitudes. This supports the finding of Wolff et al (1996a; 1996b; 1996c) that improved attitudes were associated with social contact with people with mental illness, rather than education alone.

Mental health literacy programs may focus on certain groups within the population (scope) who have a particular need for mental health education. For example, it has been argued that lack of mental health literacy can create difficulties for families and caregivers, and therefore mental health education targeted to these groups may help to improve quality of life for people with mental illness (Pickett-Schenk, Cook et al. 2000). Research which demonstrated this point was illustrated by Leff et al (1982; 1985). The study investigated the impact of a social intervention for families of people with mental illness. The aim was to determine whether a social intervention would affect the course of schizophrenia in people who were also on anti-psychotic medication. The social intervention consisted of a brief educational program, a support group for relatives, and family sessions held at their home. The educational element provided information about the causes, symptoms, prognosis and management of schizophrenia. All participants had been living with relatives prior to admission, spent more than 35 hours per week in direct contact with at least one relative, and lived close to the hospital of admission. In addition, at least one member of the family had been identified as ‘high expressed emotion’, as the authors were interested in the impact of expressed emotion on the course of schizophrenia. All participants had been prescribed anti-psychotic medication, and families were randomly assigned to either the intervention or control group. The social intervention was conducted with the intervention group for nine months, and follow-up was conducted immediately after the program, and again at two-year post-intervention. At two-year follow-up, the difference in relapse rate between the two groups was statistically significant - it was found that there had been a relapse rate of 78% in the control group, and only 20% in the intervention group. The authors concluded that the social intervention had resulted in improved outcomes for participants in terms of schizophrenic relapse.

A critique of this study was that the authors did not attempt to measure whether the social intervention had any impact on the knowledge, attitudes and behaviour of families who participated, therefore it is unclear whether the educational aspects of the program achieved changes in mental health literacy. Berkowitz et al (1984; 1990), later conducted a replicate study taking this point into consideration. It was concluded that the changes in knowledge measured immediately following the program could most likely be attributed to the impact of the educational component. The changes identified at the nine-month follow-up may have
been influenced by the therapeutic interventions in addition to the education program. In contrast to the previous study, the authors were able to demonstrate that the educational component of the program had an impact on knowledge. They acknowledged that immediate changes in knowledge were limited and were largely related to diagnosis; however they argued that initial changes may have enabled families to develop greater tolerance for their ill relatives and to continue improving their knowledge.

As shown, knowledge of mental health is the perquisite in understanding mental illness in order to assist in the recovery process or in the prevention of a more serious illness, both at individual and community level. However, much of the literature suggests that that the general public have a poor understanding of mental illness; they are unable to correctly identify mental disorders, do not understand underlying causal factors, are fearful of those who are perceived as mentally ill, have incorrect beliefs about the effectiveness of treatment interventions, are often reluctant to seek help, and are not sure how to help others (Priest et al, 1996; Jorm, 2000; Lauber et al, 2003a; Jorm et al, 2005a; Jorm et al, 2007). The ability to recognise mental disorders is thought to be important because the inability to recognise a disorder in oneself or others could result in delays seeking appropriate treatment, utilisation of inappropriate remedies, or difficulties communicating with health professionals (Jorm, 2000; Jorm et al, 2006a).

Specific studies illustrate this point, for example, one study showed that the Australian public are not very well informed about mental illness. The survey conducted in 2002 showed that 90% of respondents believed mental health was a significant issue in Australia, but overall did not have a clear understanding of mental illness. (Hight et al, 2002). When asked specifically to name important mental health problems relative to their country, depression was the most common response, followed by anxiety/stress. Fewer people identified schizophrenia/psychosis, dementia/Alzheimer’s disease, and alcohol/substance abuse as top mental health problems. Recognition and awareness has improved somewhat in Australia since the late 1990’s, following implementation of initiatives to improve mental health literacy, however researchers believe there is still room for improvement (Goldney et al, 2005; Jorm et al, 2005b; Jorm et al, 2006a; Jorm et al, 2006b).

Several studies have attempted to gauge the ability of the public to recognise and correctly label mental disorders. Much of the research involves the presentation of a vignette that describes a person with either symptoms of a major mental illness or substance abuse (using ICD-10 or DSM-IV diagnostic criteria). Following presentation of the vignette, respondents are asked a series of questions such as: what, if anything, is wrong with this person? What interventions would be helpful? What is the outcome likely to be? What is the likelihood of the person being discriminated against? Generally few members of the public are able to provide the correct diagnostic labels to mental illnesses, although most recognize that the problems as presented involve some kind of mental disorder. In a representative sample of the Australian population, Jorm et al (1997a) found that depression was correctly labelled by only 39% and schizophrenia by 27% of respondents. In a representative sample of the Swiss population, 74% identified the schizophrenia vignette as an illness, while only 40% identified
the depression vignette as an illness (Lauber et al, 2003a). In an American study, the majority of respondents were able to identify schizophrenia and major depression as mental illnesses when asked specifically how likely it was that the person in the vignette was suffering from a mental illness (Link et al, 1999). Few people identify alcohol and substance abuse as mental illnesses, although clinical evidence suggests that they are (Link, 1999; WHO, 2001).

It is not clear what influences recognition. Personal experience may not; people with major depression are no more likely than others to recognise depression in a vignette (Goldney et al, 2001). However, those who have had contact with people who have been depressed are more likely to identify depression as an illness (Lauber et al, 2003a). Age and gender may also play a role. The ability to correctly recognise and label depression in a vignette appears to be higher in younger people (Highet et al, 2002; Fisher and Goldney, 2003), and in women (Highet et al, 2002).

2.5 Attitudes & Beliefs

For the most part, in the developed world at least, mental illnesses are thought to be caused by psychosocial factors, such as environmental stressors or childhood events. Biochemical and genetic influences, although recognized as causal factors, are not considered as important as environmental ones (Jorm, 1997b; Link et al, 1999; Jorm, 2000). In a study of the public’s attitudes towards depression prior to the launch of the Defeat Depression Campaign in Britain, a majority identified psychosocial events and situations as the causes of depression, although they did agree that it was a medical condition (Priest et al, 1996). Walker and Read (2002) cite a number of studies that show that the public rejects the medical model and is quite resistant to biogenetic causal explanations for mental illnesses, preferring explanations related to environmental stressors or traumatic childhood events. Some studies suggest that serious mental illnesses such as schizophrenia are more likely to be linked to genetic causal factors compared to common mental disorders such as depression (Jorm, 1997b; Link et al, 1999).

Further research suggests that knowledge and beliefs about mental health disorders may emerge from general pre-existing belief systems about health and health interventions (Jorm et al, 1997b; Jorm et al, 2000a). For example, a belief that physical health problems are caused by lifestyle factors may lead to similar beliefs about the causes of, and appropriate treatments for, mental health problems. Enhancing mental health literacy is important because of the high prevalence of mental disorders—mental health professionals cannot possibly help everyone affected by mental health problems, and therefore knowledge and skills need to be widely distributed in the general population (Jorm, 2000).

The use of professional mental health services has greatly increased since the 1950’s (Phelan et al, 2000) although the reason for this trend is not clear. At the same time, numerous studies show that a minority of people with mental health problems seek professional help (Angermeyer and Matschinger, 1999; Jorm, 2000; Watson and Corrigan, 2001; Simonds and
Thorpe, 2003). The prevalence of mental disorders means that most people will have close contact with someone with a mental health problem at some point, but many of them lack the knowledge and skills to provide helpful responses (Jorm et al, 2005b; Jorm et al, 2007). The exact relationship between attitudes towards mental illness and help seeking is unknown (Phelan et al, 2000; Fisher and Goldney, 2003). While mental health service-use has increased, attitudes towards interventions are varied and not strongly related to actual help-seeking behaviour (Fisher and Goldney, 2003; Jorm et al, 2000a) Beliefs about the helpfulness of interventions do not always predict the use of them (Jorm et al, 2000b).

Greater treatment seeking is not associated with more knowledge about mental health issues; for example, older people have less knowledge about mental health issues and less positive attitudes towards professional mental health services, but are more likely to have been prescribed or to be taking anti-depressants (Fisher and Goldney, 2003). This may be related to their having more contact with medical doctors for age related health problems. Attitudes towards interventions vary by age, education and gender, with younger people, women and those with more education more likely to perceive mental health professionals as helpful (Angermeyer and Matschinger, 1999; Fisher and Goldney, 2003). Women are more likely than men are to use a range of interventions, including various self-help and life-style interventions (Jorm et al, 2000b).

2.6 Help-Seeking Behaviour

Overall, the literature suggests that people prefer self-help and lay support for mental issues, and less comfortable with medical interventions, especially pharmacological interventions (Angermeyer and Matschinger, 1996; Priest et al, 1996; Jorm, 2000; Angermeyer and Matschinger, 2001). Many studies highlighted psychotherapy and counselling as preferred methods for treatment by the public, and are seen as being much more effective in the treatment of mental health problems than effective than medical treatments (Angermeyer and Matschinger, 1996; Priest et al, 1996).

With regard to helpfulness of general practitioners for mental health issues, opinions are mixed. Several studies have shown that the public rate G.P.’s as useful when seeking help for depression (Jorm, 2000). However the findings are not universal - In the UK for example, a public survey showed that 60% of respondents would not consult their G.P for the treatment of depression because they felt that their doctor would consider it untreatable (Priest et al, 1996).

In terms of the treatment of schizophrenia, psychiatrists are deemed as less helpful than general practitioners (Angermeyer and Matschinger, 1999; Jorm, 2000; Goldney et al, 2005). Similarly, the general public determine psychiatric drugs as dangerous (Angermeyer and Matschinger, 1996; Jorm, 2000; Lauber et al, 2001; Hegerl et al, 2003). In a UK survey more than 70% considered anti-depressants drugs as addictive (Priest et al, 1996). Similar findings from a German study showed that 40% of respondents were less likely to use psychotropic
drugs, because they reasoned that prescriptions drugs only elevate the symptoms of a mental health issue but not cause (Angermeyer & Matschinger, 1996).

It appears that people’s personal experiences may influence choices and attitudes toward interventions. For example, some service-users and caregivers report having being subjected to some form of stigma within the health care system, and they believe that health care services-providers tend to focus more on reducing symptoms than supporting them with long-term personal recovery (McNair et al., 2002). Other studies indicate that some mental health professionals tend to hold stigmatising attitudes towards those with severe mental illnesses such as schizophrenia (Summerfield, 2001; Sartorius, 2002; Gray, 2002; Mazeh et al., 2003; Patel, 2004). Research showed that service users or patients received higher quality of care from psychologists, psychotherapists and nurses in contrast to medical consultants and psychiatrists (Caldwell and Jorm, 2000). Resentment against mental health professionals can act as a barrier to help seeking behaviour (Angermeyer and Matschinger, 1999). It appears help-seeking is determined by how people define the mental health issue and what they consider the cause of the problem, in addition to the outlook or prognosis of the problem (Angermeyer and Matschinger, 1999).

Jorm et al (2000a) also suggests there may be underlying belief systems about mental illnesses that influence attitudes to treatment. For example, one study asked young males to free associate regarding the term “mental health counselling” (Smith, 2004). The responses were highly negative, associating the term with “brain problems”, “mentally unstable”, “mental problems”, and “crazy people”. Nonetheless, participants reported that they would use counselling for life problems, suggesting a clear distinction between perceptions of mental illness and social or emotional problems.

In general, those who have a biomedical views of mental disorders (mental disorders as illnesses) are more likely to support the use of psychotropic drugs; those with a psychosocial view (mental illnesses as life crises) are not (Lauber et al., 2003a). Similarly, people who define mental health problems in terms of a psychiatric disorder and see the cause as being external or internal influences that are outside personal control are more likely to advise professional intervention (Angermeyer and Matschinger, 1999). People who attribute genetic causes to mental illnesses are more inclined to recommend medical help, i.e. medication or hospitalisation, but are less optimistic about treatment outcomes (Phelan et al., 2006). Prior et al (2003) suggested that people do not fail to seek help for mental health problems because of fear of stigma, it is because they consider them as non-medical conditions and therefore appear ambivalent in terms appropriateness and usefulness of medical treatment for what they consider everyday life problems.

Studies by Jorm et al (1997) found that members of the public tended to view pharmacological treatments for depression and schizophrenia as harmful, and to have a relatively negative view of mental health specialists compared with other health professionals. Furthermore Jorm stated that the level of mental health literacy in the population should be improved in order for individuals to recognise mental illness and
manage their own mental health more effectively. Improving mental health literacy in the general population is also important in terms of overcoming stigma associated with mental illness.

2.7 Stigma

Stigma can lead to prejudice, discrimination and negative outcomes for people with mental illness (Corrigan and Penn 1999; Commonwealth Department of Health and Aged Care, 2000). In a review of the literature on the stigma of mental illness, Hayward and Bright (1997) defined stigma as ‘the negative effects of a label placed on any group . . . in this case, those who have been diagnosed as “mentally ill”’. Corrigan and Penn (1999) stated that the impact of stigma on a person’s life might be as harmful as the effects of the mental illness. The attitudes of the public towards mental health issues are recognised as an important factor in the perpetuation of the stigma experienced by people with mental illness. Research has indicated that those with a better understanding of mental illness are less likely to hold stigmatising attitudes (Link and Cullen 1986; Brockington et al 1993; Wolff et al 1996; 1996b; Corrigan and Penn 1999). Kommana et al (1997) discussed the role of social psychology theory and attitude change in overcoming stigma, stating that changing public attitudes was a crucial step in eliminating stigma. They argued that stereotypes and misconceptions can be dispelled by promoting direct contact between the general public and people with mental illnesses; however, they also stated that overcoming stigma may be achieved more efficiently by disseminating realistic information through public education campaigns.

As illustrated, negative attitudes and discriminating behaviours towards people with mental illnesses leads to stigma. Stigma involving negative stereotypes and prejudice is often measured in terms of social distance (the degree to which people are willing to interact socially with others) (Corrigan and Penn, 1999; Corrigan et al, 2003; Phelan et al, 2000; Mann and Himelein, 2004; Lauber et al, 2004). Stigma can be enacted through social rejection and discrimination or felt as the fear of social rejection and discrimination (Scrambler, 1998). The stigmatising of mental illnesses remains pervasive and problematic and often results in active discrimination (Sims, 1993). This is of concern for a number of reasons. People may be reluctant to seek treatment for or disclose mental health problems, even common forms of anxiety and depression, for fear of social rejection and discrimination (Priest et al, 1996; Watson and Corrigan, 2001; McNair et al, 2002).

Perceived stigma may also result in treatment discontinuation (Sirey et al, 2001; Watson and Corrigan, 2001). People who do disclose or who are identified as mentally ill have reported discrimination from landlords, employers, physicians and other mental health professionals (McNair et al, 2002; Corrigan et al, 2003; Stuart, 2005). Social exclusion is a common experience (Byrne, 2001). Stigma and discrimination in the workplace frequently occurs: many employers will not hire persons with mental health problems, and disclosing mental disorders can undermine career advancement (Stuart, 2005). People may limit their social
interactions with others for fear of experiencing stigma (Perlick et al, 2001). Stigma can have negative effects on life satisfaction and self-esteem, and the experience of stigma can increase symptoms of anxiety and depression (Sims, 1993; Sartorius, 1998; Markowitz, 1998; Link et al, 2001). It may also influence how policymakers choose to allocate resources to those with mental illnesses (Corrigan et al, 2004).

Perceptions of dangerousness and unpredictability influence the desire to remain socially distant from those with mental illnesses (Link et al, 1999; Read and Law 1999; Phelan et al, 2000; Walker and Read 2002). These perceptions are not based on fact: only a small minority of individuals with mental disorders, primarily those with a specific sub-set of symptoms or co-occurring substance disorders are actually more prone to violence compared to persons without mental disorders. The risk of violence from other groups such as young male adults is similar or even higher and does not result in broad social stigmatization and desire for social distance (Read and Law, 1999; Corrigan et al, 2003). Phelan et al (2000) suggest that attitudes towards mental illnesses have taken two trajectories since the 1950’s. The public now accepts less severe problems such as depression and anxiety as more or less normal life events that can happen to anyone, but psychosis remains alien and stigmatised, and fear related to it has increased. Angermeyer and Matschinger (2001) came to a similar conclusion following a study of attitudes towards help seeking among the German population.

In Australia, Jorm et al (2000b) found that public attitudes about depression are relatively benign. Mann and Himelein (2004) suggest that reports of broad stigmatisation of all mental illnesses are inaccurate and potentially harmful, as there is much more stigma toward severe mental illness, and perceptions of broad stigmatization could deter persons with common mental disorders such as depression from seeking treatment. Although social acceptance of common mental disorders may have increased over the past few decades, fear and perceptions of dangerousness pertaining to severe mental illness have actually increased significantly (Phelan et al, 2000; Walker and Read, 2002). Individuals with schizophrenia and with alcohol and drug problems are now more likely to be perceived as unpredictable and potentially dangerous (Pescosolido et al, 1999; Crisp et al, 2000). The reason for the increase in fear related to serious mental illness is unclear, but it does not appear to be due to de-institutionalisation (Phelan et al, 2000).

The public are also generally reluctant to label common psychiatric symptoms such as depression and anxiety as mental illness and tends to characterise only severe disorders associated with bizarre or violent behaviour, as mental illnesses (Gray, 2002; Prior et al, 2003). It may be that mental disorders are stigmatised based on perceptions of normalcy: i.e. where they fit on a continuum of experience with which the public is able to relate. For example, attitudes towards obsessive-compulsive disorders (OCD) vary by symptom features, and people are much more socially rejecting towards those with obsessions related to harming than towards those with obsessions related to checking or washing (Simonds and Thorpe, 2002). In addition Lauber et al (2004) suggested that those with a medical insight
about specific mental illnesses are more likely to hold negative attitudes because they see the illness as chronically inherent.
Chapter 3
Methodology

3.1 Introduction

The methodological approach for the current study attempted to establish the level of mental health literacy, beliefs and causes about mental disorders, while ascertaining perceptions and attitudes towards mental illnesses. In addition attitudes relating to mental health interventions and help-seeking behaviour among an adult population were estimated through quantitative methods. A secondary aspect of the study aimed at determining themes relating to perspectives surrounding mental health issues using a qualitative design. Prior to commencing, a pilot study was conducted and ethical approval was sought from the ethics committee at Trinity College Dublin. Once ethical approval was granted the questionnaire was distributed to a purposive, snowball sample of adults via an internet survey tool, while a purposive sampling was also employed to recruit participants for the qualitative interviews.

3.2 Research Design

As outlined in chapter 1, there has been a limited amount of literature conducted in the Ireland in relation to mental health attitudes and perspectives. Specifically, the research conducted from an Irish perspective has been descriptive to date, that is, informative in terms of statistical knowledge, but lacking an in-depth explorative approach. To this effect the current study attempted to build upon the descriptive approach while introducing a broader body of knowledge through objective and subjective experiences. In order to accomplish these aims the current study opted to undertake a two-fold approach; (1) a quantitative aspect via structured questionnaires, and (2) a qualitative aspect through in-depth semi-structured interviews.

3.3 Survey Design

The questionnaire was developed using two public health surveys; (1) Mental health in Ireland: Awareness and attitudes 2007, and (2) Slán 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. It was decided to use these two surveys as they contained segments which aimed to establish levels of mental health literacy while understanding attitudes and perceptions concerning mental health issues. However, it is important to note that while these surveys formed the basis of the questionnaire for the current study, they were modified and expanded upon to be more precise and succinct in order to ascertain the specific aims and objectives relating to the current research question.

The modified questionnaire was designed for self-completion and formatted through Survey-Monkey. Survey-Monkey is an interactive facility and enables researchers to create their own
web-based surveys; surveys are then distributed to potential participants via email or through a designated active link.

The survey was created using ten variables, three of which were demographic questions. The three demographic questions related to, gender, age, and education. The remaining variables were sub categorised. Two variables were created to examine (a) mental health literacy, and a further two variables for (b) knowledge and beliefs, while one variable was assigned to each of the following (c) attitudes and perceptions, (d) help-seeking behaviour and (e) participant’s history with mental health problems, equating to seven variables in total. (See appendix 1).

3.4 Interview Design

The qualitative aspect of the study consisted of a semi-structured interview schedule which was reflective of the questionnaire, but included a subsection containing vignettes.

The first section of the interview schedule consisted of questions categorised into themes, namely, mental health literacy, perceptions of people with mental illness, personal experience of mental health, coping and help-seeking strategies, and stigma (see appendix 2). Given the limited amount of research on mental health literacy in Ireland it was decided to include this in-depth perspective which would be more explorative and compliment the quantitative aspect of the study as suggested by McGivern (2003).

Qualitative interviews may take the form of focus groups or individual interviews. Focus groups are elaborate ways of initiating in-depth responses but can put individuals at risk in terms of confidentiality and anonymity especially when dealing with sensitive topics. Individual interviews can be more useful when dealing with sensitive topics which require more personal and emotional descriptions. Lee (1993) acknowledges both of these issues and as the current study dealt with sensitive issues it was decided to utilise individual interviews to avoid psychological distress to participants while maintaining their anonymity.

A secondary component of the interview schedule was the vignettes. These vignettes were adopted from a study used by Jorm et al (1997a). The interview was based on a vignette of a person suffering from a mental disorder. The first vignette consisted of man showing symptoms of schizophrenia, while the second vignette described a woman displaying the symptoms of depression. Both vignettes illustrated specific symptoms in conjunction with the ICD-10 and DSM-IV criteria. Each set of questions associated with both vignette was similar and aimed to ascertain specific knowledge and perceptions about each character. The four key questions aimed to identify (a) symptoms and diagnoses, (b) attitudes towards the characters (c) stigma, and (e) help-seeking behaviour (see appendix 2).

The contexts of the vignettes were slightly modified from the original to account for any bias or generalisations. Specifically, the vignettes used by Jorm et al (1997) included the age of the person. It was decided to remove the age aspect as it may influence people’s perceptions about mental illness with age related diseases (e.g., mid-life crises, substance misuse, neurological degenerative diseases etc). A further issue with the vignettes was that the
characters were hypothetical and what the respondents said they would do to help in each situations is not necessarily what they would actually do in reality, nor is it likely to happen in the same context. Burns and Rapee (2006) support this idea, stating that it is uncertain if participants are likely to carry out the same behaviours in reality because vignettes may only utilise snap-shot descriptions of specific instances. However, McGovern (2003) suggested that vignettes are often successful as they are effective at eliciting in-depth responses to situations with limited undue psychological distress, especially when the contexts are hypothetical. Having considered the issues raised by all authors, as discussed above, and for the purposes of comparisons with other studies, the vignettes were incorporated. Specifically, it was anticipated that the vignettes could provide some useful insight or back-up in conjunction with the other questions used in the interview schedule.

In conjunction with interview schedule, demographic questions were recorded prior to the commencement of the interview and included gender, age, education race and nationality (see appendix 2).

3.5 Data collection (1)

3.5.1 The Survey

The original survey carried out by Jorm et al (2007) was distributed via a household survey - each selected household was sent a letter explaining they had been chosen to participate and an interviewer would call several days later. Interviewers who got no response from the selected household made at least two more call backs before the household was identified as a non-contact. It was decided to avoid this method of data collection for the current study on the basis of time constraints, cost implications and undue duress on participants. Specifically, the time period allocated for data collection for the current study had to be conducted over a shorter period of time and the availability of resources for postal and printing costs were minimal. More importantly however was the undue duress envisaged for residents if three calls were made to a household, leading also to possible risks for the researcher. In order to overcome these limitations an internet survey was conducted as an alternative approach. As highlighted by Best (2007) using the internet as a means to administer surveys is a cost effective and immediate method to collect sensitive data across a large demographical cohort. In addition the likelihood of impinging undue duress was eliminated.

3.5.2 Survey Procedure

The specific method through which the internet survey was administered was through electronic-mail to selected participants. Participants were selected from a mailing list known to the researcher initially. Each email (see appendix 3), contained (i) a greeting with a message regarding the survey (ii) an attachment containing an information sheet about the study and the survey (see appendix 4) and list of mental health service providers (see appendix 5), and (iii) a link provided by survey-monkey which redirected participants to the
actual survey for completion (see appendix 3). The opening page of the survey contained a consent form, which allowed participants to accept and continue with the questionnaire, or reject and exit the questionnaire. Participants who accepted and continued with the survey also had the option of exiting the survey at any point if they chose to do so. The second and third page of the survey consisted of two demographic questions, gender and age respectively. Gender was present as male and female while age was presented in actual years (18-65 inclusive) rather than sub-groups. Page 4 consisted of questions regarding mental health literacy and responses were recorded using the following options; ‘True’ ‘False’ or ‘Don’t Know’. Participants could only choose one response per question as the survey was formatted by default to allow only one option per question. Page 5 covered the same theme as page 4 using a likert-scale with the following options ‘Strongly Agree’ ‘Agree’ ‘Disagree’ ‘Strongly Disagree’ and ‘Don’t Know’. It was decided not to include a neutral option - “neither agree nor disagree” – in order to compare and contrast responses conducted with identical scales in the previous studies on mental health. One answer per question was permitted to be recorded. Page 6 contained questions regarding help seeking behaviour containing responses as ‘Helpful’ ‘Not Helpful’ or ‘Don’t Know’, allowing for only one response per question also. Page 7 asked about prevalence rates of mental health, requiring one response from a list of options. Page 8 consisted of a list of mental health problems and illnesses and participants were requested to tick three options from a list of 19 possibly options. Page 9 contained the same questions but asking for one option only. Page 10 contained questions about participant’s history or experience of mental health with 4 options, with no restrictions on the number of options chosen. The final question was demographic and referred to education level, with four options ‘Primary’, ‘Secondary’, ‘Third Level’ or ‘No Formal Education’. (See appendix 1).

3.6 Data Collection (2)

3.6.1 The Interview Schedule

The interview schedule was developed from the survey in terms of basic themes, such as mental health literacy, perception and attitudes, personal experience, help seeking behaviour and stigma. Construction of syntax was for arranged each theme in order to create a comprehensive schedule. Sub-themes and sub questions were also incorporated with addition of two vignettes. The vignettes were adopted from Jorms (2007a) original study with some modifications (see chapter 3.4 Interview Design). The interview schedule was then formatted into word document and printed as a hardcopy on paper for use by the researcher (see appendix 2).

The interview schedule contained several sections as follows:

(A) Demographics

(B) Mental health literacy

(C) Perceptions of people with mental illness
3.6.2 Interview Schedule Procedure

After participants showed interest in the study, all were informed of the study and subject matter, and arrangements were made to meet participants. Initially, all participants were emailed asking about a suitable time, date and location for interviewing. Time and date was flexible from the researcher’s point of view. Agreements were made by both parties to meet at a neutral location. Ethical considerations formed the basis of the interview location and participants agreed to meet at public library with designated discussion room, book prior by the researcher. Privacy was the main concern regarding the venue, as meeting at a public or outdoor locations could jeopardise the participant’s willingness to disclose personal details.

With regard to the interview process, all participants were made to feel comfortable. This was achieved by have a brief informal general chat. As an introduction the participant was given more information about the study and the issue about personal information and the discussion of sensitive issues was highlighted. Permission to record the conversation was discussed, and the participant was ensured of that all recordings would be kept on a USB device which was inaccessible with a private password. Once informed consent was given by the participant, demographic questions were asked informally in order to ease the participant into the interview – the demographics were taken as hand written notes by the researcher. Once the
demographic questions were asked, the participant was informed that the Dictaphone would be turned on and that the interview would commence. Throughout the interview, the researcher was conscious not to exaggerated expression such as shock or disbelief, but showed empathy through expression of words. Also the researchers body language was displayed informal yet remained attentive and to what the participants was disclosing.

Questions of a sensitive or personal nature were approached with caution. Where participants felt uncomfortable or were displaying distress, the researcher would offer to move on from that area, or terminate the interview. All participants were fully aware that they could withdraw from the interview at any time. At the end of the interview, participants were given an opportunity to ask any questions and were reminded that all coded data and transcripts would be destroyed at a later date. A list of mental health services were provided to all the participants, which included, counsellors, doctors, hospitals, help-lines, and websites.

Once the interview ended any abstract information which eluded the recordings, such as mood, body language and atmosphere of the interview were noted. The contents of the recordings were transferred to a USB device and were only accessible via a private password created by the researcher. The researcher transcribed the recordings as soon as possible, and created themes and sub-themes which emerged from the interview, in addition any new or unexpected themes or nuances were listed.

3.7 Sampling Frame & Method

As the research topic was inherently sensitive and the content of both the survey and interview schedule contained questions and themes relating to personal information it was decided to employ purposive sample with defined inclusion/exclusion criteria. First it was decided to exclude children or those up to the age of 18-years-old, and also exclude those aged 66-years or older for both the survey and interview. The age criteria was established based on one of the research aims, that is, the current study wished to explore the mental health issues among the adult population; the cut-off point at 66-years was established as a result of the pilot study which demonstrated that senior citizens are more difficult to access when conducting research via electronic methods. Another inclusion criterion was that participants had to be residing in Ireland, but not necessarily have Irish citizenship. The focus of the research was to gather information on mental health within an Irish context, rather than on native Irish citizens exclusively. No specifications were made to education, gender or history of mental health in terms of participatory criteria as these variables were important to the study to illustrate difference or similarities in terms of mental health problems among cohorts.

In terms of methods, selecting participants for the survey was determined using email addresses from the researcher’s personal email address book. From a list of 100 email addresses 10 were chosen who met the inclusion criteria. Following that, the 10 participants were sent an email out lining the nature and content of the research in the form of an information sheet and a link to the survey was attached (see appendix 3). A secondary
function of the email was to collect further data (snowball sampling). Specifically, the email contained a separate paragraph asking recipients of the initial email to forward the email onto other people who met the inclusion criteria (see appendix 6).

For the qualitative interviews the sampling frame, method and inclusion/exclusion criteria was identical to the survey, however a supplementary information sheet was included to outlining the procedure involved when conducted qualitative interviews (see appendix). Once the emails were sent and an expression of interest was made, potential participants were further informed of the research and arrangements were made to conduct the interviews once participants consented to the research.

From ethical standpoint the sampling methods incorporated allowed for the sample to voluntary participate in the research and opportunities were given to address any questions or concerns that the potential participants might have had (Murphy-Lawless, Oaks and Brady, 2004).

3.8 Sample size

The total sample size of the survey consisted of 123 participants, aged between 18-65-years-old. In terms of gender 54 were male, and 69 were female. The initial response rate was 133, however 10 of the surveys were incomplete (i.e., large proportions of the survey were not completed) and was decided not to include them in the study. Therefore the total number of completed surveys, equated to one hundred and twenty three.

The number of participants for the qualitative interview was nine, consisting of 4 men and 5 women, aged between 18- and 65-years-old. The response rate for the interviews was 12, and 9 were interviewed because of time constraints.

3.9 Ethical Issues

The fundamental ethical considerations for the survey were confidentiality. This issue of confidentiality was addressed by assuring participants that the survey was anonymous. This was achieved by explaining exactly how the survey was processed via Survey-Monkey. Specifically, participants were informed in the information sheet (see appendix 4) that Survey-monkey operated by allowing participants to complete questionnaires confidentially without the researcher identifying participants. To this effect all participants were ensured that their anonymity would be maintained. Importantly no email addresses or server addresses could be linked to the survey after the survey was submitted by the participants, therefore guaranteeing 100% anonymity. In addition participants were informed that the data obtained was only accessible to the researcher via the survey-monkey homepage using a unique password created by the researcher. A secondary issue was the storage of the data of the questionnaire, again participants were informed that all data once processed would be destroyed using an electronic shredder after a period of 3 months and that the Survey-
Monkey account would be terminated, thus eradicating any electronic data held through the account.

The main ethical concern for the interview was the recording of the data and the storage and release of the transcripts within the study. Participants were informed that the recording would be stored on a password-safe USB device and deleted after a three month period. In addition, participants were particularly concerned about the transcripts as some personal stories may be identifiable to other individuals, particularly if demographic information was released. It was agreed between both parties that the participants could read any quotes or phrases used within the write-up of the study before being submitted to a third party in order to ensure that no identifiable information was reported. Participants also had an opportunity to read and edit the transcripts, which provided reassurance of any misinterpretations on behalf of the researcher.

3.10 Pilot Study

The survey was piloted to 5 men and 5 women who were external to the final study. The purpose of the pilot study was to ensure that accessibility to the external link (survey-monkey) operated via an email. In addition, the ability to complete the survey as a self-completion questionnaire was tested. An underlying aspect of the pilot study was to identify any errors which may occur throughout the whole process of completing the survey. The feedback of the pilot study revealed that accessibility and the ability to complete the questionnaire independently were successful. However an issue arose for participants when they attempted to tick more than one option for a question which requested three responses.

Participants reported that they could only tick one answer rather than three on page 8. Having reviewed the problem technically via the creator’s page on Survey-Monkey, it appeared that the default settings were set to allow participants tick one option only. The problem was solved when the researcher changed the setting to three options. A final run of the survey as a pilot study revealed no errors and the study was distributed for completion to potential participants.

In terms of the age range chosen (18-65-years) the pilot study also revealed that people aged more than 65 were difficult to access in terms of email addresses, so participants over 65 were excluded. The lower age limit of 18 was chosen because of issues surrounding accessibility and consent because of the sensitive nature of the study.

The pilot study for the interview was conducted with one man and one woman. The main purpose was to detect any ambiguous language, sensitive issues and the relevance of themes to the research question. A secondary aspect of the pilot interview was to establish the average length of the interview in terms of time. Overall the pilot study proved successful with the exception two issues. Particularly, questions pertaining to mental health and the media were reworded as the phrase ‘media’ in and of itself suggest many aspects and nuances. Instead, words like newspaper, TV and news were used. In addition, themes relating
to political issues were removed as both participants refused to answer this question. The approximate time for each interview was 1 hour.

3.11 Data Analysis

The data obtained from the survey was entered into the “Statistical Package for the Social Sciences” (SPSS). All responses were coded into numerical values and inputted with each associated question to create a complete data set.

The qualitative interviews were analysed and transformed into a thematic framework. Initially, responses were transcribed verbatim and later coded into specific themes. Each themes contained sub themes along with new or unique responses.

3.11.1 Statistical Methods

A total score for the each of the variables 1) Mental health literacy 2) Attitudes and beliefs and 3) Help-seeking behaviour was compute. Each variable was tested using an independent sample $t$-test across the gender and age variables, while an ANOVA was conducted across education level and history of mental health variables. Descriptive statistics and frequencies were also conducted across all of the variables.

3.12 Limitations of research

The main limitation of the current research was the use of mix-methods. Difficulties occurred when attempting to create questions for the qualitative schedule based on the survey, given that qualitative and quantitative research methods are based on different theoretical perspectives, more considerations could have been taken before embarking with this approach. Furthermore, merging the results together for analysis and discussion was challenging in terms of making overall conclusions while referring back to previous literature on mental health. Another issue was the sequence in which the survey and interview was conducted. Data for the survey and information for the interview were collected concurrently; however a sequential approach may have yielded more information pertaining to the research question. Specifically, the survey could have been conducted first in order to establish unique or unusual data on mental health followed up by qualitative interviews in order to investigate these findings.

A second disadvantage of the research methodology was the use of internet survey. The main problem was control over who had access to the survey. Although the survey was only sent to participants included on the inclusion/exclusion criteria, those participants may have sent the email and survey to other individuals who may not have met the criteria and completed the survey nonetheless. A more stringent mailing list could have been created in order to have control over who had access to the survey.
Finally, the sample was not very well balanced in terms of demographics, especially among education level, with the majority of participant’s reporting having third level education, in addition more females than males participated in both the survey and the qualitative interviews. An intermediate review of the survey response rates with regard to gender and education differences could have been conducted in order to attempt to recruit a more balance sample.
Chapter 4
Results

4.1 Introduction

The results of the study are presented in two main areas of investigation: A quantitative aspect and a quantitative aspect. Both aspects of the study were based upon a common theoretical and conceptual framework, in order to provide reliable and comparative results. Specifically, each aspect of the study explored similar demographics and utilised variables and themes which were reflective within the survey and the interview in order to achieve the projects aims objectives. The first aim was to establish the level of mental health literacy, beliefs and causes about mental disorders, while ascertaining perceptions and attitudes towards mental illnesses. In addition attitudes relating to mental health interventions and help-seeking behaviour among an adult population were estimated. A third aim was to determine themes relating to perspectives associated with mental health issues.

4.2 Quantitative Study - Demographic Information

Demographic information for the quantitative aspect of the study refers four variables, 

(1) Gender
  - Male & female

(2) Age
  - Subgroups: 18-35-years-old & 36-65-years-old

(3) Education level
  - Second
  - Tertiary
  - None

(4) History of mental health
  - Personal experience
  - Cared for relative/friend
  - Experience through work/college
  - No experience

Each of the four demographic variables was examined across three test variables;

(1) Mental health literacy
(2) Attitudes/beliefs
(3) Help-seeking behaviour
While frequencies were highlighted for a further three variables,
(1) Prevalence rates
(2) Top 3 mental health issues
(3) Most important mental health issue

### 4.2.1 Gender

In terms of gender there were 69 females (56.1%) and 54 males (43.9%). The total number of respondents in the sample was 123 (see table 1).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>69</td>
<td>56.1</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>43.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Table 1 Number & Percentage of Males & Females**

### 4.2.2 Age

In terms age groups, there were 90 (73.2%) participants within the 18-35-year-old category and 33 (26.8%) within the 36-65-year-old category. The mean age of the group was 32.3 (SD= 8.6) while the median was ten. The total number in the sample was 123.

### 4.2.3 Education

In relation to highest level of education completed 33(26.8%) participants had completed second level education while 77(62.6%) reported having completed third level. Thirteen participants identified as having no formal education (see table 2).

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary</td>
<td>33</td>
<td>26.8</td>
</tr>
<tr>
<td>Tertiary</td>
<td>77</td>
<td>62.6</td>
</tr>
<tr>
<td>None</td>
<td>13</td>
<td>10.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Table 2 Number & Percentage of Education Sample**
4.2.4 History of Mental Health

In relation to participants history of mental health, 32 (26%) had experienced a mental health problem personally, 43 (35%) either cared for or was a relative of, someone with a mental health problem, 8 (6.5%) experienced mental health problems as a result of work or university issues, while 37 (30.1%) had no experience of mental health problems (see figure 1).

![History of Mental Health](image)

Figure 1 History & Experience of Mental Health Problems

4.3 Mental Health Literacy Results

Participants completed ten statements relating to mental health literacy (knowledge) and were requested to answer ‘true’, ‘false’ or ‘don’t know’. Each correctly-answered item was awarded one mark up to a maximum of ten marks per participant. A marking system was determined by the number of correct answers, on a 1 to 10 scale, with 1 being poor and 10 being excellent. A categorised marking system was created for correct answers for grouping purposes as follows; poor (1-3 correct answers), good (4-6 correct answers) very good (7-9 correct answers) excellent (10 correct answers). Of the total sample 112 (91.1%) answered 7 or more items correctly, while 11 (8.9%) answers 4 or more items correctly, indicating that the majority of the respondents have a very good knowledge of mental health issues (M= 8.12, SD= 1.06).

Table 3 shows participants responses on each item in the “mental health literacy” statements. The highest number and percentage of correctly answered for the ‘true’ statements, respectively, were items: I “only a small minority of people with psychological problems
seek help from mental health professionals”, 112 (91.1%) correct answers. Item 6 “psychological disorders like depression and anxiety disorders do not affect children” 109 (88.6%) correct answers. Item 2 “Eating disorders are psychological disorders”, 105 (85.4%) correct responses, and item 8 “A person who has recovered from mental illness will not be able to return to work”, 99 (80.5%) correct answers. item 3 Psychiatric disorders are true medical illnesses 93 (75.6%) correct responses and item 5 “During psychotherapy, clients usually lie on a couch and talk about whatever comes to mind” 95 (77.2%) correctly answered.

The number and percentage of correctly answered ‘false’ statements were items: 4 “Mental health is defined as the absence of mental disorders”, 82 (66.7%) correctly answered. Item 7 “Stress can lead to illness”, 79 (64.2%) correctly answered. Item 8 “A person with schizophrenia is a person with ‘split personality’” 99 (80.5%) and item 10 “Psychiatrists primarily use psychoanalysis as a basis of therapy”, with 47 (38.2%) correctly answered.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Only a small minority of people with psychological problems seek help from mental health professionals</td>
<td>112 (91.1%)*</td>
<td>1 (.8%)</td>
<td>10 (8.1%)</td>
</tr>
<tr>
<td>2</td>
<td>Eating disorders (e.g. anorexia nervosa, bulimia nervosa) are psychological disorders</td>
<td>105 (85.4%)*</td>
<td>10 (8.1%)</td>
<td>8 (6.5%)</td>
</tr>
<tr>
<td>3</td>
<td>Psychiatric disorders are true medical illnesses, e.g. heart disease and diabetes mellitus</td>
<td>93 (75.6%)*</td>
<td>19 (15.4%)</td>
<td>11 (8.9%)</td>
</tr>
<tr>
<td>4</td>
<td>Mental health is defined as the absence of mental disorders</td>
<td>5 (4.1%)</td>
<td>82 (66.7%)*</td>
<td>34 (27.6%)</td>
</tr>
<tr>
<td>5</td>
<td>During psychotherapy, clients usually lie on a couch and talk about whatever comes to mind</td>
<td>9 (7.3%)</td>
<td>95 (77.2%)*</td>
<td>19 (15.4%)</td>
</tr>
<tr>
<td>6</td>
<td>Psychological disorders like depression and anxiety disorders do not affect children</td>
<td>12 (9.8%)</td>
<td>109 (88.6%)*</td>
<td>2 (1.6%)</td>
</tr>
<tr>
<td>7</td>
<td>Stress can lead to illness (e.g. cancer, hypertension, mental disorders)</td>
<td>79 (64.2%)*</td>
<td>29 (23.6%)</td>
<td>15 (12.2%)</td>
</tr>
<tr>
<td>8</td>
<td>A person who has recovered from mental illness will not be able to return to work</td>
<td>18 (14.6%)</td>
<td>99 (80.5%)*</td>
<td>6 (4.9%)</td>
</tr>
<tr>
<td>9</td>
<td>A person with schizophrenia is a person with “split personality”</td>
<td>40 (32.5%)</td>
<td>65 (52.85%)*</td>
<td>16 (13%)</td>
</tr>
<tr>
<td>10</td>
<td>Psychiatrists primarily use psychoanalysis as a basis of therapy</td>
<td>35 (28.5%)</td>
<td>47 (38.2%)*</td>
<td>30 (24.4%)</td>
</tr>
</tbody>
</table>

Table 3. Responses to Mental Health Literacy Items *Correct answers
4.3.1 Mental Health Literacy & Demographic Results

In terms of socio-demographics and mental health knowledge, no significant differences were found across gender, age or history of mental health and mental health literacy; however there was a significant difference between education level and mental health knowledge as described below.

An independent samples t-test was used to examine statistically significant differences between males and females in terms of their knowledge of mental health. No significant differences were found \( t (104.979= 1.453, p>.05) \) between men (M= 18.28, SD= 3.56) and females (M= 17.41, SD= 3.08) in terms of their knowledge of mental health. (See Table 4).

An independent samples t-test was used to examine statistically significant differences between two age groups (18-35-year-olds & 36-65-year-olds) in terms of their knowledge of mental health. Levene’s test for equality of variance suggested that variances could not be assumed (\( F= 4.497, P<.05 \)) and no significant differences were found \( t (72.291= .961, p>.05) \) between 18-35-year-olds (M= 17.94, SD= 3.50) and 36-65-year-olds (M= 17.36, SD= 2.79) and their knowledge of mental health. (See Table 4).

A one-way between-groups analysis of variance was conducted to explore the relationship between education level and mental health knowledge. There were statistically significant differences in knowledge of mental health across the three different education subgroups, with people possessing third and second level education being more knowledgeable about mental health \( [F (2,121)= 7.101, p<.001] \). Despite reaching statistical significance, the actual difference between the groups was quite small (Cohen 1988); the effect size, calculated using eta squared, was .01. Post-hoc comparisons using the Tukey HSD test indicated that average score for those with third level education (M= 18.45, SD= 3.85) and second level education (M= 17.33, SD= 1.50) was significantly higher than those who reported as having no formal education (M= 15.00, SD= 0.00). (See Table 4).

A one-way between-groups analysis of variance was conducted to explore the relationship between history of mental health and level of mental health knowledge. There were no statistically significant differences in knowledge of mental health across the four different history of mental health subgroups \( [F (3,120) = 1.846, p>.05] \). The average score for those who had a mental health problem (M= 17.69, SD= 3.68), did not differ to people who had cared for someone with mental health problem (M= 16.93, SD= 2.55) or people who had experienced mental health problems through work or university (M= 19.62, SD= 3.16) nor did they differ to people with no mental health problems (M= 18.51, SD= 3.82). (See Table 4).
<table>
<thead>
<tr>
<th>Demographic</th>
<th>No.</th>
<th>Mean Score ± SD of Knowledge</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>18.28 ± 3.56</td>
<td>[t(104.979) = 1.453, p&gt;.05]</td>
</tr>
<tr>
<td>Female</td>
<td>69</td>
<td>17.41 ± 3.08</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35-Years-Old</td>
<td>90</td>
<td>17.94 ± 3.50</td>
<td>[t(72.291) = .961, p&gt;.05]</td>
</tr>
<tr>
<td>36-65-Years-Old</td>
<td>33</td>
<td>17.36 ± 2.79</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td>[F(2, 121) = 7.101,p&lt;.001]</td>
</tr>
<tr>
<td>Tertiary</td>
<td>77</td>
<td>18.45 ± 3.85</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>33</td>
<td>17.33 ± 1.50</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>13</td>
<td>15.00 ± 0.00</td>
<td></td>
</tr>
<tr>
<td><strong>History of Mental Health Problems</strong></td>
<td></td>
<td></td>
<td>[F(3, 120)=1.846,p&lt;.001]</td>
</tr>
<tr>
<td>Personal experience</td>
<td>32</td>
<td>17.69 ± 3.68</td>
<td></td>
</tr>
<tr>
<td>Cared for relative/friend</td>
<td>43</td>
<td>16.93 ± 2.55</td>
<td></td>
</tr>
<tr>
<td>Experience through work/university</td>
<td>8</td>
<td>19.62 ± 3.16</td>
<td></td>
</tr>
<tr>
<td>No history</td>
<td>37</td>
<td>18.51 ± 3.82</td>
<td></td>
</tr>
</tbody>
</table>

Table 4. Knowledge of Mental Health across Socio-demographic Groups

4.4 Attitudes and Beliefs Results

Participants completed ten statements relating to attitudes to mental health and were requested to answer ‘strongly agree’, ‘agree’, ‘disagree’, ‘strongly disagree’ or ‘don’t know’. Participants tended to subscribe to a mixed attitude towards mental health issues, with most either agreeing or disagreeing to each item.

Table 5 illustrates participant’s response to each statement in the attitude to mental health scale. Overall, the most recorded responses to all statements were to “agree”, followed by “disagree”. Specifically, for the “agree” items, the highest number and percentage recorded, respectively, were: Item 2 “I am afraid of experiencing mental health problems myself in the future”, 71 (57.7%) responses. Item 8 “People with mental health problems should have the same rights as anyone else”, 66 (53.7%) responses. Item 1 “If I suffer from mental health problems, I would not want people to know”, 53 (43.1%) responses. Item 7 “The majority of people with mental health problems recover”, 45 (36.6%) recorded. Item 10 “People with mental health problems should not be allowed to do important jobs”, 34 (27.6%).

In relation to the “disagree” items, the most recorded responses to each statement, respectively, were: Item 6 “People with mental health problems are often dangerous/violent”, 77 (59.3%). Item 4 “I would find it hard to talk to someone with mental health problems”, 73 (59.3%). Item 9 “People with mental health problems are largely to blame for their own
condition” 71 (57.7%). Item 5 “People are generally caring and sympathetic to people with mental health problems”, 46 (37.4%).

Although “agree” and “disagree” statements were mostly referred to, the “strongly agree” option was the only single most common response recorded for item 3 “Anyone can suffer from mental health problems”, with 80 (65%) responses.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If I suffer from mental health problems, I would not want people to know</td>
<td>15 (12.2%)</td>
<td>53 (43.1%)</td>
<td>42 (34.1%)</td>
<td>6 (4.9%)</td>
<td>7 (5.7%)</td>
</tr>
<tr>
<td>2</td>
<td>I am afraid of experiencing mental health problems myself in the future.</td>
<td>22 (17.9%)</td>
<td>71 (57.7%)</td>
<td>13 (10.6%)</td>
<td>8 (6.5%)</td>
<td>9 (7.3%)</td>
</tr>
<tr>
<td>3</td>
<td>Anyone can suffer from mental health problems</td>
<td>80 (65%)</td>
<td>34 (27.6%)</td>
<td>7 (5.7%)</td>
<td>2 (1.6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>4</td>
<td>I would find it hard to talk to someone with mental health problems</td>
<td>3 (2.4%)</td>
<td>10 (8.1%)</td>
<td>73 (59.3%)</td>
<td>26 (21.1%)</td>
<td>11 (8.9%)</td>
</tr>
<tr>
<td>5</td>
<td>People are generally caring and sympathetic to people with mental health problems</td>
<td>1 (.8%)</td>
<td>14 (11.4%)</td>
<td>46 (37.4%)</td>
<td>37 (30.1%)</td>
<td>25 (20.3%)</td>
</tr>
<tr>
<td>6</td>
<td>People with mental health problems are often dangerous/violent</td>
<td>0 (0%)</td>
<td>24 (19.5%)</td>
<td>77 (62.6%)</td>
<td>19 (15.4%)</td>
<td>3 (2.4%)</td>
</tr>
<tr>
<td>7</td>
<td>The majority of people with mental health problems recover</td>
<td>10 (8.1%)</td>
<td>45 (36.6%)</td>
<td>29 (23.6%)</td>
<td>0 (0%)</td>
<td>39 (31.7%)</td>
</tr>
<tr>
<td>8</td>
<td>People with mental health problems should have the same rights as anyone else</td>
<td>49 (39.8%)</td>
<td>66 (53.7%)</td>
<td>4 (3.3%)</td>
<td>2 (1.6%)</td>
<td>2 (1.6%)</td>
</tr>
<tr>
<td>9</td>
<td>People with mental health problems are largely to blame for their own condition</td>
<td>1 (.8%)</td>
<td>35 (28.5%)</td>
<td>71 (57.7%)</td>
<td>0 (0%)</td>
<td>16 (13%)</td>
</tr>
<tr>
<td>10</td>
<td>People with mental health problems should not be allowed to do important jobs such as Doctors, nurses etc.</td>
<td>11 (8.9%)</td>
<td>34 (27.6%)</td>
<td>31 (25.2%)</td>
<td>29 (23.6%)</td>
<td>1 (.8%)</td>
</tr>
</tbody>
</table>

Table 5. Responses to Attitudes and Beliefs items.
4.4.1 Attitudes and Beliefs & Demographic Results

In relation to socio-demographics and attitude to mental health, significant differences were found across gender, education and history of mental health in terms of attitudes to mental health; however no significant difference between age groups level and attitudes to mental as described below.

Reliability analysis for this scale (attitude to mental health) revealed moderate standard deviations and correct item-total correlations (all above 0.3) for each variable. The Cronbach’s alpha for this scale was 0.74, indicating that it is a highly reliable measure of attitudes to mental health.

An independent samples t-test was used to examine statistically significant differences between males and females in terms of their attitude to mental health. Levene’s test for equality of variance suggested that variances could not be assumed (F = 13.113, P<.05) and there were significant differences were found [t (96.116= 2.311, p<.05] between males (M= 26.30, SD= 6.17) and females (M= 23.95, SD= 4.61) and their attitude to mental health. (See Table 6).

An independent samples t-test was used to examine statistically significant differences between two age groups (18-35-year-olds & 36-65-year-olds) in terms of their attitude to mental health. No significant differences were found [t (118= -.101, p>.05] between 18-35-year-olds (M= 25.00, SD= 5.37) and 36-65-year-olds (M= 25.10, SD= 5.82) and their attitude to mental health. (See Table 6).

A one-way between-groups analysis of variance was conducted to explore the relationship between education level and attitude to mental health. There were statistically significant differences in attitude to mental health across the three different education subgroups, with people with second and third level education being more knowledge about mental health [F (2,117) = 3.659, p<.05]. Despite reaching statistical significance, the actual difference between the groups was quite small (Cohen 1988); the effect size, calculated using eta squared, was .01. Post-hoc comparisons using the Tukey HSD test indicated that average score for those who with second level education (M= 27.03, SD= 6.85) and third level education (M= 24.50, SD= 5.02) was significantly higher than those who reported as having no formal education (M= 23.00, SD= 0.00). (See Table 6).

A one-way between-groups analysis of variance was conducted to explore the relationship between history of mental health and attitude to mental health. There were statistically significant differences in attitude to mental health across the four different history of mental health subgroups [F (3,115) = 9.755, p<.001]. Having reached statistical significance, the difference between the groups was small (Cohen 1988); the effect size, calculated using eta squared, was .03. Post-hoc comparisons using the Tukey HSD test indicated that average score for those with no mental health problems (M= 28.57, SD= 5.27) and who had cared for someone with mental health problem (M= 24.38, SD= 4.71) differed significantly to those
who had experienced mental health problems through work or university (M= 22.75, SD= 6.56) or had a mental health problem (M= 21.84, SD= 3.80) (See Table 6).

<table>
<thead>
<tr>
<th>Demographic</th>
<th>No.</th>
<th>Mean Score ± SD of Attitude</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>26.30 ± 6.17</td>
<td>[t(96.116= 2.311, p&lt;.05]</td>
</tr>
<tr>
<td>Female</td>
<td>69</td>
<td>23.95 ± 4.61</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35-Years-Old</td>
<td>90</td>
<td>25.00 ± 5.37</td>
<td>[t(118= -.101, p&gt;.05]</td>
</tr>
<tr>
<td>36-65-Years-Old</td>
<td>33</td>
<td>25.10 ± 5.82</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td>77</td>
<td>24.50 ± 5.02</td>
<td>[F(2,117)= 3.659,p&lt;.05]</td>
</tr>
<tr>
<td>Secondary</td>
<td>33</td>
<td>27.03 ± 6.85</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>13</td>
<td>23.00 ± 0.00</td>
<td></td>
</tr>
<tr>
<td>History of Mental Health Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>32</td>
<td>21.84 ± 3.80</td>
<td>[F(3, 115)=9.755,p&lt;.001]</td>
</tr>
<tr>
<td>Cared for relative/friend</td>
<td>43</td>
<td>24.38 ± 4.71</td>
<td></td>
</tr>
<tr>
<td>Experience through work/university</td>
<td>8</td>
<td>22.75 ± 6.56</td>
<td></td>
</tr>
<tr>
<td>No history</td>
<td>37</td>
<td>28.57 ± 5.27</td>
<td></td>
</tr>
</tbody>
</table>

Table 6. Attitudes to Mental Health across Socio-demographic Groups

4.5 Help-Seeking Behaviour Results

Participants completed ten statements relating to help-seeking behaviour and were requested to answer ‘helpful’, ‘not helpful’ or ‘don’t know’. Participants responses were ambivalent (M= 16.41, SD= 3.30).

Table 7 illustrates participant’s response to each statement in the attitude to mental health scale. Overall, the most recorded responses to all statements were to “helpful”, followed by “unhelpful”. Specifically, for the “helpful” items, the highest number and percentage of recorded responses, respectively, were: Item 1 “Talking to a friend or family member”, 121 (98.4%) responses. Item 3 “Talking therapy such as counselling or psychotherapy”, 105 (85.4%) responses. Item 10 “Consulting a web site that gives information about the mental health problem”, 101 (82.1%) responses. Item 4 “Reading about people with similar problems and how they dealt with them” 98 (79.7%) responses. Item 2 “Going on a special diet or avoiding certain foods” 85 (69.1%) responses and Item 7 “Being admitted to a psychiatric hospital”, 60 (48.8%) responses.
In relation to the “not helpful” items, the most recorded responses to each statement, respectively, were: Item 9 “Taking pain killers such as Codeine, Aspirin or Panadol”, 75 (61%) responses. Item 8 “Taking sleeping pills”, 73 (59.3%) responses. Item 6 “Having an occasional drink to relax”, 53 (43.1%) responses followed by item 5 “Taking antidepressants”, 43 (35%) responses.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Helpful</th>
<th>Not Helpful</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Talking to a friend or family member</td>
<td>121 (98.4%)</td>
<td>2 (1.6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>2</td>
<td>Going on a special diet or avoiding certain foods</td>
<td>85 (69.1%)</td>
<td>18 (14.6%)</td>
<td>20 (16.3%)</td>
</tr>
<tr>
<td>3</td>
<td>Talking therapy such as counselling or psychotherapy</td>
<td>105 (85.4%)</td>
<td>6 (4.9%)</td>
<td>12 (9.8%)</td>
</tr>
<tr>
<td>4</td>
<td>Reading about people with similar problems and how they dealt with them</td>
<td>98 (79.7%)</td>
<td>20 (16.3%)</td>
<td>4 (3.3%)</td>
</tr>
<tr>
<td>5</td>
<td>Taking antidepressants</td>
<td>36 (29.3%)</td>
<td>43 (35%)</td>
<td>44 (35.8%)</td>
</tr>
<tr>
<td>6</td>
<td>Having an occasional drink to relax</td>
<td>45 (36.6%)</td>
<td>53 (43.1%)</td>
<td>24 (19.5%)</td>
</tr>
<tr>
<td>7</td>
<td>Being admitted to a psychiatric hospital</td>
<td>60 (48.8%)</td>
<td>37 (30.1%)</td>
<td>26 (21.1%)</td>
</tr>
<tr>
<td>8</td>
<td>Taking sleeping pills</td>
<td>15 (12.2%)</td>
<td>73 (59.3%)</td>
<td>35 (28.5%)</td>
</tr>
<tr>
<td>9</td>
<td>Taking pain killers such as Codeine, Aspirin or Panadol</td>
<td>19 (15.4%)</td>
<td>75 (61%)</td>
<td>29 (23.6%)</td>
</tr>
<tr>
<td>10</td>
<td>Consulting a web site that gives information about the mental health problem</td>
<td>101 (82.1%)</td>
<td>8 (6.5%)</td>
<td>7 (5.7%)</td>
</tr>
</tbody>
</table>

*Table 7. Responses to Help-Seeking Behaviour*
4.5.1 Help-Seeking Behaviour & Demographic Results

In relation to socio-demographics and help seeking behaviour for mental health issues, there were no significant differences found across gender, age or educational level in terms of help-seeking tendencies; however, significant differences were found between history of mental health and help seeking behaviour, as described below.

Reliability analysis for this scale (help-seeking behaviour) revealed moderate standard deviations and correct item-total correlations (all above 0.3) for each variable. The Cronbach’s alpha for this scale was 0.80, indicating that it is a highly reliable measure of attitudes to mental health.

An independent samples t-test was used to examine statistically significant differences between males and females in terms of their help-seeking tendencies. There were no significant differences found [t (121)= .198, p>.05] between males (M= 16.48, SD= 2.81) and females (M= 16.36, SD= 3.66) and their help seeking behaviour. (See Table 8).

An independent samples t-test was used to examine statistically significant differences between two age groups (18-35-year-olds & 36-65-year-olds) in terms of their help-seeking tendencies. No significant differences were found [t (121)= -.943, p>.05] between 18-35-year-olds (M= 16.24, SD= 3.18) and 36-65-year-olds (M= 16.88, SD= 3.61) and their help seeking behaviour. (See Table 8).

A one-way between-groups analysis of variance was conducted to explore the relationship between education level and help-seeking tendencies. There were no statistically significant differences in help-seeking behaviour across the three different education subgroups, [F (2,122) = .805, p>.05]. The average score for those with second level education (M= 17.03, SD= 2.51) or third level education (M= 16.22, SD= 3.82) did not differ significantly to those who reported as having no formal education (M= 16.00, SD= 0.00). (See Table 8).

A one-way between-groups analysis of variance was conducted to explore the relationship between history of mental health and help-seeking tendencies. There were statistically significant differences in attitude to mental health across the four different history of mental health subgroups [F (4,122) = 3.194, p<.05]. Having reached statistical significance, the difference between the groups was big (Cohen 1988); the effect size, calculated using eta squared, was .09. Post-hoc comparisons using the Tukey HSD test indicated that average score for those who had cared for someone with mental health problem (M= 17.18, SD= 3.47) differed to those who had a mental health problem (M= 14.81, SD= 3.34) and to those who had experienced mental health problems through work or university (M= 16.00, SD= 1.30) or who has no mental health problems (M= 16.81, SD= 2.92). (See table 8).
<table>
<thead>
<tr>
<th>Demographic</th>
<th>No.</th>
<th>Mean Score ± SD of Attitude</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>[t (121= .198, p&gt;.05]</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>16.48 ± 2.81</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>69</td>
<td>16.36 ± 3.66</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>[t (121= .198, p&gt;.05]</td>
</tr>
<tr>
<td>18-35-Years-Old</td>
<td>90</td>
<td>16.48 ± 2.81</td>
<td></td>
</tr>
<tr>
<td>36-65-Years-Old</td>
<td>33</td>
<td>16.36 ± 3.66</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>[F (2,122)= .805, p&gt;.05]</td>
</tr>
<tr>
<td>Tertiary</td>
<td>77</td>
<td>16.22 ± 3.82</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>33</td>
<td>17.03 ± 2.51</td>
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<tr>
<td>None</td>
<td>13</td>
<td>16.00 ± 0.00</td>
<td></td>
</tr>
<tr>
<td>History of Mental Health Problems</td>
<td></td>
<td></td>
<td>[F (4,122)= 3.194, p&lt;.05]</td>
</tr>
<tr>
<td>Personal experience</td>
<td>32</td>
<td>14.81± 3.80</td>
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</tr>
<tr>
<td>Cared for relative/friend</td>
<td>43</td>
<td>17.18± 3.34</td>
<td></td>
</tr>
<tr>
<td>Experience through work/university</td>
<td>8</td>
<td>16.00± 1.30</td>
<td></td>
</tr>
<tr>
<td>No history</td>
<td>37</td>
<td>16.81± 2.92</td>
<td></td>
</tr>
</tbody>
</table>

Table 8. Help-seeking Behaviour for Mental Health across Socio-demographic Groups
4.6 Prevalence Rate Results

Figure 2 illustrates participant’s responses to the question “what proportion of people in the population of Ireland do you think might have a mental health problem at some point in their lives? The prevalence rate results suggest that participants are not aware of how serious an issue mental health is in Ireland with 29 (23.6%) incorrectly selecting that 1 in 50 suffers from mental health issues. Only with 18 (16.2%) correctly identified that 1 in 4 have will have a mental health issues at some point in their life. A further 29 (23.6%) selected 1 in 50; while 20 (16.3%) selected 1 in 10. Ten (8.1%) respondents selected 1 in 1000, and 17 (13.8%) choose 1 in 100. Another 15 (12.2%) said 1 in 3 while 12 (9.8%) did not know.

Figure 2. Prevalence Rate
4.7 Top Three Mental Health Issues

Figure 3 highlights participant’s response to the question “What do you consider to be the top three mental health problem issues that needs to be tackled in Ireland?” The results demonstrate that participants considered alcoholism 37 (30.1%), depression 29 (23.6%) and suicide 23 (18.7%) as the top three mental health issues, respectively. Mid-ranked was stress 15 (12.2%), drug dependency 7 (5.7%), anxiety disorders and 5 (3.8%), Alzheimer’s disease 3 (2.7%). With manic depression 2 (1.6%) and schizophrenia 2 (1.6%) ranked last.

![Figure 3. Top three Mental Health Problems](image)
4.8 Most Important Mental Health Issue

Figure 4 illustrates participant’s response to the question “What do you consider to be the single most important mental health problem that needs to be tackled in Ireland?” The results demonstrate that, 47 (38.2%) considered suicide the most important mental health issue in Ireland. Next to suicide was depression 33 (26.8%), followed by alcoholism 12 (9.8%), stress 10 (9.1%) and drug dependency 7 (5.7%). Anxiety disorders 5 (4.1%), manic depression (3.3%), Alzheimer’s disease 3 (2.4%) and schizophrenia 2 (1.6%) were also ranked.
4.9 Qualitative Study – Demographics

The demographic information for the qualitative aspect of the study refers to;

(1) Gender
   • Male & female

(2) Age
   • Actual year’s: 18-65-years-old
   • Subgroups: 18-35-years-old & 36-65-years-old

(3) Education level
   • Secondary
   • Tertiary
   • None

(4) History of mental health
   • Personal experience
   • Cared for relative/friend
   • Experience through work/college
   • No experience

All of the demographic information was utilised across the all of the themes derived from the interview schedule

(1) Mental health literacy
(2) Attitudes & beliefs
(3) Help-seeking behaviour
(4)Vignettes – Stigma

4.9.1 Gender & Age

A total of 9 individuals participated in the qualitative aspect of the study. Five of these were female, and 4 were men.

The original inclusion criterion for age was 18-65-years-old. The actual age range of the individuals who participated in the study was 19-58-years-old. Specifically, the ages included: 19-year-old (female), 23-year-old (male), 26-year-old (male), 29-year-old (female), 30-year-old (female), 36-year-old (female), 39-year-old (male), 40 year-old a (male), and a 58-year-old (female).
4.9.2 Education Level

Of the 9 participants 3 had second level education, 5 had third level education and 1 had no formal education.

4.9.3 History of mental health

One participant had experienced a mental health problem, 1 had experienced mental health problems through work or while at university, 2 had cared for a relative or a family member who had experienced mental health issues, while 5 reported that they never had a mental health issue.

4.10 Mental Health Literacy Results

Overall, participants appeared to have a good level of mental health literacy. They identified general signs related to mental health problems and successfully acknowledge specific symptoms relating to mental health disorders. However, how participants identified and expressed their knowledge of mental health literacy differed across gender and age.

Specifically, male participants appeared to have a factual understanding of mental health; they highlighted suicide, depression, and drug dependency as the major mental health problems in Ireland and believe more should be done by the media to highlight mental health issues.

Younger (18-35-year-old) males considered alcoholism as the top mental health issue in Ireland while older males consider Alzheimer’s disease as a top mental health problem.

“Mental ill Health I suppose could be anything from alcoholism to schizophrenia and loads of other things in between....em or the absence of a good state of mind...alcoholism stands out though” (M, 18+).

Females describe mental health in terms of affect (i.e., experience, feeling, emotion), and were more likely to use phrases or words associated with stigmatization. They considered anxiety and depression, alcoholism as the top mental health problems. Older (36-65-year-old) females considered short-term memory loss or Stress as a top mental health issue. Almost all female participants felt there should be more done to highlight mental health in the media.

“Mental ill health is someone suffering from some kind of illness...disorder, but looking more closely I would assume that it really...well the main ones would be depression or alcoholism, I suppose stress for me...em there the big one’s that I would be aware of” (F, 36+).
Most participants recalled hearing reading or watching something related to mental health promotions or campaigns. There was a differentiation across age and gender in terms of the source of media by which participants preferred or were more exposed to.

For example, male participants recalled reading and seeing something recently about mental health issues in Newspapers or on TV. Younger males were more likely to be attentive to adverts about mental health, while older males did not. Male participants ranked the Samaritans and Aware as the best know organisations which help people with mental health issues. In terms of their mental health issues in their community male’s highlighted domestic violence, alcoholism as major mental health problems.

Meanwhile, female participants recollected seeing or hearing something recently about mental health issues in Magazines, TV and radio. Females ranked Cope and the Samaritans as the best known organisations which help people with mental health issues. Older females mentioned St Patrick’s and St James as hospitals which offer to help patients with mental health problems. In terms of their community Depression and suicide, were the main mental health issues that they were aware of.

Aging emerged as an important mental health issue, especially for older participants. Specifically, dementia and Alzheimer’s disease were seen by this group as a degenerative mental health problem, with most participants basing their knowledge via family members or friends who have been affected.

“My wife has been in and out of care home the past ten years...I couldn’t look after her...she’s been diagnosed with Alzheimer’s at 52...It’s obviously effects your mind and, I suppose that is the start of your mental health going. Em I guess older people would be more aware of that kind of illness, and you worry more about those kind [of illnesses] more” (M 36+).

All participants were surprised that one in four people will or do suffer from a mental health illness. Most males thought it was lower while two thirds of females were surprised, believing it was either much higher or extremely lower.

4.11 Attitudes & Beliefs Results

Participants understanding of mental health issues were based on the belief that mental health stemmed from a number of factors, such as, biological, environmental, and socio-economic factors. Men differed from women across age in their opinions.

Males believe that the onset of mental health issues may be between genetics or simply by chance. Of those who said it was by chance most considered socio-economic factors such as childhood experiences, coming from a lower class background, stress, financial difficulties or trauma as major determinants of developing a mental health problem.
“I’d say you could be born with a mental illness and em…you know as you get older things in society might trigger it off…it depends on your background, your family, your friends, things trigger it off” (M, 18+).

The majority of younger females believed the origin of mental health problems stemmed from personal circumstances such as, a break-up of a relationship, financial problems, stress, a job or socio-economic factors such as a coming from a lower class background. Opinion was mixed among older females, with some considering the origin of mental health problems as genetic while others mentioning socio-economic factors as prime suspects. All females believed that younger males were more prone to mental health problems.

“Perhaps girls are more likely to be sensitive and therefore more likely to be effected, you know, like…em if a girl was in a relationship and next it’s over, you known she might find the break-up hard and isn’t able to cope…she’s more likely to be down and depressed about it” (F, 18+).

The majority of male participants said they could not recognize if someone had a mental illness by their physical appearance, but would be confident in identifying mental health symptoms by other behaviours, such as gestures, poise, facial expressions, or tone of voice. Similarly, most females agreed that they could not recognise someone with a mental health problem in terms of physical or aesthetic appearance, but only by behaviour.

In terms of employment, males are more likely to feel comfortable working with individuals with mental health problems than women. Specifically, the most important determinant of participants comfort level was based on the severity of the mental health problem that the colleague presented.

“Um…again it would have to be the extent of that persons illness, if they were not interfering with the day to day running of the company, I mean interfering in a way that productivity was down well it wouldn’t be an issue for me…then again if they were causing problems it would become a major problem I would have to say.” (F, 36+).

When participants were asked if they would employ someone with a mental illness the majority of males said they would be willing to, whereas females were less likely to do so. Employment opportunities and co-worker comfort, the severity of the mental health illness played a significant role in the participant’s decisions.

“I wouldn’t hire someone with a really bad illness…like you know someone who is psychotic…or that’d be a risk to other people…or I knew it would affect their ability to do the job… …but if it wasn’t going to affect how they work I wouldn’t…I would still hire.” (M, 36+).

When asked about job roles for individuals experiencing mental health problems males were more open to equal opportunities than woman. Specifically, the severity of the mental problems and the job type were pivotal in participant’s responses. For example, female participants felt that the level of mental capabilities while undertaking a profession was crucial.
“If they’re capable of doing the job, and the illness isn’t going to restrict that person’s ability in that role well then it’s fine...em, if they can control it, but using medication might affect them...so I’m not sure how capable someone undergoing mental health problems is” (F, 36+).

Ultimately, male and female participants agreed that individuals with mental health issues should not pursue careers in the medical profession. In addition, participants suggested that those with mental health problems should not work in establishments such as medical centres, hospitals and pharmacies.

“I doubt if I could trust a doctor or a nurse who prescribed me medication and they themselves had Paranoid Schizophrenia...I couldn’t agree to that” (F, 18+).

In terms of media exposure, participants suggested that mental health promotions and campaigns are not prevalent enough to present a strong message about mental health issues across all levels of society.

“I haven’t seen enough, or remember one campaign that stands out...I remember only the negative stories...ya know like in the tabloids, they seem to have a bigger impact...I suppose ya know whereas the generic campaigns that actually support the recovery [of people with mental illness], or aim to help people are quite generic and the message doesn’t get across very well! (M, 36+).

In addition, issues about the approach by which some mediums represent mental health were highlighted, especially when portraying negative propaganda about mental illnesses.

“I’d say it’s only portrayed in the media when something really awful happens to someone and it’s printed for entertainment value...they tend [the media] to use phrases or words like psycho, nutter, odd-ball to describe someone who really is suffering from mental health problems. (F, 18+).

In relation to the benefits of using the media to create awareness about mental health participants suggested that the media could create a positive awareness surrounding mental health by using innovative methods. While some participants spoke of the media as a useful tool for highlighting general mental health issues, others expressed their concerns about the ineffectiveness of the media as a solution to mental health promotion.

“I think mental health campaigns from the media are too generalised...there needs to be more precision...personalised information, or booklets for individual families...if there was a system whereby information could be distributed to individual households by demographics which dealt with mental health issues related to those specific areas, like adolescent depression or youth suicide. (M, 36+).

Like media campaigns participants acknowledged that there is sufficient literature available about mental health in the form of fact sheets, pamphlets and articles etc., many however suggested that they had little impact.
“If I’m at the doctors or in a hospital or at the chemist I’d often see some leaflets on general health em but... and I saw a few things last month at bus stops called mind your mental health I think em or it was look after you mental health or something like that.... But em it was just a poster I didn’t really read into it a lot...but... in fact it was a bit confusing the message wasn’t clear unless you stopped and read it which I didn’t” (M, 18+).

Participants felt that the media had a major responsibility in highlighting mental illness in society, and if illustrated positively that individuals could benefit from mental health promotions and campaigns. In addition, reducing stigma in the media and breaking taboos about mental health could provide effective treatment for common mental disorders.

“I know if there was more journalists writing about mental illness in a positive way that people would be talking more about mental health and that there is no shame in suffering...be it depression, or stress, or schizophrenia...I think the media is the biggest contender when it comes to breaking barriers down, they have the power to do that and can influence peoples choices and decisions in so many ways..” (F, 36+).

4.12 Help-Seeking Behaviour Results

With respect to the help-seeking behaviour, many saw the community, family and friends as the focal point for assisting with mental health issues. The majority of participants suggested that a family member or friend would be especially relevant as a first point of contact when considering help with a mental health concern.

“I’d probably see a friend or my sister, and chat with them, and just say that something was bothering and that I wanted some advice...I’d like to think I could get support from my family if something major was happening to me like schizophrenia...or maybe they would approach me and say I was acting out of character or something like that” (F 36+).

Secondary help to family and friends were doctors or mental health professional such as counsellors, psychiatrists and psychotherapists.

“It depends on how I felt, if it was something personal bothering me I would talk to my partner, of more general like stress or I was feeling down, I’d ride it out or wait to see a doctor, and ask for antidepressants” (M 18+).

A major trend among younger participants was seeking advice or help via the internet or chat room forums. Most participants reported that the anonymity associated with the internet was the main reason for consult the web about mental health issues. In addition the cost implications were minimal when using the internet and this was another major reason why participants used this source.

“I always use the net for most things, I know the risks involved like getting wrong diagnoses, but general thing like stress and how to deal with them are useful, and depression...and if you want to make contact with other users and share stories you feel safe, and you never need to
meet them in person but the fact you can express how you feel and get to see how others cope really helps...em, I couldn’t afford to see a psychologist and I wouldn’t feel comfortable talking to someone face to face, so this [the internet] works better for me (F 18+).

In relation to specific mental health problems participants showed a lack of awareness when seeking help from service providers. Specifically, participants were unaware of the procedures involved when trying to get help for certain mental illnesses.

“Well I wouldn’t know where to go, as I said maybe you would have to hit your GP first if you trust him and you were with him a long time and you know he knows you well em that might be the first place that he could offer you some help” (F, 36+).

In addition cost implications were a major concern when seeking help. Participants felt the level of service provided at local level or at public hospitals were poor and that waiting lists were a deterrent when seeking help from public service.

“I doubt it would be any use going for a public service, because the resources are not available, I know a friend who’s been back and forth to the doctors trying to get to see a psychiatrists for her son, he’s been really bad lately and just getting worse, if you had the money you could go private, but it’s not possible nowadays it’s too expensive and I just wouldn’t be bothered myself” (F36+).

4.13 Vignettes - Mental Health Literacy Results

In relation to the vignettes, participants were asked to identify specific mental health disorders. The first vignette described Jane who was experiencing depression, while the second described John experiencing Schizophrenia.

The majority of males correctly identified Jane’s as having depression and John as having schizophrenia. Similarly, most female participants correctly identified Jane as suffering from depression and John as having schizophrenia. Older females however attributed Jane’s behaviour to having a breakdown or being bullied, and John as just being too sensitive or simply paranoid.

4.13.1 Mental Health Literacy – Stigma (Vignettes)

In terms of mental health and stigma related behavior males and females illustrated different opinions. While males had less stigmatizing attitudes, they were less likely to approach a colleague with mental health issues.

For example, most males would not approach Jane and suggests that their boss or supervisor approach her.
“I’m not sure if I’d be the right person to approach Jane...I’d be afraid to offend her...you could be digging a hole, so I’d hope the boss would approach her” (M, 18+).

Similarly, the majority of men would be reluctant to approach their male counterpart and would instead speak third party about John (E.G., boss, family member).

“I wouldn’t advise John anything at all I would be more inclined to go up to whoever was my supervisor and say I can’t work with that guy you sort it out’’ (M, 36+).

Females were more inclined to express stigmatizing attitudes but were more likely to approach a colleague nonetheless. Most female participants said they would approach Jane and help her seek help or get her to speak to a family/friend member of GP.

“Well she seems a bit erratic, maybe she’s having personal problems that she need to sort out herself…um…I know it must be hard. If she came to me and said she needed help, I’d help…If she didn’t and I could see she was in distress, I’d try and suggest we get help for her, I’d give her a contact number, or something to ease her mind, erm, I’d hope that would of some comfort” (F, 36+).

Similarly the majority women would be also approach John, and are more likely to show signs of sympathy.

“Ok well at first I would try avoid him [John] but then if he was really a bad point I’d feel sorry for him so I would try to talk to John and let him know he’s got a friend, you know if he needed to talk or if he needed to go anywhere I would go with him” (F, 36+).

4.14 Vignettes – Attitudes & Beliefs Results

From a practical perspective, participants expressed concerns working alongside individuals with mental health problems, seeing them as an occupational burden. Most female participants complained that individuals with mental health issues would be less likely to work productively, therefore creating extra work for others

“Yea it wouldn’t help if she had a problem, and the work wasn’t being done, I mean, it would be like she wasn’t there and still being paid, and then I would be left doing most of her tasks...I’d be so stressed and I wouldn’t want to be in that kind of environment at all” (F, 18+).

4.14.1 Attitudes & Beliefs – Stigma (Vignettes)

Participants were also less likely to feel comfortable working with individuals with severe mental illnesses, such as schizophrenia. Furthermore, some of the participants viewed individuals with schizophrenia as dangerous, unstable and violent.
“I’d feel he could turn on yak at any time, or think you’re talking about him and be all paranoid, he wouldn’t be stable...he could get violent” (M, 18+).

Conversely, participants were more likely to tolerate working with individuals with milder forms of mental health problems such as depression; interestingly, participants showed more expressions sympathy and empathy towards these individuals.

“I suppose if she was going through a bad patch, ye know, she was have a rough time, or something happened at home and she was depressed or just run down...I’d know that was temporary so it would pass, I’d be annoying but if it was short term I wouldn’t be too concerned...em it’s not a major problem for me.” (F 36+).

4.15 Vignettes - Help-Seeking Behaviour

With regard to the possible help strategies or referrals for the vignettes, most participants were unaware of a possible course of action. Specifically, participants were generally suggested G.P’s for Jane, who had depression, but were unaware of what do in the situation of John who had Schizophrenia. It appears most participants are informed of the symptoms of schizophrenia but cannot identify suitable help service providers.

“Um...well...I wouldn’t be certain...I suppose you’re doctor and then they could help...em but for schizophrenia I wouldn’t know what to do...I’m not 100% certain” (M 18+).

4.15.1 Help-Seeking Behaviour Stigma (Vignettes)

When asked about the assisting with seeking help for the characters in the vignettes, participants were willingly assist, but it appeared that most were only willing to assist if it didn’t involve physically assisting John/Jane to an establishment nor were they willing to directly speak to a help-service provider directly either over the phone or in person. Most participants stated they would prefer to assist with gathering information such as the name or addresses of a particular help-service provider, and the most common source that they would use would be the internet or a telephone/classified directly.

“Yea, I would be in a position to take the time out...ye know if, I’m on my lunch break, if I had spare ten minutes I’d Google up a list [of contacts], and I’d print them off or, and even get a map of the place...I wouldn’t be going with them, holding their hand, It would be up to them to go and sort it out” (M18+).
Chapter 5
Discussion & Analysis

5.1 Mental Health Literacy - Key Findings

Overall, analyses of the results demonstrate that participants appear to have a very good knowledge of mental health issues. This level of knowledge was reflected in both the quantitative survey results and the qualitative interview analysis; however a differentiation occurred across socio-demographics, particularly within the qualitative analysis of the results.

With regard to the survey, the majority of participants correctly identified issues or facts relating to mental health. At least 60% to 90% of the participants correctly identified facts relating to mental health issues. For example, over 90% correctly stated true to “only a small minority of people with psychological problems seek help from mental health professionals”, and at least 80% correctly stated false that “a person who has recovered from a mental health illness will not be able to return to work”. In addition, just under 65% reported true to “stress can lead to illness”, and more than 80% of participants correctly chose false to the statement “psychological disorders do not affect children”. This level of knowledge was also reflected within the qualitative analysis of the study. Participants were capable of discussing general issues associated with mental health and successfully identified signs and symptoms related to mental health problems such as depression, stress, and anxiety disorders; interestingly they also identified alcoholism as a cause factor for some mental health issues, and suicidal behaviour as a result of some more serious forms of mental health illnesses.

These results suggest that many members of Irish public have a very good general knowledge of mental health issues, and they also have the ability highlight important mental health problems relative to Irish society. Overall these results conflict with many international studies by Priest et al (1996); Jorm (2000); Lauber et al, (2003a) ; Jorm et al, (2005a) ; and Jorm et al, (2007) - all of who suggested that the general public have a poor level of mental health literacy. From a comparative perspective, it appears Australia shares similar mental health issues with Ireland, with many native Australians identifying depression, stress and anxiety as major mental health issues, as reported by Highet et al in 2002. However the identification of alcoholism as a mental health by problem by members of the Irish public appears to be a unique finding.

A secondary inspection of the quantitative results suggests that participants appeared to be ambivalent or uncertain with specific facts relating to the treatment and characteristics of certain mental health disorders. For example, around half of the participants surveyed incorrectly identified that psychiatrics primarily use psychoanalysis as a basis for their therapy, with more than a quarter believing this was true and a further quarter reporting not knowing. Similarly, almost half of the sample thought that a person with schizophrenia is a person with a ‘split personality’ with a third agreeing with the term and a further 13% not knowing. These results suggest that members of the Irish population are either misinformed
or unaware about the facts pertaining to serious mental illnesses and treatment. These findings are concurrent with previous research published on serious mental illnesses carried out by Goldney et al (2005); Jorm et al (2005b); Jorm et al, (2006a); and Jorm et al (2006b); who illustrated that schizophrenia or psychosis are less well known mental health issues in terms of their characteristics and treatment.

In terms of demographics, the survey results showed that males and females did not differentiate on the mental health literacy scale in terms of total item scores, nor did they differ across age, or age sub-groups. Conversely, the qualitative results showed that disparities occurred among males and females and also among age sub-groups. For example younger males (18-35-year-olds) considered alcoholism as a major mental health issue among their peers, while older males (36-65-years-olds) considered neuro-degenerative diseases such as Alzheimer’s disease as a common condition among older populations and cited it as a concern for their own mental health. Older females (36-65-years-olds) also consider aging, memory-loss and dementia as forms of mental health disorders. These results suggest that certain mental health issues can be associated with specific demographic cohorts and reflect findings highlighted by Highet et al (2002), and Fisher & Goldney, (2003). They found that males repeatedly report depression while older populations tend to report age related diseases as mental health issues.

Interestingly, participants with a history of mental health were equally as knowledgably about mental health issues and facts to those without a history of mental health. The results revealed that the total score for the mental health literacy items and those with no history of mental health were similar to those with no experience of mental health issues. These results suggest that having a mental health issue is not associated with a higher level of mental health literacy. Interestingly this finding supports the assertion by Goldney et al (2001) who stated that people with a personal experience of mental health, do not necessarily know more about mental health, than someone with no experience.

The survey also revealed that those with higher education were more knowledgeable about mental health facts. Specifically, those who were educated to third level or second level education scored higher overall on all of the mental health literacy items, than those who had no formal education. In terms of the qualitative aspect of the study those who reported caring or looking after a family member with a mental health issue appeared to more confident while speaking about mental health and where more forthcoming with solutions and practices associated with care giving and support. Of interest were participants with no formal education, who found it difficult to express or comprehend what they though mental health was but they were more likely to show empathy. The results suggest that having real life or ‘hands-on’ experience of mental health, improves understanding and specific knowledge of certain mental health issues. Conversely, lower levels of education appear to act as a barrier to understanding mental health, and how it affects individuals in terms of their overall functioning. These findings support several studies concerning education and family exposure to mental health. First, Berkowitz et al (1984; 1990), Wolff et al (1996a; 1996b; 1996c), and Holmes et al (1999) all concluded that education, such as courses, seminars or interventions can improve knowledge and in turn improve attitudes to mental health issues.
Secondly, Leff et al (1982; 1985) highlighted that exposure to mental health problems, such as living with or caring for someone with mental illness improves understanding of mental health issues.

5.2 Attitudes & Beliefs – Key Findings

In general, participant’s attitudes to general mental health issues appear positive; however participant’s specific beliefs in terms of the on-set or origin of mental health problems were negative. An analysis of the results also revealed that major differences occurred across socio-demographic factors within the quantitative results and these differentiations were exemplified further in the qualitative aspect of the analysis.

In terms of the survey, the majority of participants understood that anyone may be susceptible mental health issues with more than half agreeing that anyone can suffer from mental health problems. In addition most participants also believed that individuals are not personally responsible for the on-set of their illness and that those with mental health issues are not a threat to society in terms of violence or crimes. These findings suggest that members of the Irish public hold a positive view towards those with a mental health issues and understand that most mental health illnesses are as a result of environmental factors rather than innate or biological factors. These results concur with previous research by Jorm, (1997b; 2000) and Link et al (1999) who suggested that mental illnesses are more likely to be caused by psychosocial events rather than biochemical or genetic influences.

However a secondary inspection of the quantitative results suggests that many participants’ have a less than positive attitude in terms of their own personal mental health. For example, it appears many members of the Irish public are unlikely to disclose that they have a mental health issue with at least half of the participants surveyed agreeing that they would not want other people knowing they had a mental health problem. In addition, a larger proportion are worried they will develop a mental health illness, with more than half stating they are concerned about their future mental health. The results suggest that a large proportion of the Irish public would not be willing to reveal that they had a mental illness, suggesting that they are less likely to seek help or treatment out of fear of others knowing. Similarly, Angermeyer and Matschinger (1999); Jorm (2000); Watson and Corrigan (2001) and Simonds & Thorpe (2003) found that only a small minority of people with mental health illnesses seek help or reveal that they have a mental health issue, therefore the current study adds support to this phenomena.

Of particular interest was participant’s uncertainty relating to the prognosis and occupational capabilities of individuals with mental health issues. An analysis of the survey results found that when participants were asked if the majority individuals with mental health issues recover, more than half didn’t know or disagreed with the statement. In addition almost a third of participants felt that people with mental health mental health problems should not be allowed do important jobs such as doctors, or nurses. These attitudes regarding employment
and occupational choices were exemplified further within the qualitative results of the study. Specifically, an analysis of the qualitative results showed that participants felt that those with mental health issues should not undertake careers in highly responsible or medical professions. A further analysis of the interview results revealed why. Most participants reasoned that they would need to establish the severity of the mental health problem first and whether their illness could be controlled before they would engage in work related tasks. Interestingly, participants appeared to hold more negative attitudes towards individuals with severe mental illnesses such as schizophrenia, compared with depression. These results reveal that some members of the Irish public have more negative attitudes about mental health issues; these negative attitudes appear to be based on the lack of understanding (i.e., prognosis) and the severity of the illness, rather than the occupationally abilities of the individual, especially in the case of schizophrenia. Overall, it appears those with schizophrenia are more likely to experience negative attitudes, over those with depression. Priest et al (1996) asserted that people tend to associate depression with environmental factors, and therefore feel less threatened by this illness. This may explain why the participants in the current study responded positively to working with someone with depression and supports Priests et al findings. Conversely, Jorm, (1997b), Link et al (1999) and Walker & Read (2002), highlight that the public are more likely to reject medical explanations of mental illnesses, and since Schizophrenia has been linked to a medical diagnosis, this may explain why participants hold such negative attitudes, albeit through association.

In terms of demographics, differences occurred within the survey among gender, education level and history of mental health. With regard to the qualitative interview, an analysis of the results also showed that participant’s beliefs about mental was mixed. Specifically, in terms of gender the survey results illustrated that women tend to have more negative attitudes towards mental health than men, while the qualitative analysis exemplified this trend. Interestingly, those with second level education have a more positive attitude towards mental health than those with third level education or no formal education. The findings partial support research by Jorm et al (2000b) - they conflict with the assertion that women have more positive attitudes to mental health generally, but concur with the finding that those with higher education have more positive attitudes.

In relation to history of mental health, participants who reported having as having a mental health issue tended to have more negative attitude towards mental health than those who either care for someone with a mental health issue or had no experience of mental health problems. The negative attitudes of those with mental health issues may be explained by their own personal experiences of discrimination by others and therefore see mental health illness as a social burden. The findings of the current study concur with Byrne’s (2001) findings, who reported social exclusion is a common behaviour towards those with mental health issues. Further analysis show that care givers and those who have no history of mental health have a positive attitude to mental health, signifying they have may have more positive views in terms of recommending treatments or overseeing recovery. These findings challenge previous research carried out by Jorm et al (2005b) and Jorm et al (2007) who stated that
because of the prevalence rates of mental illness, most people are likely to encounter someone with a mental health problem but suggested that most of them will lack the knowledge or skills in providing help or assistance in terms of recovery.

Further analysis of the results illustrated differences across gender. Taking the origin and treatment of mental health issues as an example, younger males attributed either biological disposition or environmental factors as causes, with some men discussing issues around childhood experiences as risk factors leading to mental health problems in adulthood, while opting for alcohol consumption as an initial treatment method. In contrast, younger females suggested more affective examples for the onset of mental health issues such as conflicts in close family or peer relationships. In addition females tended to suggest more holistic approaches in terms of treatment and recovery with most suggesting talking therapies and self-help solutions. The findings are complimentary of research carried out by Jorm et al (2000b) who found that women are more likely than men to opt for a range of suitable interventions such as self-help or holistic therapies.

Interestingly, a unique and unifying finding of the current study is mental health and the relationship with fiscal uncertainty. Most young males highlighted financial difficulties and unemployment as a determining factor in causing mental health problems. Financial issues also ranked high as risk factor for the onset of mental health issues, with many female participants referring to the lack of current job prospects for young people. While there is no current research to support that there is a relationship between mental health in times of economic crisis, it could be suggested that economic recessions may contribute to mental health problems.

5.3 Help-Seeking Behaviour - Key Findings

Overall, analyses of the results demonstrate that members of the Irish public are more likely to seek help from family or friends and holistic therapies, such as psychological services, for the treatment of mental health issues as opposed to psychiatric or medical treatment. This trend was reflected throughout the quantitative and qualitative aspect of the study. In addition no major differences occurred across the demographics in terms of help-seeking behaviour.

With respect to the survey the results also showed that the majority of participants found talking to a friend or family member helpful, or utilizing talking therapy such as counselling or psychotherapy. A high proportion of the participants also illustrated that if they had a mental health problem that they would find consulting a website or reading about people with similar mental health issues helpful in terms of their own recovery or treatment. These preferences for help were also reflected in an analysis of the qualitative interviews with most participants suggesting that they would seek help from peers or close family members. In addition, participants also said that they would find accessing internet mental health forums to read about other people’s experiences helpful.

These results suggest that members of the Irish public are more likely to seek help which will
aid their recovery through shared experiences or understanding of their mental health problem, as illustrated - taking advice or listening to others who have experienced mental health problems or reading about their experiences. In addition participants seem to prefer psychological assistance rather than medical or psychiatric treatment. The findings of the current study contributes and supports previous research by Angermeyer and Matschinger (1996: 2001), Priest et al (1996) and Jorm, (2000) who all suggested that the public prefer self-help and lay support for mental health issues, and are less comfortable with medical interventions, especially pharmacological ones. In addition psychotherapy and counselling were seen as secondary methods for treatment, which reflects the findings of the current research also.

A closer inspection of the survey results illustrate that participants fear or reject medical models of treatment for mental health issues with just under half of those surveyed seeing a psychiatric hospital as not helpful. Interestingly more than a third felt having an alcoholic drink would be helpful for mental health issues would not be of help and the same number suggest taking antidepressants for the treatment of a mental health problem. Again the interview analysis reflected these findings with some participants suggesting consuming alcohol as an initial treatment method. While overall most participants said seeing a psychiatrist would be a last resort for the treatment of a mental illness. The results reveal that many member of the Irish public are not seeking the appropriate help for certain illnesses. Alcohol and antidepressants only contribute to mental health issue or temporarily relieve symptom, and it appears people are opting for these remedies as an alternative to prescription drugs or seeing psychiatrists. Their reasons for this decision could be because they are unaware of appropriate treatment services or fear service providers. The results concur with earlier research by Jorm et al (1997) who found individuals tended to view pharmacological treatments negatively and also have a negative view of mental health specialists because there is not enough information available for individuals to recognise mental illnesses and choose an appropriate course of action.

In terms of demographics, the results show no major differences across age, gender or education level with respect to help-seeking tendencies; however differences occurred among the sub-groups within the history of mental health category. Specifically, those who cared for someone with a mental health issue scored higher compared to those who had or have a history of mental health. These results suggest that having a history of mental health does not necessarily correlate with making the best choice for choosing an appropriate mental health treatment, and that those with mental health problems perceive some treatment forms inadequate. Another explanation maybe because those with mental health issues have experienced negative attitudes towards them by some service provider’s, or that the treatment and level of care that they experienced was of a poor standard, prolonging the mental health illness rather than treating it. These findings reflect reports by McNair et al (2002) who suggested that people’s personal experiences of mental health may influence choices and attitudes toward interventions. While Summerfield (2001), Sartorius (2002), Gray, (2002) Mazeh et al (2003) and Patel (2004) found that some mental health professionals tend to hold stigmatising attitudes towards those with severe mental illnesses, again supporting the
Interestingly, the main restricting factor in seeking help was financial issues. Many participants suggested that the financial difficulties or the cost of treatment was too expensive. This finding appears to be a result of the current economic climate in Ireland and is unique in terms of contemporary research. A final point many participants expressed was the lack of information provided for serious forms of mental illnesses such as schizophrenia with many not knowing which forms of treatment exist and who to contact for assistance in the treatment of the illness.

5.4 Stigma Results

In order to ascertain a further insight in the level of mental health literacy, attitudes and help-seeking behavior, vignettes (see appendix 2) were incorporated into the study. While it was difficult to determine the level of stigma within the survey, the qualitative analyses provided some clear indications to the level of stigma and where or why it may occur. The vignettes were examined among domains of mental health, that is, 1) mental health literacy, 2) attitudes and beliefs 3) and help-seeking behaviour. A secondary function of the vignettes was to clarify any previous understanding or opinions held by the participants within the qualitative study, across the three domains of mental health.

The vignettes contained two fictional characters in hypothetical situations - Jane, who was displaying symptoms of depression, and John experiencing symptoms of schizophrenia.

5.4.1 Vignette: Mental Health Literacy-Stigma

In terms of the vignettes - relating to mental health literacy component - an analysis of the results revealed that both male and female participants were capable of identifying the specific mental health disorders presented in each scenario. Participants successfully attributed Jane’s symptoms with depression, and John as having Schizophrenia. The analysis, when compared with the survey and qualitative study results, further verify that members of the Irish population have a very good knowledge and scope of mental health issues. Furthermore they are capable of identifying specific signs and symptoms relating to different forms of mental health issues in terms of severity; that is, mild to severe forms, such as depression and schizophrenia. These findings suggest that Ireland has a higher level of mental health literacy when compared to other countries, namely, Australia and Sweden. For example, when an Australian sample were asked about to identify similar symptoms in vignettes Jorm et al (2007) reported that natives had a poor level of mental health knowledge with less than half of participant’s correctly identifying the mental illnesses. Similarly, the Swiss, as shown by Lauber et al (2003a), were less competent at identifying depressive symptoms. However it appears that the American public are on par with members of the Irish public in terms of mental health knowledge, as Link et al (1999) found they were capable of correctly identifying both of the illnesses presented in each of the vignettes.

In terms of stigma, participants demonstrated some level of stigmatisation towards individuals with mental health issues, either directly via their behaviour or through their attitudes. In addition the level of stigmatisation among men and woman differed towards
those with mental health problems. Specifically, the results from the vignettes showed that although men held less stigmatising beliefs about mental health they were less likely to approach someone with a mental health problem. When asked if they would approach John or Jane at work men said that they would prefer if someone else approached them, suggesting a level of discomfort. While females expressed more stigmatising beliefs about mental health issues, they were more likely to engage with John or Jane at work. The findings suggest that men tend to stigmatise more through behaviour (i.e. avoiding those with mental health problems), while women hold stigmatising beliefs about mental health (i.e., negative opinions about mental health). The findings on the above analysis partially support previous literature relating to mental health literacy and stigma. First, in terms of mental health literacy Link and Cullen (1986); Brockington et al (1993), Wolff et al (1996; 1996b), Corrigan & Penn (1999). And Kommana et al (1997) indicated that those with a better understanding of mental illness are less likely to hold stigmatising attitudes; however this is not the case with the current study. Participants initially expressed a very good understanding of mental health issues; however the vignettes indicated that members of the Irish public, more-so woman, have stigmatising behaviours. What the findings do show and support is that members of the Irish public engage in social distancing, also found by Corrigan and Penn (1999), Corrigan et al (2003), Phelan et al (2000), Mann and Hamelin (2004) and Lauber et al (2004), who demonstrated that high levels of social distancing (the act whereby an individual consciously avoids or delays engaging in any kind of discourse with those who appear to show signs of mental illness) can be equated to high levels of discrimination and stigmatising beliefs.

5.4.2 Vignette: Attitudes & Beliefs - Stigma

In terms stigma and attitudes and mental health, an analysis of the results suggests that the majority of participants hold negative attitude towards those with mental health issues. When asked about working with John or Jane, the majority of participants initially felt that they would be an occupational burden as a result of having a mental health problem. These attitudes are extremely more negative than those presented in the survey or general qualitative results. The results also reveal that men and woman hold more stigmatising beliefs towards those with mental health problems. Both men and woman said they would not feel comfortable working John because he had schizophrenia, but would be more tolerable of Jane, as they didn’t see depression as a major mental health issue. The results suggest peoples beliefs about specific mental illnesses influence their level of stigmatisation. In addition, it appears that severity of a mental health determines the level of stigmatisation, suggesting that those with schizophrenia experience more stigma than those with depression or milder mental health issues. These findings support several studies on levels of severity and stigma in terms of mental health. First, Angermeyer and Matschinger (2001) found that the public now considers less severe problems such as depression and anxiety as more normal life events but they see psychosis as more severe leading to more stigmatised attitudes. Secondly, depression in the current study was seen as less severe and there were lower levels of stigmatising attitudes. This supports Jorm et als (2000b) assertion that public attitudes about depression are relatively benign. From an occupational perspective the research findings support McNair et al (2002), Corrigan et al (2003) and Stuart (2005) who found that people who disclose or who are identified as mentally ill have reported discrimination from employers, leading to
social exclusion as reported by Byrne (2001).

5.4.3 Vignette: Help-Seeking Behaviour - Stigma

In terms of treatment recommendations for John or Jane most participants correctly identified methods through which Jane but not for John. Both men and women were confident in making decisions when asked to what route Jane should take for her depression, nearly all participants said she could contact her doctor, talk to a friends, and consult an organisation or help-service provider that offers treatment for depression. Conversely, all participants were unaware of the appropriate action when seeking help or assistance for the treatment of schizophrenia. Although participants demonstrated that they would be willing to assist John or Jane in seeking help, they would only do so if it didn’t involve physically assisting (i.e. social rejection) them to an organisation or service provider especially in the case of John because he had schizophrenia. The results suggest that there is a level of shame or discomfort associated with being seen with someone who is known to have a mental health issue, and suggests that there is a higher level of stigmatisation associated with having a severer form of a mental health issue or being associated with someone who has. The findings relating to schizophrenia and social rejection may be explained by research by Pescosolido et al (1999) Crisp et al, (2000) who showed that individuals with schizophrenia and are more likely to be perceived as unpredictable and potentially dangerous; therefore participants in the current study may have held this belief. From John’s perspective, (or any individual with a mental health issue) social rejection has many consequences and may explain why so many people with mental illnesses don’t seek help. Specifically, social rejection from a mental health perspective as outlined by Priest et al (1996), Watson and Corrigan (2001), McNair et al (2002) can result in serious consequences, either people (1) don’t seek help or are reluctant to seek treatment or (2) they don’t disclose that they have a mental health problem in the first place - out of fear of social rejection and discrimination.

5.5 Prevalence & Most Important Mental Health Issues

5.5.1 Perceived Prevalence Rates

The prevalence rate results suggest that participants are not aware of how serious an issue mental health is in Ireland a little a third incorrectly selecting that 1 in 50 will suffer from mental health issue. Only a little more than a quarter surveyed knew that that 1 in 4 have will have a mental health issues at some point in their life. An analysis of the qualitative results reveal similar finding with most believing it was a higher statistic. The results demonstrate that while members of the Irish public appear to have a good knowledge of general mental health issues, their specific knowledge is quite poor, and the findings suggest that Ireland underestimates the seriousness of states mental health.
5.5.2 Top Three & Most Important Mental Health Issues

With regard to what participants considered to be the top three mental health problem issues that needs to be tackled in Ireland, the survey showed that a third consider alcoholism and a quarter considered depression, followed by suicide. The qualitative results showed a similar trend with many mentioning alcoholism and depression and stress as major mental health problems. Overall, alcoholism seems to me considered a mental health issue, and may explain the high level of depression in Irish society. Conversely stress could be also a cause factor resulting in the need for high levels of alcohol consumption. Suicide however was deemed as the most important mental health issue that needs to be addressed in Irish society. The results suggest that the Irish public understands that suicide has is a national widespread issue that need immediate attention.
Chapter 6

Conclusions

6.1 Introduction

Overall, members of the Irish public to have a very good general knowledge of mental health issues, however they tend to be uncertain with specific facts relating to the treatment and characteristics of certain mental health disorders. There also appears to be gender and generation-specific mental health issues within Ireland with older population attributing neuro-degenerative diseases as major health issues and younger men experiencing high levels of depression.

In terms of perspectives to mental health many members of the Irish public hold negative attitudes; these negative attitudes appear to be based on their lack of their specific knowledge about some mental health problems, especially schizophrenia. These attitudes in turn appear to influence their own behaviour with many suggesting that they would not disclose that they had a mental illness, indicating that they may be less reluctant to seek help. Demographically those with mental health issues tended to have more negative attitude towards mental health, however these attitudes may be based on personal experiences of discrimination by others rather than personal beliefs, and both men and woman are less likely to seek help as a result of financial hardship.

With regard to help-seeking behavior many member of the Irish public are not seeking the appropriate help for certain illnesses, however when they do they are more likely to turn to counselling services or self-help remedies. However some of these self-help remedies are in the form of antidepressants and alcohol which appears to further exasperates their problems. Demographically those with a history of mental health do not always make the best choices when choosing an appropriate mental health treatment; however this may be a result of them having perceived negative attitudes by some service provider’s, especially from the medical professions.

In relation to stigma, it appears that Irish public are more likely to engage in social distancing or social rejection towards those with mental health issues, yet their behavior illustrates high levels of stigmatization. Their expressed level of stigmatization appears to be determined by the severity of the individual’s mental health problem - those with schizophrenia are more likely to experience discrimination than those with depression.

Furthermore, mental health appears to be taboo in Ireland with many members of the Irish public expressing shame and guilt. In addition high levels of discomfort has been demonstrated by the Irish public if they appear to be associated with someone with a mental health illness which often leads to social rejection for the suffer. The consequences for suffers can be devastating, resulting in non-disclosure of mental health issues in the future and the likelihood of ceasing treatment out of fear of further social rejection and discrimination.
6.2 Education - Mental Health

As illustrated a high level of stigma exists in Ireland in relation mental health and those who experience mental health illnesses. While the Irish public have a good general knowledge of mental health issues, it appears that their understanding of specific or more serious mental health illnesses results in negative attitudes prevailing in the form of fear, rejection and discrimination against those with mental health issues. As such, an important approach in reducing stigma and informing members of the public would be the implementation of mental health education programs and information seminars. In addition the current research highlighted that members of Irish society seriously underestimate the seriousness and prevalence of mental health in Ireland. Informing and educating the public of facts about the prevalence, treatment and prognosis of mental health problems would set the foundation for further mental health knowledge while making mental health important for people, which could lead to an improvement in attitudes.

6.3 Awareness – Personal Mental health

The Irish public appear to want to have more control over their own personal mental health as opposed to their physical health; but this may be based on public attitudes that having a mental health issue is taboo, whereas it normal to talk about physical health. Members of the Irish public could take steps to start breaking down barriers surrounding mental health issues, by talking more about their mental health. While the current research indicated that many people would confide in a relative or friend, there needs to be more communication about mental health among population, in communities and nationally. A good starting point would be to encourage young people to learn about mental health, while implementing policies in schools to educate children about all aspects of mental health.

6.4 Recognising Mental Health Support

A large proportion of the Irish public recognised appropriate help-service providers but many still have negative attitudes to most forms of treatment, leading to alcohol misuse as a method of treatment. Furthermore there has been a high level of social isolation and rejection expressed towards those with mental health issues, which can lead to a poor quality of life for suffers. In order to improve awareness and change attitudes in relation to mental health in Ireland it would be imperative to promote positive behaviour which can help protect mental health, to include support by others to engage and interaction with those who already have a mental health problem.
6.5 Mental Health & Mass Media

In order to reduce discrimination against those with mental health issues information about mental health issues should be disseminated through the media, in positive forms. The mass media is a dominant force that can influence and change people’s perspectives. The results of the current study showed that the media is a primary source of information for mental health issues, such as the internet. More media campaigns could be promoted online, offering guides on mental health issues and treatment, while supporting mental health forums.

6.6 Future research

The current study examined mental health literacy, attitudes and help-seeking behaviour generally, while comparing and contrasting socio-demographics. Future research could explore the public’s knowledge and attitudes towards specific mental health professions, such as psychologists, or psychiatrics, and identify how demographical characteristics affect a person’s beliefs, attitudes and help-seeking behaviour.

Further research could also examine public knowledge of, and attitudes towards specific mental health illnesses such as schizophrenia or depression. It would also be useful to include a larger sample, and have an even spread of participants in terms of age and gender. In addition, the use of either qualitative or quantitative methods could be incorporated as opposed to mixed method approach.

While the current study looked at mental health issues among the adult population research on young people could prove informative. There appears to be a high prevalence of youth suicide in Ireland therefore research into mental health literacy, attitudes and help seeking behaviour in relation to adolescent depression could be an area that warrants future investigation.
Chapter 7
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APPENDIX 1 – Survey Monkey Questionnaire

Q1
What is your gender
☐ Male
☐ Female

2. How old are you?
☐ 18
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☐ 31
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☐ 36
☐ 37
☐ 38
☐ 39
☐ 40
☐ 41
☐ 42
☐ 43
<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Only a small minority of people with psychological problems seek help from mental health professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Eating disorders (e.g. anorexia nervosa, bulimia nervosa) are psychological disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Psychiatric disorders are true medical illnesses, e.g. heart disease and diabetes mellitus</td>
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<td></td>
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</tr>
<tr>
<td>4 Mental health is defined as the absence of mental disorders</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5 During psychotherapy, clients usually lie on a couch and talk about whatever comes to mind</td>
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</tr>
<tr>
<td>6 Psychological disorders like depression and anxiety disorders do not affect children</td>
<td></td>
<td></td>
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<tr>
<td>7 Stress can lead to illness (e.g. cancer, hypertension, mental disorders )</td>
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<tr>
<td>8 A person who has recovered from mental illness will not be able to return to work</td>
<td></td>
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<tr>
<td>9 A person with schizophrenia is a person with “split personality”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Psychiatrists primarily use psychoanalysis as a basis of therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Q4: Attitudes and beliefs Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If I suffer from mental health problems, I would not want people to know</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2</td>
<td>I am afraid of experiencing mental health problems myself in the future.</td>
<td></td>
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<tr>
<td>3</td>
<td>Anyone can suffer from mental health problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>I would find it hard to talk to someone with mental health problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>People are generally caring and sympathetic to people with mental health problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>People with mental health problems are often dangerous/violent</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>The majority of people with mental health problems recover</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>People with mental health problems should have the same rights as anyone else</td>
<td>49 (39.8%)</td>
<td>66 (53.7%)</td>
<td>4 (3.3%)</td>
<td>2 (1.6%)</td>
<td>2 (1.6%)</td>
</tr>
<tr>
<td>9</td>
<td>People with mental health problems are largely to blame for their own condition</td>
<td>1 (.8%)</td>
<td>35 (28.5%)</td>
<td>71 (57.7%)</td>
<td>0 (0%)</td>
<td>16 (13%)</td>
</tr>
<tr>
<td>10</td>
<td>People with mental health problems should not be allowed to do important jobs such as Doctors, nurses etc.</td>
<td>11 (8.9%)</td>
<td>34 (27.6%)</td>
<td>31 (25.2%)</td>
<td>29 (23.6%)</td>
<td>1 (.8%)</td>
</tr>
</tbody>
</table>
Q5: Help-seeking behaviour items

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Helpful</th>
<th>Not Helpful</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Talking to a friend or family member</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Going on a special diet or avoiding certain foods</td>
<td></td>
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<tr>
<td>3</td>
<td>Talking therapy such as counselling or psychotherapy</td>
<td></td>
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<td></td>
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<tr>
<td>4</td>
<td>Reading about people with similar problems and how they dealt with them</td>
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<tr>
<td>5</td>
<td>Taking antidepressants</td>
<td></td>
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<tr>
<td>6</td>
<td>Having an occasional drink to relax</td>
<td></td>
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<tr>
<td>7</td>
<td>Being admitted to a psychiatric hospital</td>
<td></td>
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<tr>
<td>8</td>
<td>Taking sleeping pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Taking pain killers such as Codeine, Aspirin or Panadol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Consulting a web site that gives information about the mental health problem</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Q6:

What proportion of people in the population of Ireland do you think might have a mental health problem at some point in their lives?  1 in 1000

- 1 in 100
- 1 in 50
- 1 in 10
- 1 in 5
- 1 in 4
- 1 in 3
- Don't know
Q7
From the list, what do you consider to be the top three most important mental health problems (or mental health related problems) that we need to tackle in Ireland?

- Obsessive compulsive disorder
- Drug dependence
- Anxiety disorders
- Manic Depression
- Phobias
- Eating disorders
- Suicide
- Alzheimer's disease
- Depression
- Personality disorders
- Post traumatic stress disorder
- Self harm
- Postnatal depression
- Stress
- Psychosis
- Alcoholism
- Schizophrenia
- Nervous breakdown
- Panic attacks/disorders
Q8

And which do you think is the single most important mental health problem that needs to be tackled in Ireland?

- Obsessive compulsive disorder
- Drug dependence
- Anxiety disorders
- Manic Depression
- Phobias
- Eating disorders
- Suicide
- Alzheimer's disease
- Depression
- Personality disorders
- Post traumatic stress disorder
- Self harm
- Postnatal depression
- Stress
- Psychosis
- Alcoholism
- Schizophrenia
- Nervous breakdown
- Panic attacks/disorders
Q9

What is the highest level of education you have completed?

☐ What is the highest level of education you have completed? Primary
☐ Secondary
☐ Third level
☐ No formal education
Q10

Which of the following statements applies to you

☐ I have experienced mental health problems myself
☐ I have cared for, or I am a relative of someone who has had a mental health problem
☐ I have experienced mental health problems through my work or while at university
☐ I have no experience of mental health problems
APPENDIX 2 – Qualitative Interview Schedule & Vignettes

Demographics

1. What is your gender?
2. What is your age?
3. What is the highest level of education you have completed?
4. Are you currently enrolled in college/university?
5. Are you currently employed?
6. What is your ethnicity?
7. Have you cared for someone with mental illness/mental health problem?
8. Have you worked in a health care setting?
9. Do you have an academic background in mental health or health care?
10. Are you an Irish citizen or reside in Ireland?

Knowledge of Mental Illness

12. When you hear the term mental health, what thoughts come to mind?
13. What mental illnesses do you know of?
14. Have you seen or heard about any discussions/promotions/campaigns in the media in relation to mental illness?
15. What percentage of the Irish population would you guess has a mental illness?
16. What would you say if I told you that one in four people in Ireland will suffer from a mental illness?

Attitudes toward Mental Illness

People with Mental Illness

17. Why do you believe people suffer from mental illness?
18. What is your perception of people with mental illnesses?
19. What types of people do you think get mental illnesses?
20. What do you think people with mental illnesses look like?
21. What types of families do you think people with mental illnesses come from?
22. What do you think causes people to become mentally ill?
23. Could you describe to me what people in psychiatric asylums are like?
24. Would you be comfortable talking to someone with mental health problems?
25. Who do you think is to blame for a person’s mental health problems?

Employment

26. How comfortable would you feel if you knew a co-worker/colleague of yours had a mental illness?
27. If you were an employer would you hire someone with a mental illness?
28. Do you think that people with mental illness are just as capable as people without mental illness at holding jobs?
29. Should people with mental health problems enter any profession they want to?

Impacts

30. In what ways have mental illness affected you:
   1. Personally?
   2. In day to day life?
   3. In the work place?
   4. At school?
31. Were these experiences positive/negative or neutral?
32. Would you say that mental illness has had a positive/negative or no effect on your life?

Personal Effects

33. If you believed that you had a mental illness what would you do?
   1. Who would you tell?
   2. What steps would you take?
   3. How do you think your life would change?
   4. Do you think it would have a positive/negative or no effect on your life/work/school?
34. If you were experiencing mental health problems would you want people knowing about it?

Treating Mental Illness

35. Who should someone with a mental illness see in order to get help?
36. How effective do you feel psychiatric therapies are?
37. How easy or difficult do you believe it is for persons with mental illnesses to seek help? And to become rehabilitated?
38. Do you feel that a person with a mental illness can be fully rehabilitated?
39. Do you think that people can overcome mental illnesses?
40. Do you feel that it is the responsibility of the person with the mental illness to seek help? Or should others seek help for them?

Items Affecting Views Affecting Mental Illness

Media

41. How do you feel mental illness is portrayed in the media?
42. Do the media affect the way you view mental illness?
43. Do you think the media has a negative/positive or neutral effect on the way mental health is portrayed to the public?
44. Do you think that the media could be used positively to change how mental illness is portrayed?

Vignettes

‘John is a man who was doing pretty well until about a year ago. But then things started to change. He thought that people around him were criticizing him and talking behind his back. John was convinced that people were spying on him and that he could hear what he was thinking. John couldn’t work anymore and he stopped joining in with family activities. He retreated from everything until he eventually spent most of his day in his room. John heard voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.’

1. From the information that is given, what, in your opinion, if anything is wrong with Jane?
2. Would you feel comfortable working with Jane?
3. What advice would you give to Jane?
4. Who would you recommend Jane seek help from?

‘Jane is a woman who has been feeling unusually sad or miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Jane doesn’t feel like eating and has lost weight. She can’t keep her mind on her work and puts off making decisions. Even day to day tasks seem too much for her. This has come to the attentions of Jane’s boss, who is concerned about her lowered productivity.’

1. From the information that is given, what, in your opinion, if anything is wrong with John?
2. Would you feel comfortable working with John?
3. What advice would you give to John?
4. Who would you recommend John seek help from?
Dear [participant’s name]

I'm starting the data collection phase of my project and looking for participants to complete a mental health survey. If you are interested in being part of this research you can find a detailed overview of the study which is attached with this email. Also attached is a list of mental health service providers should you wish to avail of them.

The survey itself is via Survey-monkey. Survey-monkey operates by allowing participants to complete questionnaires confidentially without the researcher identifying participants. To this effect you are ensured your anonymity is maintained.

The survey itself can be accessed via the link here

http://www.surveymonkey.com/s/6ZJLH9J

Many thanks

Luke Keating
APPENDIX 4 - Participant Information Sheet

Information Sheet

Aims and Objectives of Interview

The purpose of the survey is to obtain an insight into the attitudes and perspectives on mental health, mental health problems and mental illness among adults residing in Ireland, while attempting to understand the level of help-seeking behaviour with regard with mental health issues.

Who is being asked to participate in this survey?

A survey containing four parts is being administered via email using an external link to survey-monkey

Survey-Monkey

By using survey-monkey you will remain anonymous and your confidentiality maintained. No identifying information (i.e. name, address) will be recorded and/or used in any reports made of the findings. Your participation is entirely voluntary and may be ended at any time.

I would like to take this opportunity to thank you for taking the time to consider taking part in this project. The results will be used by Luke Keating for the purpose of completing a thesis and also, to highlight the level of awareness and issues on Mental Health and its impacts on help-seeking behaviour.

Contact Details

If you require any further Information you can contact me at 0877505651 or email keatinlu@tcd.ie

Regards,

APPENDIX 5 - Mental Health Service-providers

Resources

The following is a list of service providers available in the mental health sector which can assist and help with numerous mental health problems.

Samaritans

Samaritans is a confidential emotional support service for anyone in the UK and Ireland. The service is available 24 hours a day for people who are experiencing feelings of distress or despair, including those which may lead to suicide.

Phone: 1850609090

Web: www.Samaritans.org

Email: jo@samaritans.org

Aware

The Helpline offers a non judgmental listening ear to people who may be distressed or worried, or just need someone to talk to. You can also call the helpline if you are worried about someone who may be depressed or for information about depression or Aware services.

Phone: 1890 303 302

Web: www.aware.ie

Email: http://www.aware.ie/contact.asp
Mental Health Ireland

Mental Health Ireland is a national voluntary organisation which was established in 1966 as the Mental Health Association of Ireland. It is a company limited by guarantee with a voluntary Board of Directors representative of local Mental Health Associations and people with expertise in relevant areas.

Phone: (01) 284 1166
Web: www.mentalhealthireland.ie
Email: info@mentalhealthireland.ie

Grow

GROW is a Mental Health Organisation which helps people who have suffered, or are suffering, from mental health problems. Members are helped to recover from all forms of mental breakdown, or indeed, to prevent such happening. GROW, founded in Australia in 1957 by former mental sufferers, has a national network of over 130 Groups in Ireland. Its principal strength is the support members give each other from their own experience in matters to do with mental health. GROW is grant aided by all of the Health Boards and by the Department of Health and Children.

Phone: 1890 474 474
Web: www.grow.ie
Email: info@grow.ie

Shine

Shine is the national organisation dedicated to upholding the rights and addressing the needs of all those affected by enduring mental illness including, but not exclusively,
schizophrenia, schizo-affective disorder and bi-polar disorder, through the promotion and provision of high-quality services and working to ensure the continual enhancement of the quality of life of the people it serves. Shine has offices in Dublin, Cork, Galway, Kilkenny, Tullamore and Dundalk.

Phone: 1890 621 631 (Helpline)

Web: www.shineonline.ie

Email: http://www.shineonline.ie/index.php/main-contact

APPENDIX 5 - Mental Health Service-providers Contd.

Console

Console promotes positive mental health within the community in an effort to reduce the high number of attempted suicides and deaths through suicide.

Phone: 1800201890 (Helpline)

Web: www.console.ie

Email: info@console.ie

Bodywhys

Our mission is to ensure support, awareness & understanding of eating disorders amongst the wider community as well as advocating for the rights and healthcare needs of people affected by eating disorders.

Phone: 1890200444

Web: www.bodywhys.ie

Email: alex@bodywhys.ie

Irish Advocacy Network
Peer advocates are people who have personal experience of mental health difficulties who have achieved a sufficient level of recovery to complete an accredited training course in peer advocacy. Once they are qualified they can complete a period working with an existing peer advocate before engaging with clients on their own. This puts them in a unique position in understanding the problems faced by people with mental health difficulties.

Phone: 047 38918

Web: www.IrishAdvocacyNetwork.com

Email: admin@irishadvocacynetwork.com

APPENDIX 6 - Qualitative Email

Dear [participant’s name]

I'm starting the qualitative phase of my project and looking for participants to take part in individual interviews which will involve in-depth discussions about mental health issues, and personal experiences of mental health. If you are interested in being part of this research you can contact me directly or via email. Please find attached a detailed overview of the study and an outline of the interview themes. Also attached is a list of mental health service providers should you wish to avail of them.
Regards,

Luke Keating