Mental health stigma and gender disparity regarding attitudes toward seeking mental health treatment in Ireland.

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Abstract

Aims: The current study sought to provide a greater understanding of stigma and attitudes toward mental health services within an Irish context. This study examined how perceived public stigma and personal stigma may be related with lower intentions of seeking mental health treatment; if males reported higher perceived public stigma; and if females have more favourable attitudes toward mental health services. **Method:** An online survey was administered to participants (*n*= 445) through social media via a snowball sampling technique. The survey consisted of three scales; the Attitudes Toward Seeking Professional Psychological Help Scale, the Devaluation-Discrimination Scale and the Adapted Personal Stigma Scale. These scales consisted of likert-type statements by which the participant was asked to agree or disagree with. **Results:** Results indicated that both perceived public stigma and personal stigma were related with lower intentions with seeking mental health treatment. Both variables were found to predict treatment intentions to a statistically significant level. Additionally, females were found to have significantly more favourable attitudes toward utilising mental health services compared to males. However, contrary to previous literature, males were not found to have significantly higher levels of perceived public stigma. **Conclusion:** The findings of this study provide a greater insight to the stigmatising attitudes held among Irish adults. Future directions may benefit from the government adopting policies following international recommendations to tackle the issues stated within the study.

Introduction

Mental health is a global issue. Approximately 450 million people worldwide are suffering from some form of mental health issue, with anxiety and depression being the two most common mental health problems reported (Doherty et al., 2007). However, statistics seem to indicate that the worldwide occurrences of mental health issues are becoming increasingly prevalent (NIMH, 2019). Mental health disorders refer to a wide range of medical conditions which affect an individual's cognition which include their thoughts, feelings and mood, all of which affect the individual's behaviour (Bonney, 2008). Some commonly known mental health disorders include depression, anxiety, bipolar disorder, schizophrenia and obsessive compulsive disorder (WHO, 2019). Despite the high prevalence of mental health disorders, only a relatively small percentage of people seek professional psychological care in a timely manner (Berlund et al., 2005; Boerema et al., 2017; Wang, Lane, et al., 2005). There are various barriers that may prevent an individual from engaging in professional psychological care, such as attitudes, gender norms, financial cost and lack of awareness of treatment options (Mojtabai et al., 2011; Rickwood et al., 2007). Importantly, one of the most cited barriers within psychological research is the stigma towards mental health (Corrigan, 2004).

Stigma

Mental health disorders have been seen as a flaw and weakness in society from as far back as the Middle Ages (Overton & Medina, 2008) and these beliefs are still commonly held in modern times despite the ever increasing awareness of mental health (Corrigan & Watson, 2002). The stigmatisation of individuals suffering from mental health disorders is of particular

concern, as there is now a large body of literature displaying the consequential effects that stigma can have on the lives of those who suffer from mental health problems (Corrigan, 2000; Markowitz, 1998; World Health Organisation, WHO, 2013). Sociologist, Erving Goffman, is responsible for the origin of the term 'stigma' (Goffman, 1963). Goffman identified three types of stigma, one of which includes stigma associated with mental illness (Fitzpatrick, 2009). Various surveys taken by the general public have highlighted the stigma and commonly held negative attitudes surrounding mental illness which include; people who suffer from mental illness are incompetent, dangerous and should be locked up in mental institutions (Brockington et al., 1993; Mahsoon et al., 2020). The concept of stigma contains several components such as discrimination, stereotypes and prejudice (Haugen, McCrillis, Smid & Nijdam, 2017). Being discriminated against can result in further problems such as a low self-esteem and lack of confidence (Camp, Finlay & Lyons, 2002; Saadi & Ponce, 2020). These negative effects of the stigmatization of mental health may ruminate into other aspects of a mental illness sufferer's life such as becoming socially withdrawn (Parle, 2012) and social rejection (Scrambler, 2009).

In a social context, the subtypes of stigma, including perceived public stigma and personal stigma (Corrigan, 2004), may be influential. Perceived public stigma refers to an individual's awareness of negative beliefs and attitudes the general public holds with regard to mental health disorders (Eisenberg et al., 2009). Whereas, personal stigma, also known as self-stigma, refers to the individual's own personal negative and stigmatising beliefs towards their own mental health (Griffiths et al., 2004). Both public stigma and personal stigma can have far-reaching negative effects. The current literature seems to suggest that those who experience higher levels of both perceived public stigma and personal stigma are less likely to seek

professional psychological help (Mehta & Edwards, 2018). Negative attitudes toward mental health treatment was also associated with perceived public stigma (Pedersen & Paves, 2014). In contrast, those with lower levels of stigma were more likely to seek mental health treatment (Interian et al., 2010). This stigmatization surrounding mental illness can serve as a barrier to individuals seeking the help and medical aid they need. Stigma can also result in an individual concealing their mental disorder (Weiss, 2006) and in turn, lead to a higher risk of disability (Corrigan, 2000; Clement et al., 2015). Suicide is ranked as the leading cause of death among men, yet they are less likely to seek help for their mental health (Campbell, 2019). If an individual seeks treatment for their mental illness early enough, it can prevent further ill health; both mental health and physical health, and ultimately reduce the risk of suicide (Angermeyer, 2005).

Health Seeking Behaviour

Health seeking behaviour can be defined by the frequency of contact an individual has with their doctor or other medical professionals (Olawuyi & Adeoye, 2018). Using this as an indicator, findings within Europe indicate that men are much less likely to visit a medical professional than their female counterparts (Eurostat, 2002). Although there has been an increase in mental health literacy over the past few decades, the stigmatization and negative attitudes surrounding mental health has not lessened. Attitudes toward mental health help-seeking behaviour have been investigated previously within the literature (Roskar et al., 2017). One particular study found that the majority of participants (87.9%) showed a poor level of knowledge concerning the causes of mental health issues. This study also found that just under half of the participants (47.5%) would not want other people to know that they had a mental

illness. In addition to this, just over two-thirds of the participants reported negative attitudes toward seeking help for their mental health with males showing a significantly higher difference (Abolfotouh et al., 2019). This finding is further evidence for the hypothesis that males have less favourable attitudes towards the use of mental health services than females. In a similar manner, a study conducted by St Patrick's University Hospital in Dublin demonstrated that stigma is a major barrier when it comes to accessing treatment. The results from this study show that 40% of participants believed that undergoing treatment for mental health was seen as a sign of failure (Tinsley, 2009). The statistics highlight the stark reality of stigma echoed among various studies (Almeida, 2018). Additionally, there is significant evidence to suggest that stigma and negative attitudes surrounding mental health is still very prevalent in the modern world (Overton & Medina, 2008). In fact, a meta-analysis using Farina's and Fischer's Attitudes Toward Seeking Professional Psychological Help (ATSPPH-SF) scale to assess attitudes over the course of forty years found that attitudes have become increasingly more negative regarding psychological professional help (Picco et al., 2016).

However, the study conducted by St Patrick's University Hospital is one of very few Irish studies researching the stigma surrounding mental health and the subsequent treatment. Moreover, many of these studies only refer to particular countries, thus highlighting a gap within the literature when it comes to adult Irish populations. In addition to this, the vast majority of these studies focus on student and young adult populations (Silke, 2015), thus characteristics of these studies will affect applicability and generalisability to certain populations, demonstrating the need for further research on Irish adult populations due to the current limited literature on this population.

Although there has been an abundance of studies researching the impact of mental health disorders on an individual's day to day living (Corrigan, Druss & Perlick, 2014), it is only in recent times that researchers have begun researching the stigma of mental health help-seeking behaviours. A study conducted by Phelan et al., shows that family members of a person suffering from a mental illness often tend to hide and cover up the mental disorder from other people (Phelan et al., 1999). The findings from the majority of the aforementioned studies demonstrate that the stigma and negative attitudes surrounding mental illness is a serious obstacle for sufferers to partake in daily life and seek help for their struggles.

Gender differences

As previously mentioned, statistics indicate that suicide and depression are ranked as a leading cause of death among men worldwide (WHO, 2020). In fact, men die by suicide four times higher than their female counterparts (MHA, 2020). According to the Central Statistics Office in Ireland it has been reported that in recent years the number of deaths by suicide in Irish men has surpassed the number of road/car deaths. Ireland now has one of the highest rates of suicide in the world among men (DeBurca & Geoff, n.d.). This may, in part, be explained by the excessive difference between the number of males experiencing a mental health disorder and those seeking mental health treatment (Chatmon, 2020). Research suggests that even when males do seek treatment, it tends to be involuntarily at the point of crisis rather than something they actively seek out themselves (Seidler, et al., 2017). When treatment is delayed for mental health issues, several problems may arise, including developing comorbid disorders and the increased use of coercive methods in treatment (Williams, 2004).

Societal and gender norms guide socially acceptable behaviour (Cislaghi & Heise, 2019). A notable additional barrier to seeking mental health treatment among males is masculinity norms. Masculine norms are the societal expectations and beliefs about the way a man should behave and act within society (Miller, 2008). In Western societies, such as Ireland, masculinity is manifested by self-reliance, dominance (Iwamoto et al., 2012), stoic endurance of suffering and unwillingness to seek help (Latalova et al., 2014). Studies suggest that there is an effect of masculine norms on personal stigma which in turn results in the underutilisation of mental health services. Those suffering from mental disorders are seen as inferior and weaker for needing treatment (Vogel et al., 2011). In summary, the conformity to masculine norms has been found to be related increased mental health disorders and higher suicide rates (Pirkis et al., 2017; Milner et al., 2018) as well as lower use of mental health services (Milner et al., 2018).

In contrast, females have a higher prevalence of mental health disorders than their male counterparts. In fact, females are twice as likely as males to be diagnosed with depression within their lifetime (Salk et al., 2017). However, research has indicated that females have a more tolerant attitude towards both mental health and the utilisation of mental health services (Pederson & Paves, 2014). There have been some inconsistencies within psychological literature among female attitudes toward mental health with a handful of studies showing a non-significant effect with regard to attitudes toward mental health treatment, meaning that there was no difference between male and female attitudes (Gonzalez et al., 2009). In spite of a few inconsistencies, overall, the research suggests that there is a substantial difference among male and female attitudes toward professional psychological help. The literature suggests that gender differences in attitudes reflect greatly on whether an individual is likely to seek professional help

or not; by which the majority of studies suggest that females are more likely to see professional psychological help than males (Abrams, 2014; Gagné, Vasiliadis & Préville, 2014; Mackenzie, Gekoski & Knox, 2006)

Summary

While there have been many conflicting and contrasting results found within the literature regarding gender differences in attitudes toward seeking mental health treatment (Lally et al., 2013; (Holzinger et al., 2011), research seems to lean toward females having more favourable attitudes toward mental health treatment than their male counterparts (Campbell, 2019; Ewalds-Kvist, Högberg & Lützén, 2012). The findings from these various studies highlight the negative attitudes held by various populations across the globe which is linked to the widespread stigmatisation of mental illness. With females being more open and males being more opposed, it is clear that gender is a critical determinant as to whether an individual is going to seek professional help in a timely manner. As previously mentioned, several problems may arise due to delayed treatment for one's mental health. Thus, future research in this area is important as it is critical to tackle stigmatising attitudes which often act as a barrier to mental health services. If the results of this study replicate previous findings, the importance of strengthening research on the promotion of anti-stigma interventions and improving mental health literacy needs to be emphasised to better serve the needs of the Irish population. It may be somewhat beneficial to the public to be aware of the stark gender differences as a start to tackle the challenge of changing the negative perceptions of mental health. Education and knowledge are important factors in reducing stigma. The more people know about a topic, the less likely they are to hold negative attitudes or beliefs (HSE, 2007).

The Current Study

The purpose of this current study is to examine whether perceived public stigma and personal stigma act as barriers to Irish individuals accessing mental health treatment. In addition, the study aims to examine whether there is gender disparity regarding attitudes towards seeking mental health treatment. If the hypotheses are supported, it will be necessary for further future research to improve Ireland's mental health literacy and to beat the stigma surrounding mental health and treatment. This could potentially be tackled by introducing more up to date mental health campaigns, educational interventions and anti-stigma interventions that encourage equality between both physical health and mental health. A meta-analysis conducted in 2014 found that stigmatising attitudes decreased after educational interventions in relation to mental health were employed (Griffiths, 2014).

The research will examine the following three research questions: (1) Are perceived public stigma and personal stigma related with lower intentions of seeking mental health treatment?; (2) Do males have greater perceived public stigma than females?; and (3) Do females have more favourable attitudes toward mental health help seeking behaviours?. Apropos to previous research it is hypothesised that (1) Perceived public stigma and personal stigma are related with lower intentions of seeking mental health treatment; (2) Males will report greater perceived public stigma; and (3) Females will have more favourable attitudes toward mental health help seeking behaviours.

Methods

Participants

The research sample within the current study consisted of 441 participants. Participants were recruited using an opportunistic snowballing sampling technique. This was achieved by posting a brief description of this study and a link to the Google Forms survey to various social media sites including Facebook, Twitter, Instagram and LinkedIn. Additionally. Participants were encouraged to share the survey link with other individuals they believed to be eligible to participate. The Tabacknich & Fidell formula for calculating sample size (Tabacknich & Fidell, 2007) was a tool used to determine the sample size for this study in order to carry out a statistically powerful and accurate analysis. The formula is as follows: $N > 50 + 8m$ (N = number of participants and m = number of predictor variables). Individuals were not offered any type of incentives for participating.

The initial sample consisted of 449 participants, however four individuals were excluded from the analyses as they did not meet the inclusion criteria (in line with ethical considerations, participants were required to be eighteen years old or older). Furthermore, an additional four individuals were excluded from the analyses due to the nature of this study; the analyses were restricted to those who identified as either male or female, therefore anyone who clicked the 'other' option (i.e., non-binary) were excluded. Thus, the final sample for this study consisted of 441 participants (300 females and 140 males), with a mean age of 27.96 (SD = 152.06) ranging from 18 to 75.

Measures

Demographics. Participants were required to indicate their gender (female, male or other) and provide their age.

Attitude Towards Seeking Professional Psychological Help Scale. The 10-item Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH-SF) was used to determine the hypothesis that females will have more favourable attitudes regarding mental health treatment compared to their male counterparts. The internal reliability of this scale was 0.86 which indicates moderately good consistency within the scale (Fischer, 1970). An example of an item in this scale is as follows: *If I thought I was having a mental breakdown, my first thought would be to get professional attention*. The items in this scale are rated on a four point likert scale (agree, 3; partly agree, 2; partly disagree, 1; disagree, 0). The items 2, 4, 8, 9, 10 are reverse scored. When all the scores are summed together, higher scores will indicate more positive attitudes toward seeking professional treatment, whereas lower scores will be associated with more negative attitudes (Fischer and Farina, 1995). The Chronbach's alpha for this scale was .76 which indicates an acceptable internal reliability within the current sample.

Adapted Devaluation Discrimination Scale. The 12 item Adapted Devaluation Discrimination Scale was used in order to measure the participants' perceived public stigma. The Adapted Devaluation Discrimination Scale is a well validated study with an internal consistency of 0.86 to 0.88 in various samples including community samples and university samples (Lally et al., 2013). Participants were asked to agree or disagree with statements on a likert type scale. An

example of an item is as follows: *Most people would willingly accept a person who has received mental health treatment as a close friend.* All items could be answered as one of the following: strongly agree, 1; agree, 2; no opinion/neutral, 3; disagree, 4; strongly disagree, 5. Items 6, 9, 11 and 12 were reverse scored (i.e., strongly agree corresponds to five points instead of one point). Similar to the aforementioned ATSSPH-SF scale, once the scores are summed together, a higher score will indicate higher perceived public stigma whereas a lower score will indicate lower levels of perceived stigma. The Chronbach's alpha for this scale was (a = .89), this indicates a good internal reliability within the current sample.

Adapted Devaluation Discrimination Scale: Personal Stigma Scale. The Personal Stigma Scale is a variation of the previously used Devaluation Discrimination Scale. When used in another study, this scale demonstrated a moderately high internal consistency with a Cronbach's alpha of 0.78 (Eisenberg et al., 2009). The Personal Stigma Scale is used to measure the participants' personal stigma. It is a 4-item scale in which participants were asked to agree or disagree with the four statements. An example of an item in this scale is as follows: *I believe that a person who has received mental health treatment is just as trustworthy as the average person.* All items could be answered as one of the following: strongly agree, 1; agree, 2; no opinion/neutral, 3; disagree, 4; strongly disagree, 5. Items 3 and four were reverse scored. The Chronbach's alpha for this scale was (a = .75), this indicates an acceptable internal reliability within the current sample.

Design

The present study is a cross sectional research design as all the obtained data was collected at one specific point in time. The current study also adopted a quantitative approach, employing survey research to collect the data. A standard multiple regression was conducted in order to test the first hypothesis. This contained two predictor variables (PV's), perceived public stigma and personal stigma. The criterion variable (CV) was attitudes toward seeking mental health treatment. Independent t-tests were conducted to assess the second and third hypotheses. This examined the differences between 1) males and females perceived public stigma and 2) males and females attitudes toward seeking mental health treatment.

Procedure

The data for the current study was collected through an online survey, using Google Forms. The survey used was an anonymous, self-report questionnaire which was uploaded onto several social media platforms including Facebook, Twitter, Instagram and WhatsApp. Additionally, some participants were recruited by friends who had already completed the online survey and had sent the link on to potential participants who met the inclusion criteria. When participants had decided to participate in the current study, they were firstly provided with an information sheet that contained all the necessary information about what was involved in participating in the study as well as any possible risks or benefits of taking part (see appendix 2). Participants were also informed here that they had the right to withdraw from the study at any point up until submission, without penalty. Participants were then asked to click the "yes" box

which indicated that they have read for and understand the terms and agree to give consent to take part in the survey. The survey was completed by the participants within their own time and it took an estimated 5 to 10 minutes to complete.

The survey consisted of three sections. The first section of the survey included 12 likert style statements which were used in order to assess perceived public stigma. The second section of the survey was the Personal Stigma Scale (Lally et al., 2013) which is an adapted version of the Discrimination-Devaluation Scale used to measure personal stigma. The third section of the survey was the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Farina, 1995) and this was a 10-item likert scale survey which measured attitudes toward seeking treatment regarding mental health issues. Upon completion of this survey, participants were provided with a debrief form which contained my supervisor's and my own contact details alongside helpline contact details encouraging participants to seek help if they experienced any distress upon completion of the survey (see appendix 3).

All of the data was collected in accordance with the ethical guidelines of NCI. Within the information sheet, all risks and benefits of participating in this study were clearly outlined and there was no incentive for individuals to take part. All participants were required to and provided informed consent before participating. Additionally, contact details for helplines such as the Samaritans and Pieta House were provided in the debrief form should distress arise in any participant as a result of taking part in the study (see appendix 3).

Results

Descriptive Statistics

The sample consisted of 441 participants (n = 441). Descriptive statistics were performed for all the variables including age, perceived public stigma, personal stigma and attitudes. Means (M), standard deviations (SD), medians (MD), and range were obtained during analysis, along with tests of normality. Preliminary analysis performed on the data set indicated that all continuous variables followed the assumptions of normality. The sample consisted of 300 (67.4%) females, 140 (31.5%) males and 5 (1.1%) of individuals identifying as 'other' (i.e., non-binary or transgender). The results for all the continuous variables (age, perceived public stigma and personal stigma) are presented below in Table 1.

Table 1

Descriptive statistics for Age, Perceived Public Stigma, Personal Stigma and Attitudes.

Variable	*n*	*M* [95% CI]	*SD*	Range
Age	445	27.96 [26.82, 29.11]	12.33	18-75
Perceived Public Stigma	445	32.66 [31.83, 33.47]	8.79	12-58
Personal Stigma	445	6.13 [5.90, 6.35]	2.34	4-18
Attitudes	445	19.57 [19.06, 20.06]	5.27	1-30

Inferential Statistics

Hypothesis 1

A standard multiple regression analysis was performed to determine how well attitudes to mental health treatment could be explained by two variables including perceived public stigma and personal stigma.

Preliminary analyses were conducted to ensure no violation of assumptions of normality, linearity, and homoscedasticity. The correlations between the predictor variables and the criterion variable included in the study were examined (see Table 2 for full details). All two of the predictor variables were significantly correlated with the criterion variable, and these significant effects ranged from r = -.31 (perceived public attitudes) to r = -.16 (personal stigma). The correlations between the predictor variables were also assessed with r values. Tests for multicollinearity also indicated that all Tolerance and VIF values were in an acceptable range. These results indicate that there was no violation of the assumption of multicollinearity and that the data was suitable for examination through multiple linear regression analysis.

Table 2

Correlations between variables included in the model

Variable	1.	2.	3.
1. Attitudes	-		
2. Perceived Public Stigma	-.16	-	
3. Personal Stigma	-.31	.21	-

Since no *a priori* hypotheses had been made to determine the order of entry of the predictor variables, a direct method was used for the analysis. The two predictor variables explained 10.7% of variance in Attitudes Toward Mental Health Treatment levels ($F(2, 441) = 26.34$, $p < .001$). All two of the variables were found to uniquely predict Attitudes Toward Mental Health Treatment levels to a statistically significant level: perceived public stigma ($\beta = -.10$, $p = .029$ and personal stigma ($\beta = -.29$, $p < .001$) (see Table 3 for full details).

Table 3

Multiple regression model predicting Attitudes Toward Mental Health Treatment scores

Variable	R^2	B	SE	β	*t*	*p*
Model	**.16*** **					
Perceived Public Stigma		-.06	.03	-.10	-2.19	.029
Personal Stigma		-.64	.10	-.29	-6.31	.000

Note: *** $p < .001$

Hypothesis 2

An independent samples t-test was conducted to compare levels of perceived public stigma between males and females. There was no significant difference in scores, with males (M = 33.16, SD = 9.13), showing no significant difference than females (M = 32.23, SD = 8.59), $t(437) = -1.03$, $p = .30$, two tailed.

Hypothesis 3

An independent samples t-test was conducted to compare levels of attitudes toward seeking mental health treatment between males and females. There was a significant difference in scores, with males (M =18.16 , SD = 6.19), scoring significantly lower than females (M = 20.20, SD = 4.60), t(438) = 3.87, p = .00, two tailed. The magnitude of the differences in means (mean difference = 2.05, 95% CI: .88 to 3.20) was small (Cohen's d = .37).

Discussion

The purpose of this current research study was to determine whether the three aforementioned hypotheses were supported by the data collected within an Irish context. It was hypothesised, from prior literature, that (H1) there would be a relationship between perceived public stigma and personal stigma with lower intentions of seeking mental health treatment. This was explored using a standard multiple regression analysis; from this it was found that both perceived public stigma and personal stigma are related with lower intentions of seeking treatment. Overall, the model was significant, with the two predictor variables being significant predictors of this particular health seeking behaviour. Consistent with numerous studies (Nearchou et al., 2018; Wu et al., 2017), these findings support the existing literature that both perceived public stigma and personal stigma are powerful factors that dissuade intentions of seeking mental health treatment.

The second research question hypothesised that males will report greater perceived public stigma when compared to their female counterparts. This was explored using an independent samples t-test; from this it was found that there was no significant difference between males and females regarding perceived public stigma. The results from this analysis conflicts with prior research that suggests males often possess significantly higher levels of perceived public stigma (Mason et al., 2013; Mojtabai et al., 2011). However, the conflicting results yielded from this study may be due to methodological differences whereby the aforementioned studies often used college, university and young adult populations unlike the current study which sought to examine the Irish adult population. Additionally, previous studies have used a combination of different

scales to measure stigma such as the Self-Stigma of Seeking Help Scale (Vogel et al., 2006), the Peer Mental Health Stigmatisation Scale (McKeague et al., 2015) and the Prejudice towards People with Mental Illness Scale (Kenny et al., 2018). Thus, the use of different scales might potentially lead to different results due to differences in reliability and validity.

The third and final hypothesis, from prior research, hypothesised that females would have more favourable attitudes toward seeking treatment for their mental health compared to their male counterparts. This hypothesis was explored using an independent samples t-test. The findings from this analysis supported the hypothesis, showing that females were significantly more likely to seek treatment regarding their mental health compared to the male participants. Overall, these findings contribute to the previous body of literature, demonstrating that males are less willing to seek treatment than females.

The current study sought to provide greater understanding to attitudes concerning mental health stigma and attitudes toward seeking professional psychological help within an Irish population. As previously mentioned, both hypothesis one and hypothesis three were supported, meaning that the findings are consistent with and provide support to previous research which has suggested perceived public stigma, personal stigma and being male are all factors related with lower intentions of seeking treatment and having less favourable attitudes toward such treatment. Despite these hypotheses being supported by the results of this study, the findings are quite concerning nonetheless. Physical health and mental health are equally as important, however, it is evident that stigmatising attitudes towards mental health treatment persist among the Irish population. The implications of such attitudes has resulted in the underutilisation of mental

health services particularly for males and individuals with high levels of public and personal stigma. The literature suggests that individuals with untreated mental illness are at high risk for multiple negative outcomes which may profoundly affect not only themselves, but the people around them (Carroll, 2016). Some of these negative outcomes include worsening mental health problems, physical health problems such as an increased risk for stroke and heart attack, homelessness and can sometimes result in suicide (Stuart, 2016).

In addition to this, there could be multiple factors contributing to males having less favourable attitudes toward utilising mental health services than their female counterparts. Learned cultural attitudes, traditional masculine norms and what is commonly known as 'toxic masculinity' can often control an individual's emotions which in turn may have influenced the male participants' to report more stigmatising attitudes. Traditional masculine norms are often defined as meeting the societal expectations expected in men and manhood within a given culture (Milner et al., 2018). Toxic masculinity closely aligns with traditional masculine norms whereby certain behaviours such as crying (i.e., "boys don't cry") are frowned upon as they are seen to denounce the dominance expected in males (Milner et al., 2019). However, it is not clear as to how the male participants in this study responded to this survey; had they only considered other males like themselves in their responses and attitudes or had they also considered females in their responses. Moreover, this study does not take into account external factors that may contribute to less favourable attitudes. It is important to take into account that barriers extend beyond being male and perceived public and personal stigma. Other prevalent barriers to seeking

treatment also include low mental health literacy, financial costs and beliefs that help is not needed (Eisenberg et al., 2012).

On the other hand, contrary to the literature, we did not find that (H2) males have greater perceived public stigma. There was no significant difference between males and females with regard to public stigma, thus, resulting in the rejection of the second hypothesis. Although this study did not replicate results from previous studies, the results from this study are somewhat more promising, suggesting that Irish males do not have high levels of perceived public stigma. As a consequence, it would seem that neither males or females have a misperception of how individuals may perceive them seeking treatment. In other words, the general consensus toward seeking professional psychological help may not be as negative as one believes. Previous research has demonstrated that concerns about being viewed and treated negatively by one's family and friends are notable deterrents to seeking mental health treatment (Mason et al., 2013; Mojtabai et al., 2011). After interpretation of statistical analyses for hypothesis two, the results could be inferred as superior and more promising than previous results. Nonetheless, the results are only generalisable to an Irish adult population and further research may be needed to replicate such results for other populations.

Limitations & Strengths

Some study limitations merit comment. The current study was a cross sectional research design that relied entirely on survey data. Future research designs may benefit from the inclusion of a qualitative approach to understanding participants' perceptions and concerns regarding mental health stigma and attitudes toward mental health treatment. In addition to this, when

researching the literature, many studies also included mental health literacy scales in their research. Consequently, results from these studies suggest that low mental health literacy was another contributing factor to the underutilisation of mental health services (Milner et al., 2019; Thai et al., 2020). However, the current study did not take mental health literacy scores into account when examining attitudes toward mental health services.

Moreover, due to the cross sectional nature of this study, no causal relationships can be inferred. To progress from this study, future research would benefit from using a longitudinal study to better infer causation. Additionally, although the sample ranged from ages 18 to 75, the sample within this study was predominantly younger adults, and thus, would not be entirely generalisable to the older population. The current worldwide coronavirus pandemic should also be taken into consideration. Due to restrictions within Ireland, individuals were only able to virtually participate which meant access to wifi, a smart phone or laptop was necessary, and thus, computer/technology illiterate individuals were unable to partake. It should be noted that there was a slight gender bias toward females in the sample for the current study; 300 (67.4%) females and 140 (31.5%) males. However, this aligns with current research which states that females are much more likely to partake in surveys, questionnaires and experiments compared to males (Daly et al., 2011).

Nonetheless, despite the aforementioned limitations, the current study also has its strengths. Firstly, in spite of the gender bias, by using a sample size formula ($N > 50 + 8m$), the current study was able to exceed the number of required participants (Tabachnick & Fidell, 2007). The benefits of a large sample size include the results being more representative of the

population, limits the influence of outliers and is also a way to combat uncertainty (Biau, Kernéis, & Porcher, 2008). As previously mentioned, the second hypothesis was rejected, however, the results are much more promising than expected. Results show that there is no difference or significant high levels of perceived public stigma in both males and females. This is a strength as it is a step in the right direction towards de-stigmatising mental health and mental health services. Lastly, due to the anonymous and confidential nature of the survey for this study, it is likely that the social desirability bias did not play much part in participants' answers as studies have shown that anonymity tends to reduce social desirability in participant's responses (Joinson, 1999).

Future Research/Directions

Knowledge in this field, particularly in an Irish context, is quite limited. However, it is evident from the current study that understanding stigma is integral to reduce its negative impact on help seeking behaviours and treatment engagement. There is no doubt that some of the findings of this study devalues the mentally ill and mental health services to a certain extent due to the stigma held. However, as previously mentioned, stigma is not the only barrier to those seeking mental health treatment, with accessibility and financial cost being other cited barriers. Mental health services are not seen as a key priority to the Irish government, with only 5.2% of the overall health budget being allocated to the mental health sector (Fagan, 2020). According to Slainte Care, 10% of the health budget should be allocated to the mental health sector, thus, the 2020 Irish budget demonstrates that Ireland is below international recommendations (HSE, 2019).

Moving forward, given the magnitude of challenges posed by mental health stigma and other barriers, it is evident that there needs to be sufficient effort to fund research to provide robust evidence to support policy decisions on investment in the mental health sector. An example of emerging policy framework includes the World Health Organisation Mental Health Action Plan which aims to "promote mental health, reduce stigmatisation and promote human rights across the lifespan" (WHO, 2013). Ideally, Ireland needs to follow suit on these international recommendations. In addition to this, in future work, investigating the effectiveness of mental health stigma campaigns and interventions might prove important. Currently, there is limited research done on the effectiveness of such campaigns and interventions in Irish populations. However, other international studies have had promising results, suggesting that anti-stigma interventions had reduced stigmatising attitudes after a four week follow up (Mehta et al., 2015). Additionally, such interventions had seen a reduction in both perceived public stigma and personal stigma (Waqas et al., 2020). However, more research is necessary to investigate the longevity of attitude changes after interventions have ended as there is not enough research to determine whether these attitude changes remain long term.

Lastly, the current study used a cross sectional design and so, due to the cross sectional nature of this study, no causal relationships can be inferred. To progress from this study, future research would benefit from using a longitudinal study to better infer causation. As well as that, future research might also include longitudinal studies to investigate the long term effects of stigmatising attitudes and to examine whether these attitudes change throughout the lifespan.

Conclusion

This study has contributed to mental health stigma research focusing on attitudes and gender disparity. Two of the three initial hypotheses had significant results giving further evidence to the literature that males have less favourable attitudes to seeking mental health treatment and that both perceived public stigma and personal stigma act as significant barriers to seeking treatment. In spite of the second hypothesis being rejected, the findings were in fact more promising than anticipated; neither males or females have high levels of perceived public stigma. While this cross sectional study is one of the few studies investigating mental health stigma and gender disparity within an Irish context, future studies may benefit from using longitudinal data to determine if these results stay consistent throughout an individual's lifespan or if anti-stigma interventions and improved mental health literacy can influence these stigmatising attitudes and beliefs held within Ireland. Moreover, the broader implications of this study are perhaps how the Irish government could adopt newer policies in alignment with international recommendations and allocate more monies to the mental health sector in order to tackle these current issues.

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Appendices

Appendix 1

Attitudes Toward Seeking Professional Psychological Help Scale

Instructions:
Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

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

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help
5. I would want to get psychological help if I were worried or upset for a long period of time
6. I might want to have psychological counselling in the future
7. A person with an emotional problem is not likely to solve it alone; they are likely it solve it with professional help
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me
9. A person should work out their problems; getting psychological counselling would be a last resort
10. Personal and emotional troubles, like many things, tend to work out by themselves

Scoring:
Reverse score items 2, 4, 8, 9 and 10. Then add up the ratings to get a sum. Higher scores indicate more positive attitudes toward seeking professional help.

Appendix 2

Study Information Sheet

Participant Information Leaflet

Title of study:

Mental health stigma and gender disparity in attitudes toward seeking mental health treatment in Ireland.

You are being invited to take part in a research study. Before deciding whether to take part, please take the time to read this document which explains why the research is being done and what it would involve for you. If you have any questions about the information provided, please do not hesitate to contact me using the details at the end of this leaflet.

What is this study about?

I am a final year student in the BA Psychology programme at National College of Ireland. As part of my degree I must carry out an independent research project.

For my project, I aim to investigate mental health stigma and how gender differences influence people to seek mental health treatment among Irish adults/adults living in Ireland. The study involves a quick online questionnaire which you can take part if you wish.

Will taking part be confidential and what will happen to my data?

The questionnaires are anonymous, it is not possible to identify a participant based on their responses to the questionnaire. All data collected for the study will be treated in the strictest confidence. Responses to the questionnaire will be stored securely in a password protected/encrypted file on the researcher's computer. Only the researcher and their supervisor will have access to the data. Data will be retained for five years in accordance with the NCI data retention policy.

What will happen to the results of the study?

The results of the study will be presented in my final dissertation, which will be submitted to National College of Ireland.

Who should you contact for information?

If you have any further questions regarding the study or concerns, please feel free to contact the researcher, Aisling Mullally via email: x18731285@student.ncirl.ie or my thesis supervisor Aine Maguire (afmaguir@tcd.ie).

What will taking part in the study involve?

If you decide to take part, there will be likert-type statements on three different scales where you will be asked to agree or disagree with each statement. Upon completion of the study, you will be encouraged to send the study link to other individuals who meet the inclusion criteria of the study. However, this is completely voluntary.

You can take part in this study if you are aged 18 and live in Ireland.

You cannot take part if you are under the age of 18 or do not live in Ireland/are not an Irish citizen.

You have been invited to take part in this study as you meet the criteria of this study and we would like to hear your response to the questionnaires provided.

Do I have to take part?

No. Participation is voluntary; you do not have to take part, and a decision not to take part will have no consequences for you. If you do decide to take part, you can withdraw from participation at any time before you submit your response. However, it will not be possible to withdraw your responses once you have submitted due to participant confidentiality.

What are the possible risks and benefits of taking part?

There are no direct benefits to you for taking part in this research. However, the information gathered will contribute to research that helps us to understand our research question.

There is a small risk that some of the questions and statements contained within this survey may cause minor distress for some participants. If you experience this, you are free to discontinue and exit the survey. Contact for relevant support services are also provided at the end of the questionnaire.

Appendix 3

Debrief form

Debrief

Thank you for participating as a research participant in the present study concerning your attitude towards seeking professional psychological help in Ireland.

If you know or are aware of any friends, family or acquaintances who fit the inclusion criteria for this study (Irish and above the age of eighteen), we encourage you to ask them to take part in this study. We request that you do not discuss the contents of the questionnaire with them until after they have completed it to ensure no biases occur within their responses. Your cooperation and participation is greatly appreciated.

If you have any further questions regarding the current study, please feel free to contact the research via email: x18731285@student.ncirl.ie, or the thesis supervisor Aine Maguire: afmaguir@tcd.ie

In the event that you feel psychological distress following by taking part in this study, we encourage you to use one of these avenues if this case arises. Pieta House: (01) 458 5490 or Aware: 1800 80 48 48.

Again, thank you for your participation.

Appendix 4

Adapted Devaluation Discrimination scale

Please indicate whether you agree or disagree with the following statements.

1. Most people would willingly accept a person who has received mental health treatment as a close friend.
2. Most people believe that a person who has received mental health treatment is just as intelligent as the average person.
3. Most people believe that a person who has received mental health treatment is just as trustworthy as the average person.
4. Most people would accept a fully recovered person who has received mental health treatment as a teacher of young children in a public school.

5. Most people feel that receiving mental health treatment is a sign of personal failure*.
6. Most people would not hire a person who has received mental health treatment to take care of their children, even if they had been well for some time*.
7. Most people would think less of a person who has received mental health treatment*.
8. Most employers will hire a person who has received mental health treatment if he/she is qualified for the job.
9. Most employers will pass over the application of a person who has received mental health treatment in the favour of another applicant.*
10. Most people in my community would treat a person who has received mental health treatment just as they would treat anybody else.
11. Most people would be reluctant to date someone who has received mental health treatment*.
12. Once they know a person was in a mental hospital, most people will take his opinions less seriously*.

All items above are answered from: Strongly agree, 1; Agree, 2; no opinion, 3; disagree, 4; strongly disagree, 5.
Items with a '*' are reversed scored, e.g., 'Strongly agree' corresponds to five points instead of one point.

Appendix 5

Personal Stigma Scale

Personal Stigma Scale

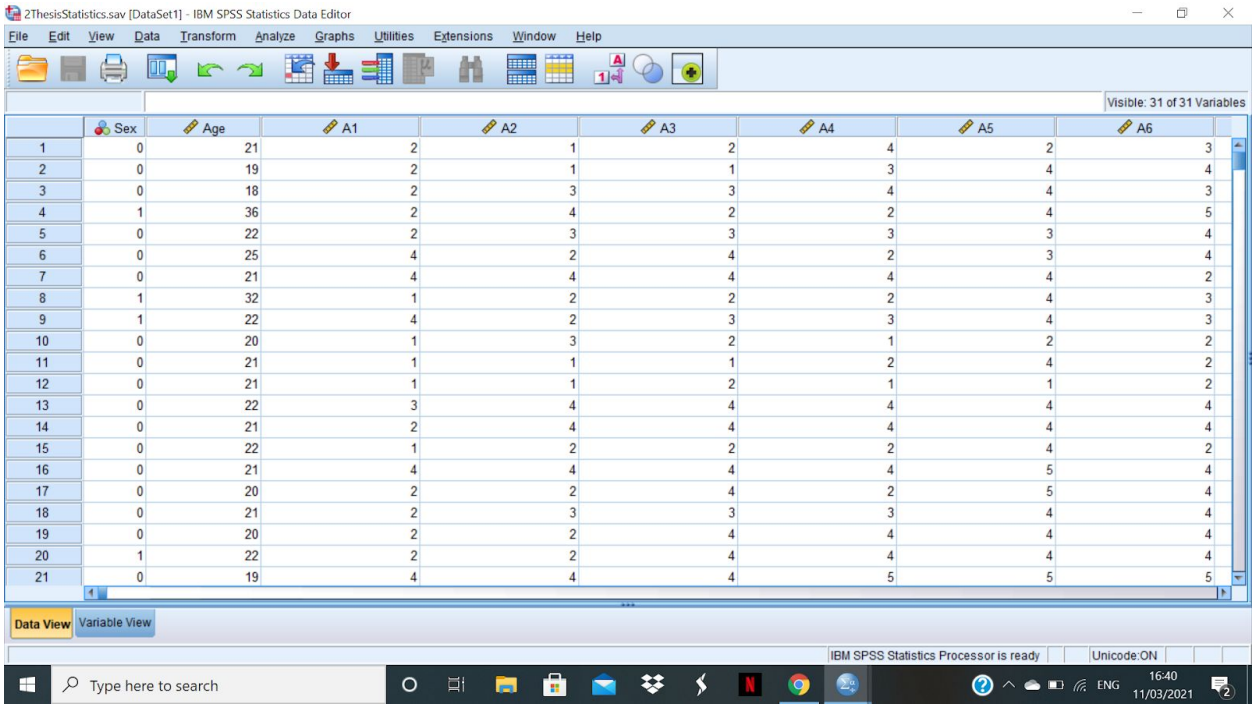
Please indicate whether you agree or disagree with the following statements.

1. I would willingly accept a person who has received mental health treatment as a close friend.
2. I believe that a person who has received mental health treatment is just as trustworthy as the average person.
3. I would think less of a person who has received mental health treatment*.
4. I would be reluctant to date someone who has received mental health treatment*.

All items above are answered from: Strongly agree, 1; Agree, 2; no opinion, 3; disagree, 4; strongly disagree, 5.
Items with a '*' are reversed scored, e.g., 'Strongly agree' corresponds to five points instead of one point.

Appendix 6

SPSS Data



Appendix 7

SPSS Output Log