Public Attitudes Towards People with Mental Health Problems: A Comparative Study of Ireland and Hungary

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B.A. (Hons) in Psychology

Submitted to the National College of Ireland, March 2021

Submission of Thesis and Dissertation

National College of Ireland

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Abstract

Aim: Research into attitudes towards people suffering from mental health problems indicate an issue of stigma around mental health in Europe, especially in Eastern European countries. Drawing from the Opinion About Mental Illness Scale, (est. 1962) this study aimed to compare the five factors of attitudes towards mental health issues across the Hungarian and Irish population. The hypotheses presented that the Irish population will have a more positive attitude towards people with mental health problems. Demographic variables were also taken into account as the other aim of the current study; gender differences in the five dimensions of stigmatizing attitudes was investigated. **Method**: The Opinion About Mental Illness Scale was administered to participants (N=108) which was distributed across social media. These questions administered five attitudes: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. **Results:** Results indicated that overall the Irish population is holding a significantly more positive attitude towards people with mental health issues as compared to the Hungarian population, with the exception of benevolence. Practical implications are suggested for this. The current study did find a significant gender difference in the five factors of attitudes. **Conclusion:** The results of the present study suggests interventions aimed at promoting positive attitudes towards mental health in Hungary. Implications of future research aims are also discussed.

Keywords: stigma, Hungarian population, Irish population, stereotypes, negative and positive attitudes, mental health

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Introduction

Mental health should be looked upon as a human capital in society; it is the ability to live, work and enjoy social interaction by making meaningful connections, contributes to cohesion and security, a sense of belonging and support; when we live in a sense of well-being, we flourish (Huppert et al., 2009). Yet, on the other side of the spectrum, individuals that suffer from mental illnesses often face a negative, stigmatizing attitude, discrimination and social rejection perpetuated by peers as well as being denied opportunities and care due to negative stereotyping (Corrigan and Kleinlein, 2005). Stigma occurs when the general community creates stereotypes and unfavorable characteristics or beliefs against a specific group (Corrigan, 2004).

Described as a 'global epidemic', 792 million people all around the world suffered from any type of mental health disorders in 2017 (Richie and Roser, 2018). The World Health Organisation concluded that social stigma plays a role in community attitudes towards mental illnesses (WHO, 2011,p.1.). Despite the plethora of individuals being affected globally, research shows that more than 70% of people with mental illnesses do not receive treatment from health care staff; this is due to the public health approaches to stigma and discrimination that facilitates access to mental health care (Henderson et al, 2013). It is evident that better knowledge about mental illness and more positive attitudes and tolerance towards those that suffer from mental illnesses correlate with stronger intentions to seek help (Rusch et al., 2011). In support of these findings, such discriminatory behaviour is shown to be associated not just with lower rates of help-seeking and under treatment, but also social exclusion impacting on ones self-stigmatizing attitudes where a person internalizes ideas held by the public (Evans-Lacko et al., 2012; Link and Phelan, 2001). As a consequence, stigma leads to a delay of treatment (Link and Phelan, 2011).

According to past research these stigmatizing attitudes come from cultural backgrounds with mentally ill individuals being perceived and described as dangerous, unpredictable, unstable, irresponsible and incurable (Todor, 2013 Corrigan et al., 2001; Chung, Chen, & Liu, 2001; Mahto et al., 2009; Mehta et al., 2009; Kazantzis et al., 2009). Mental health related stigma shares a public health importance in Europe to tackle the consequences that stigma brings about such as higher rates of death, poverty, unemployment, crime and social exclusion (Evans-Lacko et al., 2014).

To understand stigma, it is vital to research its underlying factors. Link and Phelan (2001) recognised stigma as a multidimensional phenomenon. Its cognitive construct is made of stereotypes and prejudice, with discrimination being a behavioural construct that results from the cognitive construct (Corrigan and Shapiro, 2011). Researchers in the past have often surveyed the population on their attitudes towards mental patients and scoring them based on dimensions of prejudice of mental illness stigma. Cohen and Struening (1962) recognised five dimensions of stigmatising attitudes; authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. These components were assessed and identified by other researchers in the past as a tool to assess negative and positive oriented attitudes towards mental health issues and stigma (Jones et al., 1984; Link & Phelan, 2001).

Authoritarianism

Authoritarian traits suggest a strong adherence to traditional social norms and beliefs; they tend to organise their world in terms of hierarchy (Duncan et al, 1997; Altemeyer, 1988). Authoritarians favour controlling other's behaviour through harmful means that they view as threatening to the social order or so-called 'deviant' groups (Altemeyer, 1988).

Mental health stigma manifests itself in the attitudes and beliefs of mental health professionals. In regards to mental health services, an authoritarian may view these services as an unwanted intrusion into their personal life, and an attempt to change their fundamental values. Authoritarianism in this context refers to the expression of a prejudicial attitude against persons with mental health issues by viewing them as inferior. Individuals scoring higher on this spectrum are considered to hold negative attitudes towards mental health services (Furr et al., 2003). This concept of prejudice drives discriminatory behavior and poor treatment outcomes of mental illness (Fox et al., 2018). Prejudice towards people with mental illness appears to be the outcome of ideology. The strong associations with authoritarianism appears to be the most important factor when it comes to predicting proposed behavioural consequences such as negative feelings for people with specific mental illness and behavioural intentions (Kenny et al., 2018).

Social Restrictiveness

Social Restrictiveness embodies the negative attitude that people suffering from mental health problems are dangerous to society. Socially restrictive attitudes towards people with mental illness are prevalent among different settings. Shashwath and colleagues (2016) found that hospital faculty members endorsed negative attitudes towards mental disorders, including getting married to a man previously suffering from mental health problems or excluding them from the public, although this study was conducted in India. In an Irish setting, respondents that identified mental disorders incorrectly, perceived those who suffered from them less dangerous (O'Keeffe et al., 2016). On the other hand, based on a 15 year long longitudinal study, Hungarian individuals with a lower familiarity of mental disorders were correlating with higher social restrictiveness (Buchman-Wildbaum et al., 2018). These researches show a great example of the impact culture has on orientations and views on mental health. Interestingly, females tend to show a more humanitarian attitude towards

mental disorders than males, with the exception of social restrictiveness (Pascucci et al., 2017). In contrast, female mental health trainees and professionals desired less social distance from people with mental disorders as compared to men in mental health care (Cashwell el al., 2011).

Benevolence

Benevolence is a positive, nurturing view towards people suffering from mental health problems, this is considered as a positive attitude, if scored high on the scale of benevolence (Byrne, 2001). Others argue that making attributions about disorders is considered as framing mental illness as a brain disorder for which people do not recover, supporting benevolence stigma; the idea that people suffering from mental health problems are innocent and need to be controlled and while it is a well-intentioned view, it could be disempowering in the sense of viewing them as less-competent (Corrigan, 2004). The Irish population is more benevolent towards people with mental health problems than Hungarians (Aznar-Lou et al., 2015). There are a number of factors influencing benevolence. Increased age is associated with scoring higher on benevolence when it comes to measuring benevolence in a longitudinal study, the findings suggested that the change is due to life-span adaptation (Poulin and Cohan Silver, 2008). In contrast, children tend to be extremely benevolent and hold a paternalistic view of mental patients (Weiss, 1985). Leong and Zachar (1999) suggests that benevolence is also predicted by education about mental health; those that are the most (eg. health care professionals) and least educated tend to be the most benevolent. This is in line with other scholars that measured level of benevolence of volunteers in a mental health setting over time, where the participants adapted a more positive ideology towards patients by the end of the 6 months (Beckerman, 1972). Furthermore, positive view of God as benevolent correlated with higher chances of seeking mental health services and having a more positive view towards these (Ironson et al., 2011).

Research suggest that religious education and benevolence (believing in a forgiving God) has a good impact on adolescents' well-being in the Irish population (Meehan, 2019).

Mental hygiene ideology

Mental hygiene ideology values mental health issues as a treatable illness, and it is considered a positive attitude (Wallach, 2004). It embodies the idea that mental illness is an illness like any other (Rabkin, 1972). Research shows that education on mental hygiene has an impact on becoming less authoritarian in both males and females (Costin and Kerr, 1966). However, males tend to hold a more negative mental hygiene ideology than females in general (Prasai et al., 2018; Drevenstedt and Banziger, 1977). There is a gap in literature when it comes to measuring mental hygiene in Ireland. On the other hand, research suggested that mental hygiene education is strong in Hungary, these efforts show a positive correlation with positive ideology on mental hygiene (Trinn and Molnar, 2001).

Interpersonal Etiology

Interpersonal etiology represents the view that mental health problems arise from interpersonal experiences. Environmental, genetic and developmental factors all influence interpersonal etiology (Corrigan and Watson, 2002). These include social skills, negative symptoms, neglect as a child and perceived physical attractiveness were all contributors to stigma (Penn et al., 2000). Research has shown that psychiatrists and psychologists score the highest on interpersonal etiology which suggest less stigma as opposed to non-mental health professionals (Smith and Cashwell, 2010). Couture and Penn (2003) found through a detailed investigation of existing studies on the topic, that interpersonal contact tends to reduce stigmatizing views.

Furthermore, studies revealed that there are tactics that individuals use to manage stigmatization through interpersonal influence; patients facing public stigma tend to resist stigmatization when they have a stronger sense of meaning in life, more unsafe experiences and broader information network (Smith and Bishop, 2019).

Gender

As with any given context, sociodemographic variables are also an important influence on any research. Bradbury (2020) concluded that general attitudes towards mental health is reportedly improving in recent years, however many people still hold stigmatized views, particularly the influence of gender role has been shown in past research to influence stigmatizing attitudes. The study suggested that females tend to respond more positively than males. Gender- based differences may differ due to biomedical, psychosocial or epidemiological reasons; this refers to hormonal, anatomical, coping, personality and population-based factors (Afifi, 2007).

One underlying factor identified of men being less frequently referred to mental health services is the traditional male gender role of men being less likely to discuss emotional issues among themselves; males tend to differ in interpersonal etiologies in regards to being less likely to discuss their feelings and struggles with a same gender family member or friend (Vogel et al., 2014; Brody and Hall, 2008). Ward and Doherty (2007) conducted a research which showed that Irish females were more willing to disclose distressing information to others than Irish males. Females tend to be more open-minded and pro-integration to interact with persons subject to mental illness than males (Ewalds-Kvist et al., 2013). These finding are in line with other studies where the results confirmed that males are more likely to experience self- stigma and public stigma associated with help-seeking and open mindedness (Topkaya, 2014). Controversially, a comparison study across European countries has shown openness to seek professional help, however perceiving these as not

valuable, with Hungarian males scoring higher in negative attitudes, than the Irish population (Coppens et al., 2013) Females tend to be more benevolent and hold higher mental hygiene ideology perspectives, whereas men are more authoritarian and more socially restrictive which all accounts for attitudes towards mental illness (Leong and Zachar, 1999).

Additionally, studies on peer support and gender among college students reported low scores of confidence in their ability to support a friend and low intention to assess risk of harm, males scored poorer on their quality of mental health first aid skills than female peers (Davies et al., 2016). Younger males often report more negative views as compared to middle-aged adults (Gonzales, 2011). Williams and Pow (2007) concluded that young adults tend to have more negative attitudes than females due to the lack of understanding of the importance of mental health, the lack of interest to know more about the topic and the thought that they had already been given enough education.

The current study

Social acceptance of individuals living with serious mental health issues in Hungary, being an Eastern European country, is well below that of other European countries (Ács et al., 2019). The impact of negative stigmatization can be explained through research where permissive public attitudes are correlating with higher suicide rates (Schomerus et al., 2015). Suicide rates in Hungary are among the highest in Europe. In comparison to Ireland, an example of a North-western European country, experiencing 9.2% of suicides per 100.000 people, whereas Hungarian statistics reveal 19% of suicides per 100.000 in 2015 (Eurostat, 2015). The reason for such drastic differences between the two countries can be revealed through looking at the funding allocated to mental health care services. The budget for mental health services accounted 5.3% of the overall healthcare budget in Ireland whereas, although the budget for mental healthcare being unreported, between 2006-2010 there was a reduction of psychiatric funding in Hungary as seen from the closure of many Psychiatric Centres and

reducing outpatient services (Kurimay, 2010; Eurostat, 2015). However, despite the efforts of public and private funding being allocated for mental health care services, stigma towards the ones in need of these services can impede these efforts by affecting their willingness to seek professional help, leaving them in a dark place of despair, feeling of loneliness, lacking in motivation and rehabilitation. (Corrigan et al., 2003; Foster, 2006). Literature suggest a decline in suicide rates over the past years in Hungary as a comprehensive national public health programme was adopted in 2002 to tackle mental health related disorders. In prevention of suicide and depression The National Public Health Programme addressed mental disorders as well as the National Children Health Programme paid more attention on focusing on strengthening the mental health of children and adolescents (Kurimay, 2010).These statistics reveal the need to focus on mental health related issues as such psychological studies could suggest the underlying factors of high suicide rates. Therefore, it is important to look further into these causes as it could suggest possible interventions to tackle ones willingness to avail of mental health services. Telephone help-line services are maintained with a low budget having 20 hotlines operating in the whole country whereas The Samaritans suicide prevention help-line is supported by 6 telecom companies in Ireland as a free-phone helpline (Eurostat, 2005). These figures suggest the lack of support available in Hungary which could have a negative orientation on mental health stigmas and help-seeking. The willingness of help-seeking is an important factor when it comes to attitudes towards mental health issues.

Although a growth in research can be observed on the topic of stigma, it is still unequally distributed across European countries, with North-western European counties leading the frequency of research on the issue, compared to Eastern European countries experiencing lower share of publications, creating a gap in literature. To address this gap, the purpose of the current study is to compare the two cultures is to illuminate differences or unexpected similarities. Despite efforts made to measure public attitudes towards mental health

across European countries, there is a gap in literature when it comes to comparing Ireland and Hungary specifically. Kohls and colleagues (2017) found that across four European countries, Hungary was showing the most negative results towards personal stigma and attitudes towards depression, whereas Irish had the most favorable attitudes. However, at the time of this research Ireland was reinforced a mental health awareness campaign (Your Mental Health), and Hungary was undergoing elections and a major flood that might have hindered the outcomes of this research (Coyle, 2017; Kiss, 2019). It is crucial to compare two countries; one high in suicide rates and individuals suffering from mental health problems; one lower, to find associations and therefore to be able to implement interventions. Furthermore, it is important to account for gender differences to cater for education and mental health services.

Based on the research, the current study aims to use the OMI Scale, the 5 factors of stigmatizing attitudes to assess the populations' attitudes towards people suffering from mental health issues. We hypothesize, based on prior literature that:

1. The Irish population will have a more positive attitude towards people suffering from mental health issues compared to the Hungarian Society.
2. Females will have a more positive attitude towards people suffering from mental health issues as compared to males in regards to both Ireland and Hungary.

Methodology

Participants

The sample for the current study consisted of 108 (Hungarian: *n* = 54; Irish: *n* = 54). Of the Hungarian nationalities recruited 15 were men and 39 were female, ranging between 18 to 54 years in age. Of the Irish participants, recruited 20 were men and 34 were females, participants ranged in age from 18 to 51 years. All participants willingly volunteered to complete the online survey, and were sampled by non-probability, convenience sampling. The questionnaire was distributed across social media websites such and Facebook and Instagram. An English-translated questionnaire to the Irish population was supplied, and a Hungarian version to the Hungarian population for better understanding of the questions. In line with the ethical considerations, the participants were required to be over 18 years of age. Written informed consent was given by all participants.

Measures

The questionnaire was created using a platform named Google Forms. The study questionnaire included questions to gain a general profile of the participants in this study by establishing their age and gender. Demographic questions were used to gain an insight into how much support is available to an individual, and their education of mental health, however these questions were not used in the study during the analysis of the data. There was no empirical research behind these questions, and it would have taken away from the validation of the study.

Opinions About Mental Illness (OMI) Scale:

Developed in the 1960's by Cohen and Struening (1962), the OMI scale sought the coverage or salient domains of stigma to measure attitudes towards mental illness. The scale consist of 51 statement about the presentation and treatment of severe mental illness, which

respondents rate using a 6-point agreement scale (1-Stongly Disagree to 6-Strongly Agree). The participants were asked to indicate the number provided which comes closest to saying how they feel about each statements. The statements were measuring 5 dimensions of stigmatizing attitudes: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. Once the data was collected, the statements were computed into these 5 dimensions to create them as separate variables. This was completed by following the original research paper and its guidelines, to sort each question into the right category. This measure has been found to have a good reliability. This was established by the examination of Cronbach's Alpha. The original reliability of this scale being 0.75 to the current study (α: 0.75), indicates that the scale demonstrates predictive and construct validity, and high level of internal consistency with the current sample.

Design

The study used a quantitative, between-subject approach with a non-experimental, cross-sectional research design. There were five continuous dependent variables which were as follows: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. To investigate the hypotheses these levels were compared as different groups, the categorical independent variable being nationality, Hungarian and Irish. Demographic factors such as gender, was also taken into account. Gender was used as a categorical variable with males and females being compared against their levels of authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. Both of these hypotheses were measured using a t-test. (See Appendix A for evidence of data).

Procedure

The participants were recruited through online platforms, by the means of collecting data using an online questionnaire, Google Forms. This questionnaire was shared on the researcher's social media accounts, such as Facebook and Instagram, through a link. I also allowed the post and link of the questionnaire to be open to be shared by other social media users to allow for the questionnaire to gain attention. When individuals decided to take part in the study and click on the link, they were taken to the questionnaire where first they were provided with an information sheet (Appendix B and C.) explaining the study and its risks or benefits of participation. The participants were provided with a consent form (Appendix B and C); where it was clearly stated that they can withdraw from the study any time without penalty. They were only able to take part in the study once they confirmed that they were over the age of 18, and if the clicked a 'yes' box to establish that they understood and read carefully over the study, and that they give permission to use their data anonymously in the interest of the research. This was an important step in the creation of the questionnaire form, to be in accordance with the ethical guidelines of NCI. They also had to confirm that they were born and raised in Ireland or Hungary. Once this all has been established, they were able to proceed with the questionnaire, which took approx. 15-20 minutes.

The questionnaire consisted of two sections. The first section measured the participant's knowledge about mental health, and their surrounding mental health support when needed. This section also queried the participant's age and gender. The second section consisted of the Opinions About Mental Illness (OMI) Scale (Cohen and Struening, 1962) which is a commonly used questionnaire in past studies to measure the population's opinion about mental health based on five stigmatising attitudes. (Appendix D and E) Upon completion of these, the participant was taken to a debriefing form (Appendix. F and G) where the researcher's and her supervisor's contact details were provided along with phone lines to

mental health services (such as NiteLine and Samaritans) in case of distress cause to the individual due to the completion of the study.

Results

Descriptive Statistics

The current data is taken from a sample of 108 participants (*n* = 108). This consisted of 67.6% females (*n* = 73) and 32.4% males (*n* = 35) overall. 50% of the sample was Hungarian (n=54) and 50% was Irish (n=54) Of the Hungarian nationalities recruited 15 were men and 39 were female, ranging between 18 to 54 years in age. Of the Irish participants, recruited 20 were men and 34 were females, participants ranged in age from 18 to 51 years.

There are five continuous variables including authoritarianism, social restrictiveness, mental hygiene ideology, interpersonal etiology and benevolence. Mean, standard deviation, minimum and maximum scores are displayed in Table 1 below.

Table 1

Descriptive statistics and reliability of all continuous variables

	Mean	SD	Skewness	Kurtosis	Minimum	Maximum
Authoritarianism	51.95	13.46	1.89	2.45	26	99
Social restrictiveness	36.37	10.51	.78	1.43	18	77
Interpersonal Etiology	20.93	7.85	.916	1.33	8	47
Benevolence	47.19	6.86	.706	.201	35	68
Mental Hygiene	50.36	7.75	-.152	.094	28	71
Age	25.03	9.18	1.89	2.45	18	51

Inferential Statistics

Preliminary analyses were performed to ensure no violation of the assumptions of normality and homogeneity of variance. Tests for normality revealed that mental hygiene ideology, social restrictiveness and benevolence were non-normally distributed, whereas authoritarianism and interpersonal etiology were normally distributed. Levene's test for equality of variance was non-significant for both authoritarianism (p = .96) and interpersonal etiology (p = .82); concluding that the data does not violate the assumption of homogeneity of variance.

An independent samples t-test was conducted to compare levels of authoritarianism and interpersonal etiology between the Hungarian and the Irish population. There was a significant difference in scores of authoritarianism, the Irish population being lower in mean scores (M = 46.26, SD = 11.91) than Hungarians (M =58.10, SD = 12.38), $t(98) = -4.87$, p =.01, two-tailed. The magnitude of the differences in the means (mean difference = -11.84, 95% CI: -16.65 to -7.01) was large (Cohen's d = .9). There was also a significant difference in scores of interpersonal etiology, with the Irish population scoring lower in mean scores (M = 17.51, SD = 6.92) than Hungarians (M =24.77, SD = 7.06), $t(100) = -5.22$, p =.01, two-tailed. The magnitude of the differences in the means (mean difference = -7.06, 95% CI: -10.00 to -4.50) was large (Cohen's d = 1.03).

A non-parametric, Mann-Whitney test was performed to compare levels of benevolence, mental hygiene ideology and social restrictiveness between the Hungarian and the Irish population. The test indicated that benevolence was significantly higher for Hungarians (Mean Rank=64.97) than for the Irish (Mean Rank=37.87), U= 589.50, p=.01. Mental hygiene ideology was significantly greater for Irish (Mean Rank= 56.53) than for Hungarians (Mean Rank= 45.13), U=986.50, p=0.05. Social restrictiveness was significantly

lower for the Irish (Man Rank= 36.58) than for Hungarians (Mean Rank= 66.92), *U*= 508.00, *p*=.01.

To measure gender differences in regards to mental hygiene ideology, social restrictiveness, benevolence, interpersonal etiology and authoritarianism an independent samples t-test was conducted. Levene's test for equality of variance was non-significant for both authoritarianism ($p = .47$) and interpersonal etiology ($p = .96$); concluding that the data does not violate the assumption of homogeneity of variance. There was a non-significant difference in scores of authoritarianism, females scoring slightly lower in mean scores ($M = 50.24$, $SD = 13.41$) than males ($M = 55.26$, $SD = 13.10$), $t(98) = -1.79$, $p = .07$, two-tailed. The magnitude of the differences in the means (mean difference = -5.02, 95% CI: -10.60 to 0.55) was small (Cohen's $d = .3$). There was also a non-significant difference in scores of interpersonal etiology, with females scoring lower in mean scores ($M = 22.11$, $SD = 7.55$) than males ($M = 22.63$, $SD = 8.31$), $t(100) = -1.53$, $p = .01$, two-tailed. The magnitude of the differences in the means (mean difference = -2.52, 95% CI: -5.80 to -.75) was small (Cohen's $d = .03$).

Non-parametric, Mann-Whitney test revealed that benevolence was non-significantly higher for men (Mean Rank= 56.91) than for females (Mean Rank= 48), *U*= 1026, 5, *p*=.42. Males scored higher on social restrictiveness (Mean Rank= 56.91) than females (Mean Rank= 49.32), *U*= 938, *p*=.15. This indicates a non-significant result. Mental hygiene ideology was non-significantly greater for men (Mean Rank, 51.63) as compared to females (50.68), *U*= 1117, 5, *p*=.88.

Discussion

Stigmatizing attitudes are prevalent cross-culturally, and drawing from the original study of Cohen and Stuening (1962), five dimensions of attitudes influence positive or negative opinions of people with mental health problems. The current study aimed to compare the Hungarian and Irish population in their attitudes towards people suffering from mental health problems in the means of five dimensions of stigmatising attitudes, authoritarianism, benevolence, mental hygiene ideology, interpersonal etiology and social restrictiveness. Furthermore, it also aimed to investigate the gender differences within each variable.

Scoring lower on authoritarianism is considered to be a negative attitude and it is made up of items such as: ’every mental hospital should be surrounded by a high fence and guards’ and ‘regardless of how you look at it, patients with severe mental illness are no longer really human’. Social restrictiveness is also a negative variable with orientations towards ideas such as: ‘patients discharged from mental hospitals may seem all right, they should not be allowed to marry’. On the other side of the spectrum, benevolence and mental hygiene ideology are positive variables that one would wish to score high on, these include views like: ‘mental illness is an illness like any other’ and ‘anyone who tries hard to better himself deserves the respect of others’. Finally, interpersonal etiology is considered to be positive nor negative, it embodies the belief that development in the childhood has an impact on mental health, for example: ‘if parents loved their children more, there would be less mental illness’ (See Appendix B and C for items in the questionnaire). Through the investigation of past research and findings, two hypotheses were formulated to address the aims of this study.

It was hypothesized from prior literature, that (H1) the Irish population will hold a more positive attitude towards people with mental health problems. This was explored using an independent samples t-test analysis and a Mann-Whitney test due to the violation of the assumpion of normality. Upon performing these analyses, it was found that the irish population

is less authoritarian, they scored lower on social restrictiveness and interpersonal etiology, and they scored higher on mental hygiene ideology. These findings indicate that the Irish population does hold a more positive attitude towards people suffering from any kind of mental health issues as compared to the Hungarian population in general. This is consistent with numerous studies where Hungary and Ireland was described in their levels of authoritarianism, social restrictiveness, mental hygiene ideology and interpersonal etiology (Coppens et al., 2013; Kohls et al., 2017; Pachankins and Branstrom, 2018). Surprisingly to the researcher, Hungary scored higher on benevolence as compared to Ireland. This conflicts with prior research, in the sense that benevolence is considered to be a positive attitude (Papadopoulos and Leavey, 2002), whereas other researchers also argued that this dimension is favouring benevolence stigma (Corrigan and Watson, 2004). It is important to note, that the hungarian population scored higher on items of benevolence such as: 'although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life' and that 'there is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed' (Appendix B and C).

For H2 it stated that apart from nationality, females would overall score more positively towards attitudes of people with mental health problems than males. These gender differences were investigated with relation to the extent of the five attitudinal dimensions. results from both the independent samples t-test and Mann-Whitney test revealed non-significant results for all results, indicating that men and females does not differ in stigmatizing attitudes towards people with mental health issues. However just to note, females scored slightly lower in authoritarianism, interpersonal etiology, social restriction and benevolence. Surprisingly, men responded more positively to mental hygiene ideologies, than females. However, these were all non-significant results. As found by other researchers, the significance of socio-demographic variables is inconsistent and the predictive power of these variables on

stereotypical thinking and discriminating behavior is relatively low (Van´t Veer et al., 2006; Phelan et al.2008).

Based on the above findings, it can be concluded that hypothesis 1 (H1) can be accepted partially, and hypothesis 2 (H2) is rejected.

Practical Implications

Reducing the stigma and discrimination associated with mental illness is an important topic of research, policy and intervention work. As discussed in the current study, what drives stigma may differ for groups and individuals. Approaching stigma as a social process requires the understanding of the factors behind stigmatizing attitudes and therefore effectively combating it (Ungar et al., 2016). Research suggest that personal experience of mental health related issues have an effect on forming a more positive attitude towards these issues (Trute & Loewen, 1978). Hoven et al, 2008 suggest that mental health awareness has a positive impact on opinions about mentally ill individuals, however such support is not available in all schools and workplaces. Shockingly, mental health related stigma is still present in health-care settings (Henderson et al., 2014). Educational interventions are an effective strategy to target these health care professionals, more knowledge on the topic results in confidence and skills to treat mental illness and a positive interaction with patients. Furthermore, countering the disposition of perpetrators and supporting those who are being affected to limit their vulnerability is also a practical implication to reduce stigma (Weiss, 2006).

Implementing national programs to positively change social attitudes is an important role in the reduction of stigma associated with mental health problems. Coyle et al., (2016) implemented a partnership to create a view of mental health problems as part of being human, these efforts has shown excellent changes in reducing stigma. Unfortunately, Hungary as a society will need to step forward and realize the effects of stigmatization on mental health problems, and there is a serious social stigma attached to these, as also highlighted in the current

study (Takacs et al., 2013; Weber and Bugarszki, 2007). Due to the comparison of two cultures, we can draw practical implications to cater for different cultures, morals and social norms differ in countries, which all have an effect on stigmatization.

Strengths, Limitations and Future Research

One of the strengths of the present study is that it is addressing a gap, to the researcher's knowledge, that has been never looked into specifically. It is extremely rare to find literature comparing Hungary and Ireland specifically, in terms of stigma and mental health. Furthermore, the research on the topic of attitudes towards mental health is scarce in a Hungarian setting. As this study found a significant difference in opinions about people with mental health problems comparing the two countries, future research may be needed to tackle stigmatizing attitudes in Hungary. The measuring questionnaire (OMI scale) also has several important strengths. Without a doubt, the questionnaire has been used in many different settings. The items were carefully examined and selected as opposed to other items in other scales in this area of research. Another advantage to the scale is its coverage of salient issues, and recognizing the five dimensions of stigmatizing attitudes. Lastly, this measure and its long history allows for the possibility of assessing changes in attitudes over time. This questionnaire was used in the past in so many populations and settings that it allows for sourceful comparisons in literature. This is a self-report questionnaire that was easy to be anonymized to protect respondents' sensitive information and perhaps promote truthful responses.

There are number of limitations to be considered in the present study. Firstly, there was a limited sample, which would not account for the gender differences past studies have found when compared to the five dimensions of attitudes. More females than males took part in this study, which might have skewed the data and analyses. Secondly, the data was non-normally distributed. This could also be due to insufficient data, which can cause a normal distribution to look completely scattered. Perhaps for future research, a larger sample size might be a better

option to allow for normally distributed data. Sampling bias is another possible weakness of the current study; there is not enough sample to represent the population the researcher was looking to study.

Furthermore, while the OMI scale revealed many strengths, there are also weaknesses associated with this measure. The entirety of the scales relied on self-report measures which was a limitation of the current study. Individuals can be consciously or unconsciously influenced by social desirability and provide biased responses that are considered to be more socially preferred. Additionally, mental health issues were not specified in this study, for future implications the mental disorder is recommended to be accounted for separately as opposed to just a label of 'mental health problems'. Participants might differ in attitudes in different types of mental disorders due to prevalence or familiarity (eg. anxiety and schizophrenia). Moreover, a disadvantage of the OMI scale is that it was developed in the 60's. This may result in the wording of the questions being confusing, outdated or have different meanings as compared to today's world. The scale also contains double barrelled items, which are items that include two separate ideas which is poor psychometric practice. Lastly, the present study did not account for individual and cultural demographics, the implications for future research is to also consider cultural factors; as highlighted in the introduction countries differ in their opinions of mental health issues, especially when comparing continents. Therefore, more research to be conducted that also takes cultural factors into account.

Conclusion

Overall there is a consistent evidence that the Hungarian population has a more negative attitude towards people suffering from mental health problems as compared to the Irish population. Future studies may implement these findings to tackle this issue and find an intervention. Studies should also focus on longitudinal studies, and research interventions to tackle this current issue of stigmatization of people with mental health issues. It is important to

continually update knowledge and research due to negative stereotyping and its negative health outcomes associated with it, such as: self-stigma, failure to attend mental health care facilities, suicide, deteriorating mental health and exclusion. As the present study found no significance in gender differences and attitudes toward mental health issues, research on this topic is suggested. While this study was a novel attempt to expand on previous research, implications of gender equality to be taken into account in future studies as an expansion on previous research due to its relevance.

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Appendices

Appendix A

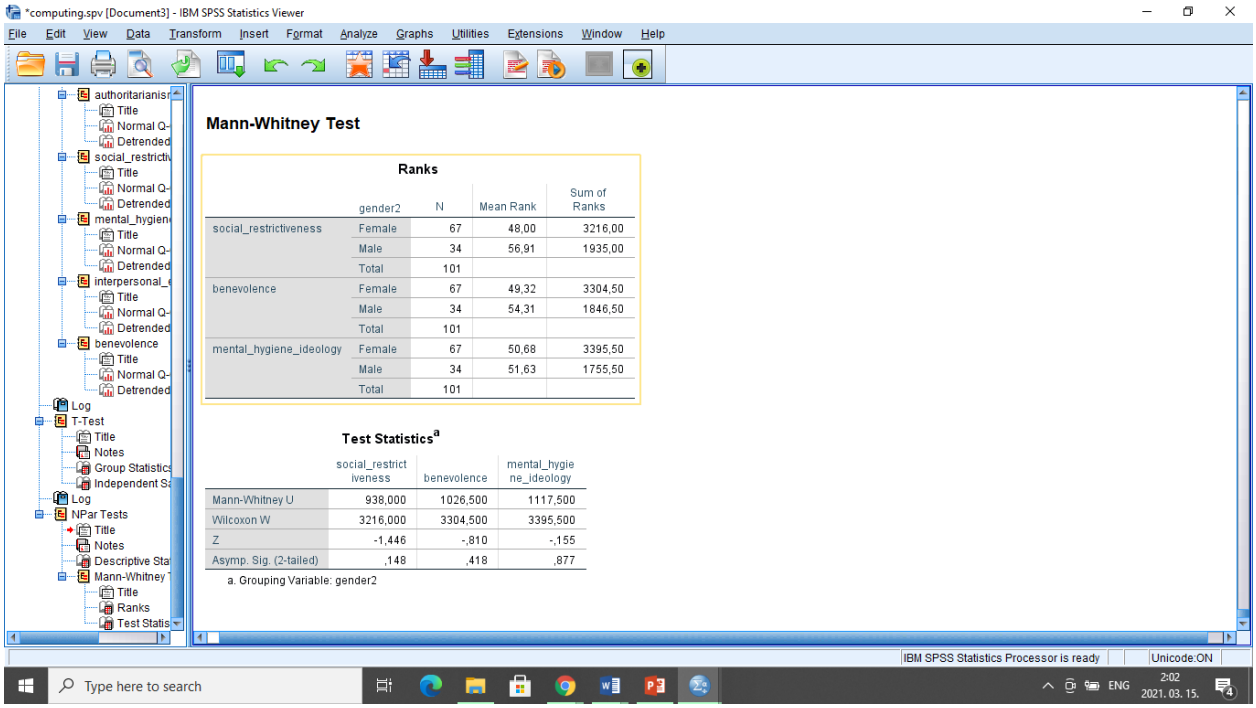
Evidence of data and SPSS output (full data file available upon request)

*ez.sav [DataSet1] - IBM SPSS Statistics Data Editor

File Edit View Data Transform Analyze Graphs Utilities Extensions Window

	Name	Type	Width	Decimals	Label	Values
1	ParticipantN...	Numeric	3	0		None
2	Lanugage	Numeric	1	0		{1, irish}...
3	@1.Mentalh...	String	3	0		None
4	@2.Ihavese...	String	3	0		None
5	NiteLine	String	3	0		None
6	Awareinmys...	String	3	0		None
7	age	Numeric	2	0		None
8	gender	String	17	0		None
9	@1.Nervous...	Numeric	1	0		{1, strongly ...
10	@2.Mentalil...	Numeric	1	0		{1, strongly ...
11	@3.Mostpat...	Numeric	1	0		{1, strongly ...
12	@4.Althoug...	Numeric	1	0		{1, strongly ...
13	@5.Ifparent...	Numeric	1	0		{1, strongly ...
14	@6.Itiseasy...	Numeric	1	0		{1, strongly ...
15	@7.People...	Numeric	1	0		{1, strongly ...
16	@8.People...	Numeric	1	0		{1, strongly ...
17	@9.Whena...	Numeric	1	0		{1, strongly ...
18	@10.Althou...	Numeric	1	0		{1, strongly ...
19	@11.Therei...	Numeric	1	0		{1, strongly ...
20	@12.Eventh...	Numeric	1	0		{1, strongly ...
21	@13.Mostm...	Numeric	1	0		{1, strongly ...
22	@14.Thesm...	Numeric	1	0		{1, strongly ...
23	@15.People...	Numeric	1	0		{1, strongly ...
24	@16.People...	Numeric	1	0		{1, strongly ...

Data View Variable View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File Edit View Data Transform Insert Format Analyze Graphs Utilities Extensions Window Help
Mann-Whitney Test
Ranks
gender2 N Mean Rank Sum of Ranks
social_restrictiveness Female 67 48,00 3216,00
Male 34 56,91 1935,00
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benevolence Female 67 49,32 3304,50
Male 34 54,31 1846,50
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mental_hygiene_ideology Female 67 50,68 3395,50
Male 34 51,63 1755,50
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Wilcoxon W 3216,000 3304,500 3395,500
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Appendix B

OMI Scale (English Version)

NB: The statements that follow are opinions or ideas about mental illness and patients with mental illness. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements, while many people disagree with each of these statements. We would like to know what you think about these statements. Each of them is followed by six choices indicated by the scale below.

1. Strongly agree
2. Agree
3. Not sure but probably agree
4. Not sure but probably disagree
5. Disagree
6. Strongly disagree

Please indicate the number provided which comes closest to saying how you feel about each statement.

1. Nervous breakdowns usually result when people work too hard.

1 2 3 4 5 6

2. Mental illness is an illness like any other.

1 2 3 4 5 6

3. Most patients in mental hospitals are not dangerous.

1 2 3 4 5 6

4. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

1 2 3 4 5 6

5. If parents loved their children more, there would be less mental illness.

1 2 3 4 5 6

6. It is easy to recognise someone who once had a serious mental illness.

1 2 3 4 5 6

7. People who are mentally ill let their emotions control them: normal people think things out.

1 2 3 4 5 6

8. People who were once patients in mental hospitals are no more dangerous than the average citizen is.

1 2 3 4 5 6

9. When a person has a problem or a worry, it is best not to think about it, but keep busy with more pleasant things.

1 2 3 4 5 6

10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

1 2 3 4 5 6

11. There is something about mental patients that makes it easy to tell them from normal people.

1 2 3 4 5 6

12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.

1 2 3 4 5 6

13. Most mental patients are willing to work.

1 2 3 4 5 6

14. The small children of patients in mental hospitals should not be allowed to visit them.

1 2 3 4 5 6

15. People who are successful in their work seldom become mentally ill.

1 2 3 4 5 6

16. People would not become mentally ill if they avoided bad thoughts.

1 2 3 4 5 6

17. Patients in mental hospitals are in many ways like children.

1 2 3 4 5 6

18. More tax money should be spent in the care and treatment of people with severe mental illness.

1 2 3 4 5 6

19. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

1 2 3 4 5 6

20. Mental patients came from homes where the parents took little interest in their children.

1 2 3 4 5 6

21. People with mental illness should never be treated in the same hospital as people with physical illness.

1 2 3 4 5 6

22. Anyone who tries hard to better himself deserves the respect of others.

1 2 3 4 5 6

23. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

1 2 3 4 5 6

24. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

1 2 3 4 5 6

25. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.

1 2 3 4 5 6

26. People who have been patients in a mental hospital will never be their old selves again.

1 2 3 4 5 6

27. Many mental patients are capable of skilled labour, even though in some ways they are very disturbed mentally.

1 2 3 4 5 6

28. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

1 2 3 4 5 6

29. Anyone who is in a hospital for a mental illness should not be allowed to vote.

1 2 3 4 5 6

30. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

1 2 3 4 5 6

31. The best way to handle patients in mental hospitals is to keep them behind locked doors.

1 2 3 4 5 6

32. To become a patient in a mental hospital is to become a failure in life.

1 2 3 4 5 6

33. The patients of mental hospitals should be allowed more privacy.

1 2 3 4 5 6

34. If a patient in a mental hospital attacks someone, he should be punished, so he doesn't do it again.

1 2 3 4 5 6

35. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

1 2 3 4 5 6

36. Every mental hospital should be surrounded by a high fence and guards.

1 2 3 4 5 6

37. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with severe mental illness.

1 2 3 4 5 6

38. People who are unable to work because of mental illness should receive money for living expenses.

1 2 3 4 5 6

39. Mental illness is usually caused by some disease of the nervous system.

1 2 3 4 5 6

40. Regardless of how you look at it, patients with severe mental illness are no longer really human.

1 2 3 4 5 6

41. Most woman who were once patients in a mental hospital could be trusted as baby sitters.

1 2 3 4 5 6

42. Most patients in mental hospitals don't care how they look.

1 2 3 4 5 6

43. College Professors are more likely to become mentally ill than are businessmen.

1 2 3 4 5 6

44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalised mental patients.

1 2 3 4 5 6

45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

1 2 3 4 5 6

46. Sometimes mental illness is punishment for bad deeds.

1 2 3 4 5 6

47. Our mental hospitals should be organised in a way that makes the patient feel as much as possible like he is living at home.

1 2 3 4 5 6

48. One of the main causes of mental illness is a lack of moral strength or will power.

1 2 3 4 5 6

49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

1 2 3 4 5 6

50. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

1 2 3 4 5 6

51. All patients in mental hospitals should be prevented from having children by a painless operation.

1 2 3 4 5 6

SCORING

Add up items to create the five dimensions of attitudes such as authoritarianism, benevolence, mental hygiene ideology, interpersonal etiology and social restrictiveness. The original research paper was used to do this (Cohen and Struening 1962)

Appendix C
OMI Scale (Hungarian Version)

A következő állítások véleményeket vagy ötleteket tartalmaznak a mentális betegségről és a mentális betegségben szenvedő betegekről. Ebben a témában számos véleménykülönbség mutatkozik. Más szavakkal, sokan egyetértenek a következő állításokkal, míg sokan nem értenek egyet ezen állításokkal. Szeretném tudni, hogy mit gondol ezekről az állításokról. Mindegyiket hat választást követi az alábbi skála.

1. Teljes mértékben egyetértek
2. Egyetért
3. Nem biztos, de valószínűleg egyetért
4. Nem biztos, de valószínűleg nem ért egyet
5. Nem ért egyet
6. határozottan nem ért egyet

Kérjük, jelezze a megadott számot, amely legközelebb áll ahhoz, amit gondol az allitottakrol.

mentalklinika=pszichiatria/pszihoterapiai klinika.

1. Az idegösszeomlások általában akkor következnek be, amikor az emberek túl keményen dolgoznak.

1 2 3 4 5 6

2. A mentális betegség olyan betegség, mint bármely más.

1 2 3 4 5 6

3. A mentális betegeknek valo kórházakban (pszichiatria/pszichoterapiai klinika) a legtöbb beteg nem veszélyes.

1 2 3 4 5 6

4. Noha a pszichiatriarol/ pszichoterapiai klinikarol mentesített betegek rendben lehetnek, de nem kene hogy valaha házasodhatjanak.

1 2 3 4 5 6

5. Ha a szülők jobban szeretik gyermekeiket, akkor kevesebb az eselye hogy mentális betegségek kialakulnak.

1 2 3 4 5 6

6. Könnyű felismerni valakit, aki valaha súlyos mentális betegségben szenvedett.

1 2 3 4 5 6

7. A mentális betegek hagyják, hogy érzelmeik iranyitsak őket: a normális emberek gondolkodnak mielott dontest hoznak.

1 2 3 4 5 6

8. Azok az emberek, akik egykor pszichiatrian/pszichoterapiai klinikan voltak betegek, nem veszélyesebbek, mint az átlagpolgárok.

1 2 3 4 5 6

9. Ha egy személynek van problémája vagy aggodalma, a legjobb, ha nem gondolkodik róla, hanem kellemesebb/pozitivabb dolgokra gondol/ elfoglalja magat.

1 2 3 4 5 6

10. Van egy olyan karaktere a mentális betegeksegtol szenvedoknek, amely megkönnyíti a normál emberektől való megkulonboztetest.

1 2 3 4 5 6

11. Annak ellenére, hogy a pszichiatrian/pszichoterapiai klinikan a betegek vicces módon viselkedhetnek, helytelen nevetni rajtuk.

1 2 3 4 5 6

12. A legtöbb mentális beteg hajlandó dolgozni.

1 2 3 4 5 6

13. A pszichiatrian/ pszichoterapiai klinikan levo betegek gyermekeinek nem szabadna engedélyezni a latogatast.

1 2 3 4 5 6

14. Azok, akik, sikeresek a munkájukban ritkán szenvednek mentális betegsegekben.

1 2 3 4 5 6

15. Az emberek nem szenvednének mentális betegsegekben, ha elkerülnék a rossz gondolataikat.

1 2 3 4 5 6

16. A pszichiatrian/pszichoterapiai klinikan a betegek sok szempontból hasonlíthatnak a gyermekeikhez.

1 2 3 4 5 6

17. Több adopénzt kellene költeni súlyos mentális betegségben szenvedők kezelésére.

1 2 3 4 5 6

18. Peldaul egy szívbetegnek csak egy problemaja van, míg a mentális betegek teljesen különböznek a többi betegtől.

1 2 3 4 5 6

19. A mentális betegsegben szenvedok olyan csaladba szulettek, ahol a szülők kevés érdeklődést mutattak gyermekeik iránt.

1 2 3 4 5 6

20. A mentális betegségben szenvedő embereket soha nem szabadna ugyanabban a kórházban kezelni, mint a fizikai betegséggel rendelkezőket.

1 2 3 4 5 6

22. Bárki, aki hajlando megbirkorkozni a mentalis betegsegeivel, megérdemli mások tiszteletét.

1 2 3 4 5 6

23. Ha kórházaink elegendő, jól képzett orvossal, ápolóval és segédkészlettel rendelkeznének, sok beteg jobban érezné magát a kórházon kívüli életben.

1 2 3 4 5 6

24. Egy nő bolond lenne férjhez menni olyanhoz aki súlyos mentális betegségben szenvedett, meg akkor is ha úgy tűnik, hogy teljesen felépült.

1 2 3 4 5 6

25. Ha a mentálisan beteg szülők gyermekeit normális szülők nevelnek fel, akkor valószínűleg nem válnanak kesobb ok is betegge.

1 2 3 4 5 6

26. Azok az emberek, akik pszichiatrian/pszihoterapiai klinikan szenvedtek, többé nem lesznek regi onmaguk.

1 2 3 4 5 6

27. Számos mentális beteg képes képzett munkavégzésre, annak ellenére, hogy bizonyos értelemben mentálisan zavart.

1 2 3 4 5 6

28. A pszichiatria/pszichoterapiai klinikak inkább börtönöknek tűnnek, mint olyan helyeknek, ahol mentális betegseggel szenvedőket lehet gondozni.

1 2 3 4 5 6

29. A mentális betegség miatt kórházban tartózkodó személyeket nem szabadna engedni szavazni.

1 2 3 4 5 6

30. Sok ember mentális betegségét a szüleik gyermekkorban történő kulonlete vagy válása okozza.

1 2 3 4 5 6

31. A pszichiatrian/pszichoterapiai klinikan levo betegek kezelésének legjobb módja az, ha zárt ajtók mögött tartják őket.

1 2 3 4 5 6

32. A pszichiatrian/pszichoterapiai klinikak betegevé válása egyenlo azzal hogy az élet kudarcá válik.

1 2 3 4 5 6

33. A mentálklinikák betegeinek tobb maganeletet kene hagyni.

1 2 3 4 5 6

34. Ha egy mentális klinikan lévő beteg megtámad valakit, akkor büntetni kell hogy ne csinálja újra.

1 2 3 4 5 6

35. A mentalklinikakak orokkel kene orizni es magas keritessel kene elkeriteni.

1 2 3 4 5 6

36. Minden mentalklinikat el kene keriteni es oroknek kene oriznie masok biztonsaga erdekeben.

1 2 3 4 5 6

37. A törvénynek lehetővé kene tennie egy nő számára, hogy elváljon a férjétől, mihelyt súlyos mentális betegséggel szenved a ferfi es ezaltal mentálklinikara kerul.

1 2 3 4 5 6

38. Azoknak, akik mentális betegség miatt nem képesek dolgozni, pénzt kellene kapniuk megélhetési költségekre.

1 2 3 4 5 6

39. A mentális betegséget általában valamilyen idegrendszeri betegség okozza.

1 2 3 4 5 6

40. A súlyos mentális betegségben szenvedő betegek már nem igazán emberek.

1 2 3 4 5 6

41. Azok a nok akik egyszer mentálklinikan voltak betegek, megbizhatoak annyira hogy bolcsodekben dolgozzanak.

1 2 3 4 5 6

42. A mentálklinika legtöbb betegét nem érdekli, hogy néznek ki.

1 2 3 4 5 6

43. A főiskolai professzorok valószínűleg mentálisan serultebbe válnak, mint az üzletemberek.

1 2 3 4 5 6

44. Azok az emberek, akik mentalis betegsegben szenvednek, de nem reszesulnek apolasban klinikan, kevesbe javulnak, mint azok, akik igen.

1 2 3 4 5 6

45. Bár néhány mentális beteg ugy tunik hogy rendben van, veszélyes egy pillanatra is elfelejteni, hogy mentálisan beteg.

1 2 3 4 5 6

46. A mentális betegség egy büntetés a rossz cselekedetekért. (Karma)

1 2 3 4 5 6

47. A mentálklinikakat úgy kene berendezni, hogy a beteg minél otthonosabban érezze magát.

1 2 3 4 5 6

48. A mentális betegségek egyik fő oka az erkölcsi morál vagy az akaraterő hiánya.

1 2 3 4 5 6

49. Alig vagy semmit nem lehet megtenni azert hogy a mentális kórházban a betegek rendesen el legyenek látva, hogy kényelmesen legyenek és jól táplálkozzanak.

1 2 3 4 5 6

50. Számos mentális betegsegben szenvedo szivesen marad addig a kórházban, amíg nem érzik jobban magukat, még akkor is, ha nem lenne kotelezo.

1 2 3 4 5 6

51.Az olyan betegeket, akik klinikai segitsegre szorulnak, meg kene muteni fajdalommentesen hogy a jovoben ne lehessen gyerekuk.

1 2 3 4 5 6

Appendix D
Consent form

Social perception of people with mental health problems

You are being invited to take part in a research study. Please take time to read the following information carefully to understand why the research is being done and what it would involve for you.

You will be completing the Opinions about Mental Illness Scale which will include questions about your experience and opinions on people suffering from mental health problems.It will also ask about how much support you think is available around your environment, and your overall education on such mental health related problems. Completing the questionnaire will take about 10-15 minutes.

Before proceeding further, I have to advise you that you can only take part in the study if:

- You were born and raised in Ireland
- You are or over the age of 18
- You are able to read and understand the questions

Risks and Benefits

Your participation is voluntary. You may refuse to take part in this study by exiting the survey at any time up until your answers are being submitted. You will receive no direct benefits from participating in the study

There are no foreseeable risks involved other than those encountered in day-to-day life. If you find any of the questions uncomfortable to answer you can simply skip that particular question. If you experience any discomfort please do not hesitate to contact the provided support services, myself or the research supervisor.

Confidentiality and Data Storage

The data will be stored in a password protected electronic format that only the researcher, myself will have access to, all data remaining confidential and anonymous. The will be no names, addresses, IP addresses or any identifiable information asked, that would allow a participant to be traced down and all responses remain anonymous and completely confidential. No one will know whether you have had participated in the study, or not.

Results

The final research paper with the results of the study will be submitted to National College of Ireland for grading, as well as I am considering to hold a presentation of the findings at the PSI Conference for further recognition and gaining attention of others, as well as there is a slight possibility of the paper getting published. In such case I will be making the information regarding publication and presentation on my social media platforms available.

Informed Consent Form

I am 18 years of age, I was born and raised in Ireland and I consent to participate in the study.

Appendix E
Consent form (English Version)

A társadalom viszonya a mentális problémákkal küzdő emberekhez.

Kovács Viviennek hívnak, és a National College of Ireland pszichológia hallgatója vagyok. Tanulmányaim részeként, kutatást kell végeznem, amelynek célja a mentális betegségek, rendellenességek és sztigmák, valamint azok mögöttes tényezőinek társadalmi véleménye es hozzáállását fogja tanulmányozni.

A tanulmány témája

A kérdőív a következő témaköröket foglalja magába; az ön viszonya a mentális problémákkal küzdő emberekhez; elérhető e támogatás a környezetében ha ilyen problémákkal küzdene valamint az ön meglévő ismerete erről a témakörről. A kérdőív kitöltése 10-15 percet vesz igénybe.
Ahhoz hogy a kérdőív kitöltésében részt vegyen, az alábbi kritériumoknak kell megfelelnie:
-Magyarországon született és nőtt fel
-Minimum 18 évesnek kell lennie

Fontos tudnivalók

Fontos tudatnom önnel hogy a részvétel önkéntes. Elutasithatja a tanulmányban való részvételt bármikor, addig amíg nem nyújtja be véglegesen a válaszokat. A tanulmányban való részvétele nem fog közvetlen haszonnal járni önnek, azonban a válaszai segítenek nekem abban, hogy közelebbről tudjam tanulmányozni a mentális egészséggel es stigmákkal kapcsolatos társadalmi felfogást.A minden napi életben felmerülő kockázatokon kívül más, előre nem látható kockázat nem jár ennek a kérdőívnek a kitöltésével. Lehet, hogy néhány kérdést kényelmetlennek talál majd, azonban lehetőség van ezeknek a kérdéseknek a kihagyására amelyekre bármilyen okból nem kíván válaszolni. Ha bármilyen kérdése van a tanulmánnyal vagy a kérdőívvel kapcsolatban, kérem vegye fel a kapcsolatot a kutatás vezetővel (Fearghal O'Brien) e-mailben (Fearghal.Obrien@ncirl.ie) (angol nyelven), vagy velem; Kovacs Vivien-nel az x17145708@student.ncirl.ie e-mail címen.

Titoktartás/adatvédelem

A válaszokat jelszóval védett elektronikus formában fogom tárolni, ahol egyetlen részvevő sem lesz azonosítható. A kerdőívben nem lesz olyan kérdés amivel azonosító jellegű információhoz jutnék, és lehetővé tenné a résztvevő nyomon követését, tehát az összes válasz névtelenül van benyújtva. Senki nem fogja tudni hogy részt vett ebben a tanulmányban, vagy sem.

Beleegyező Nyilatkozat

Elismerem hogy elmúltam 18 éves, Magyarországon születtem és beleegyezem a válaszaim felhasználására kutatás céljából.

Appendix F

Debriefing form (English version)

Thank you for your participation, I hope you found the questions and the experience enjoyable and interesting. Your response provides me to be able to research social attitudes of people experiencing mental health issues.

As I mentioned, your participation in this study is voluntary and you will not be receiving any benefits from completing this study other than learning more about the topic.

The data obtained in this study will be analysed and the results will be presented as my final year thesis in a research paper format, as well as presenting it to fellow students and lecturers as part of the project.

Should you have any questions or queries about the research, its purpose and this questionnaire please feel free to get in touch via e-mail:

Vivien Kovacs: x17145708@student.ncirl.ie

Fearghal O'Brien (research supervisor): Fearghal.Obrien@ncirl.ie

If you feel in any way distressed or uncomfortable after taking part in this study please contact any of these helplines:

Samaritans (available 24 hours a day): 01 116 123

Aware (available 10am to 10pm every day): 01 661 7211

Appendix G

Debriefing form (Hungarian Version)

Köszönöm hogy kitöltötte a kérdőívet!

Ha bármilyen kérdése van a tanulmánnyal vagy a kérdőívvel kapcsolatban, kérjük, vegye fel a kapcsolatot a kutatási vezetőmmel (Fearghal O'Brien) e-mailben (Fearghal.Obrien@ncirl.ie) (angol nyelven), vagy velem; Kovács Viviennel az x17145708@student.ncirl.ie e-mail címen.