The relationship between demographic factors and familiarity and attitudes towards mental illness

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Thesis Presented in Partial Fulfilment of the Requirements for the Bachelor of Arts (Hons) Degree in Psychology, Submitted to the National College of Ireland, March 2025

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Acknowledgement

I would like to express my sincere gratitude to my thesis supervisor Dr Lynn Farrell for the patient and friendly support, knowledge and guidance provided throughout this project. I would like to thank all the staff from the library and math support at NCI who have guided me along the way. I would also like to thank all the participants who participated in this study. Finally, I would like to thank my mother and friends for their continued support and encouragement.

Abstract

This study investigates the relationship between demographic factors (gender, age, socioeconomic status, education level) and familiarity and attitudes towards mental illness and borderline personality disorder in Ireland. Findings indicated that gender and familiarity were significant predictors, with females displaying more negative attitudes compared to males. Higher familiarity was unexpectedly linked to more negative attitudes. SES and education level were not statistically significant predictors, though individuals with higher SES showed more negative attitudes towards general mental illness, while those with lower SES held more negative views on borderline personality disorder. Age was also non-significant, though older adults showed a trend towards more negative attitudes. Limitations include a small sample size (N=92) and an overrepresentation of younger participants and individuals with low familiarity. These findings highlight the need for targeted stigma-reduction interventions and further research on females and individuals with high familiarty towards mental illness.

Keywords: negative attitudes, stigma, demographic factors, mental illness

Table of Contents

Introduction

Mental health is a spectrum (Adam, 2013). Someone may be on the positive, in-between or negative side of the spectrum. However, it might change over time due to our experiences (Wu et al., 2023). Undoubtedly, mental illness is a widespread public health issue that impacts people in all demographic categories, yet attitudes towards mental illness can vary significantly across different demographic factors (Gonzalez et al., 2009). Studies have shown that not only the general public hold negative attitudes towards mental illness, but also health professionals hold similar negative attitudes (Crisp et al., 2000; Wu et al., 2020). Clement et al. (2015) suggested that stigma associated with mental illness has a small to moderate negative effect on people seeking help for mental illness. These attitudes influence public stigma and the efficacy of mental health interventions, which emphasises the importance of gaining a deeper insight into the factors that predict attitudes towards mental health (Corrigan & Watson, 2002).

Visible efforts are being made in Ireland to lessen stigma and promote mental well-being, as mental health interest has grown in society and policy attention. According to the survey by St Patrick's Mental Health Services (2022), the percentage of people who received treatment for a mental health issue during the previous five years increased from 26% in 2018 to 39% in 2022. These findings also show that more people are seeking mental health care, which may indicate that stigma is no longer as significant as it once was. The Irish government seeks to strengthen mental health support services and lessen stigma by promoting programs like 'Sharing the Vision: A Mental Health Policy for Everyone' that covers stakeholders such as children, young people, and the elderly (Department of Health, 2020). Despite growing public awareness and knowledge of mental disease, attitudes towards persons with mental illnesses are yet far from ideal (Schomerus et al., 2012). Additionally, a 30-year study period (1990-2020) study indicated that stigma for acute schizophrenia has

increased in Germany, while depression has only slightly improved, which suggests the perceived normalisation of mental health illness does not appear to successfully change the negative attitudes towards severe mentally ill people (Schomerus et al., 2022). Therefore, it is extremely important to examine the predictors of negative attitudes towards mental illness.

Demographics

Age

Age and gender are the most common demographic factors and have been studied numerous times over the years. Yet the results show inconsistency. Interestingly, Jorm and Wright (2008) found a complex pattern in how age relates to different types of stigma. As people age, stigma as 'dangerous/unpredictable', 'stigma perceived in others' and 'reluctance to disclose' tend to increase. However, 'social distance' and 'weak, not sick' are reduced with age. Many findings suggested that older people hold more negative attitudes than younger people (Conner et al., 2010; Ewalds-Kvist et al., 2012). However, in recent years, studies indicated that younger people expressed greater degrees of stigma towards the vignette characters displaying symptoms of mental illness compared to older people. (Clarkin et al., 2024). In addition, it highlighted that it is due to younger people holding 'mental illness as personal weakness' beliefs. These results align with research in different contexts, such as in Ireland (Lally et al., 2013), Sweden (Mackenzie et al., 2019) and among medical practitioners (Wijeratne et al., 2021).

Gender

Gender has been extensively studied over the years. Similar to age, the results also appear inconsistent. Gender-based differences can be attributed to various factors, including biological, psychosocial, epidemiological, and global perspectives, which are also referred to as genetic, personality, and population-based risk factors (Afifi, 2007). A mixed-methods study by Keating (2010) in Ireland indicated that women generally held more negative

attitudes towards mental health compared to men. This study stated that male participants were more likely to hire individuals with mental health conditions and to feel more comfortable working with people with mental health conditions than female participants. This finding aligns with another study showing that women hold a more fearful and avoidant attitude towards those with mental illness compared to men (Ewalds-Kvist et al., 2012). However, in contrast to these findings, O'Brien's (2016) findings reported no significant differences between males and females in attitudes towards mental illness. Conversely, Jorm and Wright (2008) indicated that consistent with several studies, male participants displayed higher levels of stigma in terms of 'social distance', 'dangerous/unpredictable', 'weak not sick', 'stigma perceived in others' and 'reluctance to disclose' (e.g., Dolphin & Hennessy, 2016; Latalova et al., 2014; McKenzie et al., 2022; Wang et al., 2007). However, male participants were less likely to recognise stigma in others, which may be linked to their lack of information and understanding of mental health issues in general (Cotton et al., 2006). This study highlights how mental health stigma can serve as a barrier to help-seeking behaviour, particularly for men who are already less inclined to seek help due to societal masculine norms and self-reliance (Seidler et al., 2016). Failing to recognise stigma can result in an even lower likelihood of men seeking help, which is especially concerning given the high rates of suicide, drug use, and alcohol consumption among Irish males (Cleary, 2012).

Edu level

Multiple studies indicated that a higher education level was correlated with those who hold more positive attitudes towards individuals with mental health conditions (Bedaso et al., 2016; Lanfredi et al., 2019). These studies partially align with the findings of Reta et al. (2016), which indicated that a higher level of education is linked to higher social restrictiveness compared to a lower level of education. Lanfredi et al. (2019) also suggested that the willingness to interact with individuals with mental illness and help-seeking

intentions were the primary factors contributing to positive changes in general attitudes towards mental illness. A lower education level was significantly associated with negative attitudes towards mental illness (Cook & Wang, 2010; Yuan et al., 2016). However, Reta et al. (2016) contradicted this finding and suggested that individuals with a lower education level have a stronger belief in community mental health than those with a higher education level. There were few studies indicated that there are no statistically significant differences between education levels and attitudes towards mental illness (Li et al., 2018). However, research in Ireland highlighted that people with a second-degree education hold a more positive attitude towards mental health than people with no formal education or third-degree education (Keating, 2010). These findings explain higher education levels do not necessarily equal more positive attitudes towards mental illness. An interesting study by Al Omari et al. (2022) indicated a strong positive association between knowledge and positive attitudes among students but a modest negative association among teachers by examining and comparing knowledge and attitudes towards mental illness among secondary school students and teachers. This outcome was similar to the previous findings but highlighted the importance of early mental health education and training that is possible to reduce negative attitudes towards mental illness.

Socioeconomic status (SES)

SES is an indicator of an individual's combined economic and social position that is positively associated with improved health. There are three common factors, including education, income, and occupation (Baker, 2014). A paper in Ireland suggested that participants who had higher SES were more likely to identify schizophrenia symptoms (O'Keeffe et al., 2015). Similarly, another study supported that higher SES individuals tend to hold more positive perceptions about mental illness and are more likely to engage in active learning, which leads to destigmatising mental health issues (Huang et al., 2025). However, a

study on drug addiction demonstrated that individuals with a low income hold a lower stigma level towards hypothetical individuals with an opioid addiction in terms of dangerousness (Goodyear & Chavanne, 2019). This result may be due to drug abuse being highest among individuals living below the poverty line, which indicates higher familiarity. However, some studies suggested that other mental illnesses are perceived differently than drug addiction, such as suicide and depression (Park et al., 2015) and ADHD (Owens, 2020). For example, a British study demonstrated a link between greater SES and stigma towards schizophrenia (Holman, 2014). This aligns with previous studies indicating a correlation between income and negative attitudes towards mental illnesses. Conversely, Yuan et al. (2016) suggested inconsistent results that people who have a relatively low monthly income show a more negative attitude towards mental illness. Surprisingly, unemployed or unable-to-work participants were associated with more positive attitudes towards mental illness. Foster et al. (2018) partially supported that higher subjective SES was associated with decreased empathy and knowledge of mental illness. On the contrary, a more recent study indicated that a strong correlation was found between SES and having trouble communicating with severely mentally ill patients (Pybus et al., 2023). For every increase in financial difficulty, there was a gradient of decreasing tolerance.

The findings in this SES and attitudes towards mental illness are inconsistent. There has been a scarcity of studies of SES in the Irish context in recent years. Given Ireland's socioeconomic inequalities in mental health care, knowing how SES influences attitudes towards mental illness is important (Putra et al., 2024).

Familiarity / Piror exposure

It has been demonstrated that familiarity with mental illness, whether from personally dealing with mental issues or knowing someone, could have impacted, lessened stigma and increased empathy (Alexander & Link, 2003; Corrigan & Watson, 2002; Couture & Penn,

2003). Corrigan et al. (2001) proposed that people were less likely to believe individuals with mental illness were dangerous and socially distance from them if they were somewhat familiar with serious mental illness. This result indicated a reverse association between familiarity and the stigma towards mental illness due to familiarity reducing fear. Similar studies conducted on different populations also indicated that increased familiarity with mental illness reduces the likelihood of endorsing negative attitudes, such as studies conducted on medical staff and students (Arvaniti et al., 2008), Nigeria (Adewuya & Makanjuola, 2008), schizophrenia and major depression (Angermeyer et al., 2004), eating disorder (Brelet et al., 2021) and China (Li et al., 2024). However, some studies found no significant correlation between familiarity with autism and bipolar disorders (Durand-Zaleski et al., 2012). These results may be due to differences in how different mental disorders were understood and perceived, which suggests that familiarity may not necessarily lead to reduced stigma across all mental disorders.

While multiple studies suggest higher familiarity was related to less negative attitudes, there were some studies which contradict this finding. Some studies demonstrated that higher familiarity (family and service providers) is not necessarily related to lower levels of stigma (Corrigan & Nieweglowski, 2019; Koschorke et al., 2021). This study suggested that intimate family (parents or spouse) may feel burdened living with an individual with mental illness and affected by associative stigma (Corrigan & Nieweglowski, 2019). Moreover, extremely high familiarity and family burden may cause decreased quality of life or emotional drain or stress (Caqueo-Urízar et al., 2014; Ivarsson et al., 2004; Sales, 2003; van der Sanden et al., 2016). Therefore, it caused negative attitudes towards mental illness. Similarly, Fang et al. (2020) suggested family caregivers with higher familiarity may display severe negative attitudes and discriminatory behaviours towards people with mental illness. These findings may be attributed to the finding of Ran et al. (2021) that there was a strong link between the

reduced stigma of mental illness and contact quality, which suggests positive interactions with individuals with mental illness can improve attitudes and vice versa. An Irish pilot study suggested that individuals with a personal history of schizophrenia, bipolar disorder, or autism hold more positive attitudes and behaviours towards these groups (Hargreaves et al., 2024). Since this study consists of the majority of the findings in other countries, therefore personal familiarity may be considered an important factor for reducing negative attitudes towards mental illness in Ireland. To conclude, the majority of the existing studies would agree that greater familiarity was more likely to reduce negative attitudes (Angermeyer et al., 2004; Potts & Henderson, 2020; Steiger et al., 2022) and high familiarity lead to negative attitudes mostly occurred when family burden was involved, as previous literature mentioned.

Borderline personality disorder

According to Bourke et al. (2018), there were 2.87 million individuals with Borderline Personality Disorder (BPD) in Ireland. BPD is one of the most stigmatised mental health illnesses, which often receives negative attitudes from the general population and even healthcare professionals (Aviram et al., 2006; McDonagh et al., 2020). Individuals with BPD are typically seen as manipulative, attention-seeking, or difficult to treat and are often more negatively stigmatised than other mental illnesses such as schizophrenia or depression (Aviram et al., 2006; Klein et al., 2022; Markham & Trower, 2003; Sheehan et al., 2016). Such negative attitudes towards BPD may cause barriers for individuals with BPD to seek treatment and even affect the quality of care (Knaak et al., 2017; Subhas et al., 2021). These public negative attitudes may be based on misconceptions regarding BPD symptoms, particularly emotional instability, self-harming behaviours and being aggressive (Black et al., 2004; Elliott & Ragsdale, 2024).

Even more concerning is the fact that mental health professionals may exhibit greater stigma towards individuals with BPD compared to those with other mental illnesses (Bodner

et al., 2015; Treloar, 2009). Numerous studies indicated that mental health professionals hold negative attitudes, less empathy, frustration, an unwillingness to interact and pessimism about recovery of individuals with BPD (Chrysovalantis & Stelios, 2022; Markham & Trower, 2003; McGrath & Dowling, 2012; Treloar, 2009). Interestingly, Bodner et al. (2015) found that psychiatrists who have a greater fear of death tend to exhibit stronger negative attitudes toward patients with BPD. This finding might have an association with the tendency of self-harming or suicidal behaviours with BPD. An Irish study partially aligns with these previous findings and suggested the majority of psychiatric nurses believe that caring for individuals with BPD is more challenging than caring for individuals with other psychiatric conditions. However, they did not believe BPD was untreatable (James, 2017). Although the majority of the existing research reported negative attitudes towards BPD, Cleary et al. (2002) indicated that 95% of mental health workers (n=229) expressed their interest in gaining additional education and training in the management of individuals with BPD.

While researching the relationship between demographic factors and attitudes towards BPD, there are very limited findings on this topic in both Ireland and other countries. Masland and Null (2021) indicated that male vignette characters with BPD were perceived as more dangerous and triggered anxiety, whereas female vignette characters were perceived as pity. Many research focuses on attitudes towards mental illness in general, but there has been extremely limited investigation of the relationship between demographic factors and familiarity and attitudes towards BPD. Given the prevalent negative attitudes surrounding BPD, addressing this gap is crucial for developing more targeted interventions to improve public and mental health professionals' perceptions of BPD.

The Present Study

Several studies have suggested that there is a lack of diversity in demographic variables when investigating how these factors predict attitudes towards mental illness in the

Irish context (Maksimovica, 2022). Moreover, the relationship between demographic factors and familiarity and stigma towards BPD is complex, with mixed findings reported in the literature and little research conducted in Ireland to date. This research aims to overcome the past limitations in the Irish context by employing multiple demographic factors as predictors to explore the relationship between demographic factors, familiarity and attitudes towards mental illness.

Understanding the causes of negative attitudes is important. Self-reported attitudes often directly affect our deliberate behaviour (Dovidio et al., 2002). Imagine if an organisation or policymaker holds a negative explicit attitude towards mental illness. This can not only lead to inequality for individuals with mental health issues but also worsen the stigmatisation in society. Numerous studies across various countries have proven that negative attitudes towards mental illness are significantly linked to a reduced likelihood of seeking professional help due to a fear of stigma, discrimination and other barriers (Brouwers, 2020; Clement et al., 2015; Rose et al., 2011; Rüsch et al., 2013; Shi et al., 2020). These studies highlighted similar results across different cultural backgrounds.

Stigma not only affects the overall mental wellness of society by acting as a barrier to seeking help but also affects other societal problems. An Irish study suggested that employers with negative attitudes towards mental illness are less likely to hire individuals with mental illness due to the stigma of being less reliable or violent (Ó Feich, Pádraig & Brunkard, 2017). A considerable body of evidence supports these similar findings in individuals with schizophrenia (Uçok et al., 2012) (Brouwers, 2020; Cook, 2006; Corrigan et al., 2008; Hand & Tryssenaar, 2006; Østerud, 2022). This situation may cause unemployment among individuals with mental illness, which may worsen their current conditions and affect recovery progress (Brouwers, 2020). However, a more recent Irish study indicated that employers are more willing to hire applicants with mental illness if they have support to

navigate the challenges in working with them, such as individual placement and support employment programmes (Tighe & Murphy, 2021). Furthermore, it is essential to recognise that grouping all individuals with mental health issues together ignores the reality that the degree of negative attitudes might vary depending on the type of diagnosis and the severity of the symptoms (Brouwers et al., 2019).

To conclude, this study aims to investigate whether different demographic factors and familiarity with mental illness among adults in Ireland predict attitudes towards mental illness in general and BPD. This research aims to provide a comprehensive analysis of the relationship between demographic factors, familiarity and self-reported attitudes towards mental illness in Ireland, thus contributing to the development of effective mental health interventions for targeted groups. The research question is as follows: do demographic factors and familiarity with mental illness predict attitudes towards mental illness among adults in Ireland? Based on the previous literature review, the hypotheses for this research are as follows: There will be a significant relationship between attitudes towards mental illness and demographic factors (age, gender, education level, SES) and familiarity with mental illness.

Methodology

Participants

This study recruited 92 participants from the general population in Ireland (Males: n = 48; Females: n = 43; Non-binary: n = 1). The single non-binary participant was excluded from the gender variable due to the insufficient sample size for statistical analysis. With only one individual in this category, it was not feasible to conduct meaningful comparisons, and merging this category with other gender groups would not be appropriate. According to Green (1991), the formula for calculating sample size for multiple regression analysis is as follows: 50 + (8 × number of independent variables). This study included five independent

variables, which indicates that the minimum sample size is 90. Participants were selected using convenience sampling and online recruitment methods. A recruitment poster was shared on social media platforms such as Facebook, Instagram and WhatsApp. The inclusion criteria required that participants be over 18 years old, fluent in English to understand the materials and instructions and currently residing in Ireland. No restrictions were placed on gender, ethnicity, education level or familiarity with mental illness to ensure a diverse sample. Participants were required to provide informed consent before completing the questionnaire. Out of all recruited participants, 30 (32.6%) were White Irish, 20 (21.7%) were Asian or Asian Irish - Indian/Pakistani/Bangladeshi, 11 (12%) were any other White background, 8 (8.7%) were Black or Black Irish – African, 10 (10.9%) were Asian or Asian Irish – Chinese, 5 (5.4%) were Asian or Asian Irish - any other Asian background, 4 (4.3%) were other including mixed background, 2 (2.2%), 1 (1.1%) was White Irish traveller and 1 (1.1%) was Black or Black Irish - Any other Black background.

Measures

Demographic factors and familiarity

In the demographic questions, participants were asked to indicate their gender, age, ethnicity, educational level and SES. They were also asked to indicate their familiarity with mental illness using the Level of Contact Report (Corrigan et al., 2001). The Level of Contact Report (LCR) is a self-report measure designed to assess an individual's degree of personal contact with mental illness. This scale consists of 12 items on different levels of intimate contact with a person with mental illness. Each item is graded on an 11-point scale from 1 (the lowest level of contact) to 11 (the highest level of contact). For example, minimal contact *'never observed a person with mental illness'* to personal experience *'has a serious mental illness'*.

Short-Form Community Attitudes Toward Mental Illness (SF-CAMI)

SF-CAMI (Tong et al., 2020) is a 20-item scale measuring attitudes towards individuals with mental illness with three subscales: Benevolence (five items), Fear and Exclusion (eight items), and Support and Tolerance (seven items). It excludes items 1, 5, 9, 23, 29, 2, 8, 10, 12, 16, 26, 27, 33, 35, 6, 15, 24, 28, 31, and 34 from the original CAMI developed by Taylor & Dear (1981). Participants rated each item on a 5-point Likert scale, from 1 (strongly disagree) to 5 (strongly agree). A higher total score indicates negative attitudes towards mental illness, with the highest possible total score being 100. A good Cronbach's alpha (α = 0.85) indicates a high internal consistency for the scale within this sample (Tong et al., 2020). An intraclass correlation coefficient of 0.62, which indicates moderate test-retest reliability (Tong et al., 2020).

Attribution Questionnaire-9 (AQ-9)

AQ-9 (Corrigan, 2006) is a nine-item scale with the highest factor loadings selected from the AQ-27 (Corrigan et al., 2003) that measures stigma towards mental illness through responding to a vignette about a person with a mental illness. It has nine subscales: blame, anger, pity, help, dangerousness, fear, avoidance, segregation and coercion (Corrigan et al., 2006). Participants rated each item on a nine-point Likert scale from 1 (none at all) to 9 (very much), with higher scores indicating more negative attitudes towards individuals with mental illness. Cronbach's alpha ranged from (α = 0.67 to 0.79), with an average Cronbach's alpha of 0.72 (Amestoy, 2023). Rather than using the most commonly referenced schizophrenia as the vignette sample mental illness, this paper is going to use the vignette that describes the symptoms of BPD, including emotional components and behavioural examples relevant to those symptoms. Total scores range from nine to 81, with higher scores indicating more negative attitudes.

Design

All statistical analyses were completed using SPSS statistical software version 29. Descriptive statistics were examined to ensure all measures meet all statistical assumptions. This study employed a quantitative approach and implemented a cross-sectional research design. There were four predictor variables (PVs) were included: age, gender, educational level, and familiarity with mental illness. The criterion variable (CV) was attitudes towards mental illness, measured by SF-CAMI scores and AQ-9 scores. To assess the hypothesis, the two CVs conducted multiple regression analysis separately to explore the significant relationship between explicit attitudes towards mental illness and demographic factors (age, gender, educational levels and SES) and familiarity towards mental illness.

Procedure

Participants will access the survey via an online survey tool (Google Forms) and will participate online. The questionnaire used in this study was an anonymous and self-report questionnaire. Once participants click on the link to take part, they will be taken to a separate browser and will see the study information sheet first (Appendix 1). Once they have read the study information, they will click 'Next' and be presented with the consent form (Appendix 2). If the participant consents to participate in the study, they will then click 'Next' to access the first survey, demographic information (Appendix 4), which will take approximately 3 minutes. Then, access the second survey, SF-CAMI (Appendix 5), which will take approximately 5 minutes. Lastly, the third survey, AQ-9, will take approximately 3 minutes (Appendix 6). Participation will take approximately 11-15 minutes in total. There is no time limit for completing the surveys, so participants are free to take breaks between the surveys as they need.

The questionnaire consisted of three sections. Section 1: demographic information (6 questions) and experience with mental illness will be assessed using the level of contact

report (Corrigan et al., 2001). These demographic questions were asked as the PVs of this study. However, ethnicity was included to gain a general profile of the participants, and it was excluded from the data analysis. Section 2: a validated SF-CAMI questionnaire (Tong et al., 2020). It is a self-reported scale to assess public attitudes towards individuals with mental illness (Tong et al., 2020). Section 3: a validated AQ-9 (Corrigan, 2006). It is a shorter version of AQ-27, which was extracted from the AQ-27 (Corrigan et al., 2003). Once the surveys are complete, participants will receive the debriefing form (Appendix 3). It provided helpline numbers and contact information for participants if the questionnaire caused any distress to the individual.

Results

Descriptive Statistics

The current data is taken from a sample of 92 participants (n = 92). The sample consisted of 48 males (52.7%) and 43 females (47.3%). A preliminary analysis was conducted to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. Descriptive statistics for the categorical variables of this study are presented in Table 1.

This study had five continuous variables, including Age, Prior Exposure/ Familiarity, SES, Total SF-CAMI Scores and Total AQ-9 Scores. Descriptive statistics for all five variables are presented in Table 2.

Table 1

Frequencies for the current sample on each demographic variable (n = 92)

Variable	Frequency	Valid %
Gender		
Male	48	52.7

Female	43	47.3
Educational levels		
Upper Third Level	32	34.8
Lower Third Level	51	55.5
Secondary Level	9	9.8

Table 2

Descriptive statistics of all continuous variables (n = 92)

Variable	*M* [95% CI]	*SD*	Range
Age	25.07 [23.66 - 26.47]	6.79	18 - 47
Familiarity	3.82 [3.34 - 4.29]	2.29	1 - 10
SES	6.25 [6.0 - 6.50]	1.21	3 - 10
Total SF-CAMI Scores	74.90 [72.63 - 77.18]	11.0	50 - 97
Total AQ-9 Scores	24.90 [23.87 – 25.93]	4.97	14 - 44

*Note. M = mean; CI = Confidence interval; SE = Standard errors of B; n = 92. Statistical significance: *p < .05; **p < .01; ***p < .001*

Inferential Statistics

SF-CAMI

Multiple regression was run to predict attitudes towards mental illness (SF-CAMI scores) from gender, age, educational level, SES and familiarity. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. There was linearity as assessed by partial regression plots and a plot of

studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.979. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardised predicted values. Tests for multicollinearity also indicated that all Tolerance and VIF values were in an acceptable range. The assumption of normality was met, as assessed by a P-P Plot.

Since no prior hypotheses had been made to determine the order of entry of the predictor variables, a direct method was used for the multiple linear regression analysis. The five independent variables explained 21.6% of the variance in attitudes towards mental illness F (6, 84) = 3.852, p = .002, with all five variables significantly contributing to the prediction ($p < .05$). R^2 for the overall model was .22 with an adjusted R^2 of .16, which indicated a small size effect (Cohen, 1988). The beta weight suggests that gender and familiarity with mental illness were statistically significant predictors of negative attitudes toward mental illness among five variables (β = .24, p = .02 and β = .31, p = .003, respectively). Also, familiarity is a stronger predictor compared to gender. The correlations between the predictor variables and criterion variables are presented in Table 3.

Table 3

Multiple regression model predicting SF-CAMI scores

Variable	R^2	*B*	*SE*	β	*t*	*p*
Model	.22					
Age		.18	.17	.11	1.07	.29
Gender (Male)		5.34	2.29	.24	2.33	.02
Upper third level		-1.01	2.44	-.04	-.41	.68
Secondary third level		-1.26	3.72	-.03	-.34	.74
SES		.37	.88	.04	.41	.68

Familiarity	1.49	.49	.31	3.04	.003

Note. R^2 *= R-squared;* β *= standardized beta value; B = unstandardized beta value; SE = Standard errors of B; n = 92. Statistical significance: *p < .05; **p < .01; ***p < .001*

AQ-9

Multiple regression was run to predict attitudes towards BPD (AQ-9 scores) from gender, age, educational level, SES and familiarity. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.14. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardised predicted values. Tests for multicollinearity also indicated that all Tolerance and VIF values were in an acceptable range. The assumption of normality was met, as assessed by a P-P Plot.

Since no prior hypotheses had been made to determine the order of entry of the predictor variables, a direct method was used for the multiple linear regression analysis. The five independent variables explained 12.5% of the variance in attitudes towards mental illness $F(6, 84) = 2.01$, $p = .07$, with all five variables not significantly contributing to the prediction ($p > .05$). The R^2 value was .13 with an adjusted R^2 of .06, which indicated a small size effect (Cohen, 1988). The beta weight suggests that familiarity with mental illness contributes most to predicting negative attitudes towards BPD ($\beta = -.22$, $p = .041$). The correlations between the predictor variables and criterion variables are presented in Table 4.

Table 4

Multiple regression model predicting AQ-9 scores

Variable	R^2	*B*	*SE*	β	*t*	*p*

Model	.13					
Age		.06	.08	.08	.70	.48
Gender- Female		-.94	1.09	-.01	-.86	.39
Upper third level		1.07	1.17	.10	.92	.36
Secondary third level		-1.29	1.78	-.08	-.72	.47
SES		-.28	.42	-.07	-.66	.51
Familiarity		-.49	.23	-.22	-2.07	.04

Note. R^2 *= R-squared;* β *= standardized beta value; B = unstandardized beta value; SE = Standard errors of B; n = 92. Statistical significance: *p < .05; **p < .01; ***p < .001*

Discussion

The present study aimed to examine how well demographic factors (age, gender, educational level and SES) and familiarity predict attitudes towards mental illness in Ireland. Additionally, it investigates whether various predictors differently predict attitudes towards mental illness in general and attitudes specifically toward BPD. Based on the inconsistent findings in current literature, it was hypothesised that there is a significant relationship between attitudes towards mental illness and both demographic factors and familiarity with mental illness. The results of this study supported only some of the hypotheses, as there was a statistically significant effect of gender and familiarity in predicting attitudes towards general mental illness (SF-CAMI). This study demonstrated that only familiarity had a statistically significant effect on predicting attitudes towards BPD (AQ-9). However, it is important to note that the overall regression model (AQ-9) for assessing attitudes towards BPD was not statistically significant. Therefore, the significance of this predictor should not be regarded as a confident conclusion and should be interpreted with caution. This could be due to a small sample size (n=92) or chance. In conclusion, this study found that age, educational level and

SES have no significant effect in predicting attitudes towards mental illness in general, and familiarity is the strongest predictor compared to the other variables.

The results indicated that familiarity was the most significant contributor to predicting attitudes towards mental illness in general and BPD. The data suggested a statistically significant positive relationship between familiarity and negative attitudes towards mental illness. Conversely, there was a statistically significant negative relationship between familiarity and negative attitudes towards BPD. This result contrasts with the majority of existing literature, which indicated that greater familiarity was associated with lower stigma (Adewuya & Makanjuola, 2008; Alexander & Link, 2003; Corrigan et al., 2001). However, the current results align with previous literature showing that intimate carers (e.g., family members and service providers) frequently face emotional burdens and associative stigma, resulting in negative attitudes towards mental illnesses (Corrigan & Nieweglowski, 2019; Koschorke et al., 2021). The unexpected finding of the current study implies that the level of familiarity alone may not be sufficient to influence attitudes and the quality of familiarity is crucial (Ran et al., 2021). Some studies suggested that the quality of contact with individuals with mental illness could greatly influence attitudes towards mental illness (Islam & Hewstone, 1993). One study added that good, voluntary, and meaningful contacts lessen stigma, whereas stressful, forced, or overwhelming experiences might worsen negative attitudes (Ran et al., 2021). These findings could explain the results of the current study regarding the association between greater familiarity with mental illness and negative attitudes towards mental illness. Even though this study also found that high familiarity with mental illness was significantly linked to less negative attitudes towards BPD, which aligns with many studies in the field. For example, a pilot study in Ireland supports this finding, as research demonstrated that personal experience with mental illnesses such as schizophrenia, bipolar disorder or autism leads to more positive attitudes (Hargreaves et al., 2024). People in

Ireland with higher familiarity might hold a more positive attitude towards individuals with BPD. However, due to the model not being statistically significant, familiarity should not be regarded as a reliable predictor.

There was a statistically significant positive relationship between gender and negative attitudes towards mental illness. This indicated that female was a significant contributor to predicting negative attitudes towards mental illness in general. Therefore, this predictor supports the hypothesis of this study. However, there was a non-significant negative relationship between gender and attitudes towards BPD, indicating males predicted attitudes towards BPD with a non-significant effect. These contradictory results highlighted the complexity and inconsistency of which gender predicts attitudes towards mental illness. The previous literature emphasised that this topic presents mixed results. Nonetheless, the present findings align with previous literature, indicating that females in Ireland were generally more reluctant to interact with individuals with mental illness than males (Keating, 2010). Conversely, another study in Ireland examined medical students' attitudes towards mental illness and suggested that female participants hold less stigma towards individuals with mental illness (O'Connor et al., 2013). However, another study demonstrated that females did not appear to differ in their attitudes towards individuals with mental disorders compared to males (Holzinger et al., 2011). Furthermore, the present study found that males were more associated with negative attitudes towards BPD than females, though this was with a non-significant association. A large sample study revealed that men exhibited significantly higher levels of stigma towards depression than women (Jones et al., 2011). Similarly, another study suggested that male mental health non-professionals displayed a stronger desire for social distancing from individuals with mental illness compared to male mental health professionals and females (Smith & Cashwell, 2011). These findings may relate to previous literature indicating that masculine norms of being stoic and strong can discourage help-seeking

behaviour and that males typically have less knowledge of mental illness (Judd et al., 2008; Murray et al., 2008; Seidler et al., 2016). These findings could be the explanation of the present study that males predict negative attitudes towards BPD.

The results indicated that age was not a statistically significant predictor of negative attitudes towards mental illness. Therefore, this predictor does not support the hypothesis of this study. Nevertheless, older adults tend to predict more negative attitudes towards mental illness in general and BPD compared to younger adults. However, a non-significant result does not imply that age and attitudes have no relationship; this finding might be explained by limitations in this study (see Strength & Limitations). This finding contradicts previous literature suggesting that younger individuals hold more negative attitudes towards mental illness than older individuals. While many studies indicate a strong link between age and stigma (Clarkin et al., 2024; Ewalds-Kvist et al., 2012), the results remain inconsistent. Research comparing younger and older adults has yielded mixed findings regarding stigma towards mental illness, with some studies indicating that younger individuals exhibit more negative attitudes than older adults in terms of perceptions of dangerousness and social distance (Clarkin et al., 2024; Farrer et al., 2008; Reavley & Jorm, 2011). Conversely, Baral et al. (2022) suggested that the older generation perceives depression more negatively than the younger generation due to lower mental health literacy. Further research indicated that older individuals tend to believe that character weakness causes schizophrenia, despite having high mental health knowledge (Farrer et al., 2008). A study conducted over the past two decades highlighted a far more complex pattern of social change in levels of mental health stigma across various age groups over time (Pescosolido et al., 2021). These findings align with those of Jorm and Wright (2008), who suggested males's stigma towards mental health changes over time.

The results indicated that SES was not a statistically significant predictor. Therefore, this predictor does not support the hypothesis of this study. However, individuals with higher SES tend to predict more negative attitudes towards mental illness in general compared to those with lower SES. On the other hand, low SES individuals tend to predict more negative attitudes towards BPD than those with higher SES. The findings of this study suggest a complex relationship between SES and attitudes towards mental illness. Furthermore, the results are inconsistent with the existing literature. Several studies have demonstrated that people with higher SES hold less stigma as they have more education and greater exposure to mental health awareness (Huang et al., 2025; Potts & Henderson, 2020; Wang et al., 2021). Nevertheless, many other studies support the evidence of the current study. For instance, one study found that higher income was associated with increased levels of mental illness stigma, social dominance orientation, and mental illness controllability attributions (Foster, 2021). This finding highlighted that high SES individuals possess a more wealthy environment, which could lead them to perceive certain phenomena as more controllable compared to those with lower SES (Foster, 2021). Similarly, another study indicated that individuals with a higher SES are more prone to self-blame for mental illness, leading to greater stigma (Foster & O'Mealey, 2021). Despite the non-significant findings, the results of this study may still provide valuable insights into the Irish context.

This study indicated that education levels have no statistically significant impact on predicting negative attitudes towards mental illness in general and BPD. Therefore, this predictor does not support the hypothesis of this study. The finding also indicated that among three educational levels (secondary, lower third and upper third level), the lower third level (degree or diploma) predicted more negative attitudes towards mental illness in general. Conversely, upper third level (Master or PhD) predicted negative attitudes towards BPD. A vast amount of studies highlighted that higher education levels were associated with lesser

stigma, as greater knowledge and exposure to mental health ideas could lead to increased understanding and awareness (Potts & Henderson, 2020; Shim et al., 2022). However, the results are not always consistent. In Iraq and Iraqi Kurdistan, a study conducted among university students found that the majority of participants had negative attitudes towards individuals with mental illness in terms of separation, benevolence and stereotyping (Omar et al., 2024). This finding can be explained by a lack of mental health education in Iraq. Many studies have proven that those who have greater knowledge of mental health are less prone to hold negative attitudes and more likely to recognise mental illness (Fleary et al., 2022; Jorm, 2000; Link & Cullen, 1986). These findings show the significance of cultural and educational variables in predicting attitudes towards mental illness (Eylem et al., 2020). Cultural differences could be one of the explanations for the present study due to the diverse ethnicity among participants. Future studies should consider focusing on cultural differences in predicting attitudes towards mental illness. The negative perceptions reported among university students in Iraq may be attributed to a lack of mental health education, emphasising that mental health education and knowledge are the keys to decreasing negative attitudes towards mental illness.

Implication

The current study aims to investigate the relationship between demographic factors and attitudes towards mental illness in Ireland in order to provide insightful knowledge for future research, policy and intervention implications. This study emphasises the necessity of measuring attitudes towards various mental health diseases, particularly highly stigmatised or misunderstood ones like borderline personality disorder, schizophrenia, antisocial personality disorder and bipolar disorder (Hazell et al., 2022). While public attitudes towards mental illness have been extensively researched, specific mental disorders such as BPD receive little

attention despite their high stigma. Future research should investigate attitudes towards a variety of mental health illnesses in order to provide more focused anti-stigma interventions. On the other hand, as previously mentioned, mental health professionals often display negative attitudes towards individuals with mental illness compared to the general public. Mental health professionals play a significant role in shaping the social perception of mental illness and affecting the patient's experiences of treatment (Fatunbi et al., 2025). Imagine if a patient was being stigmatised or discriminated against by mental healthcare professionals in treatment. It will not only affect the treatment outcome but also might highly reduce help-seeking behaviours. Therefore, more research is needed to better understand the attitudes of mental health professionals towards different mental illnesses and to design focused interventions to eliminate stigma within this group.

Furthermore, the selection of demographic factors requires careful thought in future studies. In this study, age, SES, and education level did not reveal statistically significant associations with negative attitudes, which implies that other factors may have a greater influence on predicting attitudes towards mental illness. A study in Ireland indicated that individuals who live in urban areas display more positive attitudes towards depression (Kennedy, 2017). Therefore, future studies could investigate the relationship between urban and rural areas and attitudes towards mental illness.

Lastly, the significant findings on familiarity and gender indicate that stigma-reduction interventions should based on these two factors. Given that increased familiarity and females were associated with more negative attitudes, interventions should focus on enhancing the quality of contact with individuals with mental illness rather than merely increasing exposure and knowledge and targeting females.

Strengths and limitation

One of the strengths of this study is its attention to many demographic factors, such as age, gender, educational level and SES, as well as familiarity, which allows for a more comprehensive understanding of the predictors of negative attitudes towards mental illness. This study is one of the few in Ireland that uses demographic factors and familiarity to predict attitudes towards both general mental illness and BPD. Therefore, this thesis might provide an insight view for the field in Ireland. Another strength of this research is its cost-effectiveness, as it was conducted through an online survey. Future studies can easily replicate this research without any financial burden.

This study has several limitations. Firstly, the sample size is small, which limits the generalizability of the results, as a larger and more diversified sample could produce different results. Future research should aim for a more balanced and representative sample to improve the validity of the findings. The second limitation is that 45% (n = 92) (see Figure 4) of participants scored only one to two points for the level of familiarity, indicating that individuals with higher familiarity were underrepresented. This may have influenced the AQ-9 results, particularly regarding attitudes towards BPD, as previous research demonstrates that different levels of familiarity might lead to varying stigma levels. Another limitation is the sample was weighted towards younger people, with 51% of respondents aged between 18 and 22. This under-representation of older people may have influenced the study's findings, particularly the link between age and attitudes towards mental illness. This may be due to the fact that most of the participants are recruited from universities. Therefore, the sample lacks representation of older adults who may hold different attitudes towards mental illness. This study relied on self-report measures to assess attitudes towards mental illness and BPD in Ireland. As a result, there is a possibility of social desirability bias influencing participants' responses and future studies should consider conducting both explicit and implicit attitudes at

the same time. Therefore, it will provide a more in-depth and comprehensive result in predicting attitudes towards mental illness in the Irish population.

Conclusion

This study examined how age, gender, SES, education, and familiarity predict attitudes towards general mental illness and BPD. The findings revealed that gender and familiarity were strong predictors of negative attitudes, while age, SES, and education had no statistically significant effects. Women exhibited more negative attitudes than men, which aligns with evidence showing that fear and avoidance of mental illness are more prevalent among women. Additionally, greater familiarity was associated with more negative attitudes, likely due to familial burden or existing societal stigma. The lack of significant findings for age, SES, and education emphasises the complexities of stigma and suggests that other factors, such as geographic factors (urban versus rural living), may be more powerful predictors. Given that a considerable proportion of the Irish population lives in rural areas, future research should look into how geographical factors affect stigma. Furthermore, the underrepresentation of participants with high familiarity and older participants indicates the need for a more balanced and larger sampling in future studies.

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Appendices

Appendix 1

Information sheet

Information Sheet

Purpose of the Study.

I am Wing Lam Leung, an undergraduate student in the Department of Psychology at the National College of Ireland. As part of my final year project, I am undertaking this research study, '*The relationship between demographic factors and attitudes toward mental illness*.' This research is focused on investigating how attitudes across different demographic factors, such as age, gender, education, familiarity with mental illness and socioeconomic status, predict explicit attitudes toward mental illness.

What will the study involve?

The study will involve completing an online survey, which may take 11-15 minutes.

You will be asked about your attitudes towards mental illness including questions such as: "Mental illness is an illness like any other" and "How dangerous would you feel John is?" You will read a vignette about a person with a mental health disorder that briefly mentions self-harm. You will also be asked about your familiarity with mental illness which will ask you to indicate whether you have had a serious mental illness. If these questions are too distressing for you, you do not have to take part in this study.

Who has approved this study?

This study has been reviewed and received ethical approval from the National College of Ireland Research Ethics Committee. You may have a copy of this approval if you request it, and the approval no. from the National College of Ireland is 07012025.

Who can take part?

You can take part in this study if you are aged over 18 and currently residing in Ireland.

Do you have to take part?

No, you are not obligated to participate in this research. However, we hope that you will agree to take part and give us some of your time to complete the survey. It is entirely up to you to decide whether or not you would like to participate. If you decide to participate, you are free to withdraw at any time without giving a reason. Once you have submitted your questionnaire, it will not be possible to withdraw your data from the study because the questionnaire is anonymous and individual responses cannot be identified. There is a small risk that these questions may cause some individuals upset or distress. If you feel that these questions may cause you to experience an undue level of distress, you should not take part in the study.

What information will be collected?

We will first gather your demographic information, such as age, gender, and education level, and then your attitudes toward people with mental illness.

Will your participation in the study be kept confidential?

Yes. The questionnaire is 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 fully anonymised and stored securely in a password-protected/encrypted file on the researcher's computer. Data will be retained and managed in accordance with the NCI data retention policy. Note that anonymised data may be archived on an online data repository to facilitate validation and replication, in line with Open Science best practice and conventions and may be used for secondary data analysis.

No information will be distributed to any unauthorised individual or third party. Only the researcher and academic supervisor will have access to the data collected. Due to the anonymous nature of this study, your individual data cannot be made available to you. Should you wish to follow up on the results of this research, please contact the researcher.

What will happen to the results?

The results of this study will be presented in my final dissertation, which will be submitted to the National College of Ireland. The project results may also be presented at conferences and/or submitted to an academic journal for publication.

What are the possible disadvantages of taking part?

I don't envisage any negative consequences for you if you participate in this research. However, if you subsequently feel distressed when answering the questions in the survey, please find support relevant to your country here: https://linktr.ee/ggrsupports or visit Samaritan Ireland or call 116 123 for their 24-hour helpline.

What if there is a problem?

If you experience any issues or concerns while completing this study, please contact me (x21239843@student.ncirl.ie). Similar to above, if you find yourself distressed or needing support following the completion of this survey, please see the relevant support here: https://linktr.ee/ggrsupports or visit Samaritan Ireland or call 116 123 for their 24-hour helpline.

For further information
You may contact the principal researcher, Wing Lam Leung at x21239843@student.ncirl.ie or my supervisor, Dr Lynn Farrell, will gladly answer your questions about this study. You may contact her at lynn.farrell@ncirl.ie

Any further queries? If you need any further information, you can contact me:

Principal Investigator
Wing Lam Leung
X21239843@student.ncirl.ie
Undergraduate student
Dept. of Psychology
National College of Ireland

Thank you for taking the time to read this

Appendix 2

Consent form

Consent form

In agreeing to participate in this research, I understand the following:

- The method proposed for this research project has been approved in principle by the Departmental Ethics Committee, which means that the Committee does not have concerns about the procedure itself as detailed by the student. It is, however, the above-named student's responsibility to adhere to ethical guidelines in their dealings with participants and the collection and handling of data.
- If I have any concerns about participation, I understand that I may refuse to participate or withdraw at any stage by exiting my browser.
- I understand that once my participation has ended, that I cannot withdraw my data as it will be fully anonymised.
- I have been informed as to the general nature of the study and agree voluntarily to participate.
- All data from the study will be treated confidentially. The data from all participants will be compiled, analysed, and submitted in a report to the Psychology Department in the School of Business.
- I understand that my data will be retained and managed in accordance with the NCI data retention policy, and that my anonymised data may be archived on an online data repository and may be used for secondary data analysis. No participants data will be identifiable at any point.
- At the conclusion of my participation, any questions or concerns I have will be fully addressed.

☐ Please tick this box if you have read and agree with all of the above information.

☐ Please tick this box to indicate that you are providing informed consent to participate in this study.

Appendix 3

Debrief sheet

Thank you for taking part in this research. Your time is greatly appreciated. Your contribution has helped to investigate how attitudes across different demographic factors predict explicit attitudes toward mental illness.

Should you have any questions about this study, please reach out to the researcher, Wing Lam Leung, x21239843@student.ncirl.ie or the academic supervisor, Dr Lynn Farrell, lynn.farrell@ncirl.ie

If you felt distressed when answering questions in the survey, please find support relevant to your country here: https://linktr.ee/ggrsupports or TextAboutIt is a free and confidential 24-hour text line. To reach out, text HELLO to 50808. You may also reach out to Samaritans helpline to chat online or call their 24-hours helpline on 116123.

Appendix 4

Demographic information

1. Are you an Irish resident or currently living in Ireland?

☐ Yes
☐ No

2. Gender

☐ Woman
☐ Man
☐ Non-Binary
☐ Prefer to self-describe: _____

3. Age

_____

4. Educational level

☐ Primary level education and below
☐ Secondary level (e.g., Inter or Junior Cert or Leaving Cert)
☐ Lower Third level (e.g., diploma, degree)
☐ Upper Third level (e.g., Masters or PhD)

5. Do you have prior exposure to mental illness? Please select all situations below that you have experienced in your lifetime in relation to mental illness.

☐ Never observed a person with mental illness
☐ Observed, in passing, a person with mental illness
☐ Watched a movie about mental illness
☐ Watched television documentary about mental illness
☐ Observed person with mental illness frequently
☐ Worked with a person with mental illness
☐ Job includes services for persons with mental illness
☐ Provides services to persons with mental illness
☐ Family friend has mental illness
☐ Relative has mental illness
☐ Lives with a person who has mental illness
☐ Has a serious mental illness

6. Socioeconomic status

   Think of a scale with 10 points representing where people stand in Ireland. At point 10 are people who are the best off – those who have the most money, the most education, and the most respected jobs. At point 1 are the people who are worst off – those who have the least money, the least education, and the least respected jobs or no job. Where would you place yourself on this scale? Please indicate on the scale where you consider yourself to be by selecting a number from 1 to 10.

   1: worst off; i.e. struggle the most financially, least education, jobs deemed by society as least respected/no job

   10: best off; i.e. most financially secure, best education, jobs deemed by society as most respected

   _____

7. Ethnicity

- ☐ White Irish
- ☐ White Irish traveller
- ☐ Roma
- ☐ Any other White background
- ☐ Black or Black Irish - African
- ☐ Black or Black Irish - Any other Black background
- ☐ Asian or Asian Irish – Chinese
- ☐ Asian or Asian Irish - Indian/Pakistani/Bangladeshi
- ☐ Asian or Asian Irish - any other Asian background
- ☐ Arab
- ☐ Other including mixed background

Appendix 5

SF-CAMI Questionnaire

SF-CAMI

The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

SA=Strongly Agree, A=Agree, N=Neutral, D=Disagree, SD=Strongly Disagree

1. There should not be any over-emphasis that the mentally ill endanger the public
   SA A N D SD

2. The situation that mentally ill have for too long been the subject of ridicule should be put to an end
   SA A N D SD

3. The mentally ill should not be isolated from the rest of the community
   SA A N D SD

4. The most effective therapy for many mental patients is to let them go back to a normal community
   SA A N D SD

5. Mental patients need the same kind of control and discipline as a young child.
   SA A N D SD

6. Increased spending on mental health services is a waste
   SA A N D SD

7. The mentally ill are far less of a danger than most people imagine
   SA A N D SD

8. Residents should accept the location of mental health institutions in their neighbourhood to serve the needs of the residents
   SA A N D SD

9. The mentally ill should not be treated as if they are outcasts of society
   SA A N D SD

10. There have been sufficient existing facilities of mental health services
    SA A N D SD

11. A woman would be very unwise to marry a man who has suffered from mental illness, even though he seems to have regained normality
    SA A N D SD

12. Mental health facilities should be kept out of residential neighbourhoods
    SA A N D SD

13. The best way to handle the mentally ill is to keep them behind locked doors
    SA A N D SD

14. The mentally ill don't deserve our sympathy.
    SA A N D SD

15. I would not want to have a neighbour who has been mentally ill
    SA A N D SD

16. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services
    SA A N D SD

17. Virtually anyone can become mentally ill
    SA A N D SD

18. It is best not to have any contact with a person who has mental problems
    SA A N D SD

19. Most women who were once patients in a mental hospital can be trusted to take care of babies
    SA A N D SD

20. It is frightening whenever to think of people with mental problems living nearby
    SA A N D SD

Appendix 6

AQ-9 Questionnaire

AQ-9

John's sense of self often changes, and he feels empty inside. He notices his thoughts change when under stress, as he thinks people are planning to hurt him. John broke up with his partner because they said John's mood changes hour to hour and that John could not control his anger or his impulse to gamble and binge drink. John would often think his partner was perfect and then pull back when his high standards were not met. He also sometimes became frantic when his partner tried to leave after fights. John often cuts his skin in response to his overwhelming emotions. John has a diagnosis of borderline personality disorder.

CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.

1. I would feel pity for John.

1 2 3 4 5 6 7 8 9

none at all very much

2. How dangerous would you feel John is?

1 2 3 4 5 6 7 8 9

none at all very much

3. How scared of John would you feel?

1 2 3 4 5 6 7 8 9

none at all very much

4. I would think that it was John's own fault that he is in the present condition.

1 2 3 4 5 6 7 8 9

none at all very much

5. I think it would be best for John's community if he were put away in a psychiatric hospital.

1 2 3 4 5 6 7 8 9

none at all very much

6. How angry would you feel at John?

1 2 3 4 5 6 7 8 9

none at all very much

7. How likely is it that you would help John?

1 2 3 4 5 6 7 8 9

Definitely would not help definitely would help

8. I would try to stay away from John.

1 2 3 4 5 6 7 8 9

none at all very much

9. How much do you agree that John should be forced into treatment with his doctor even if he does not want to?

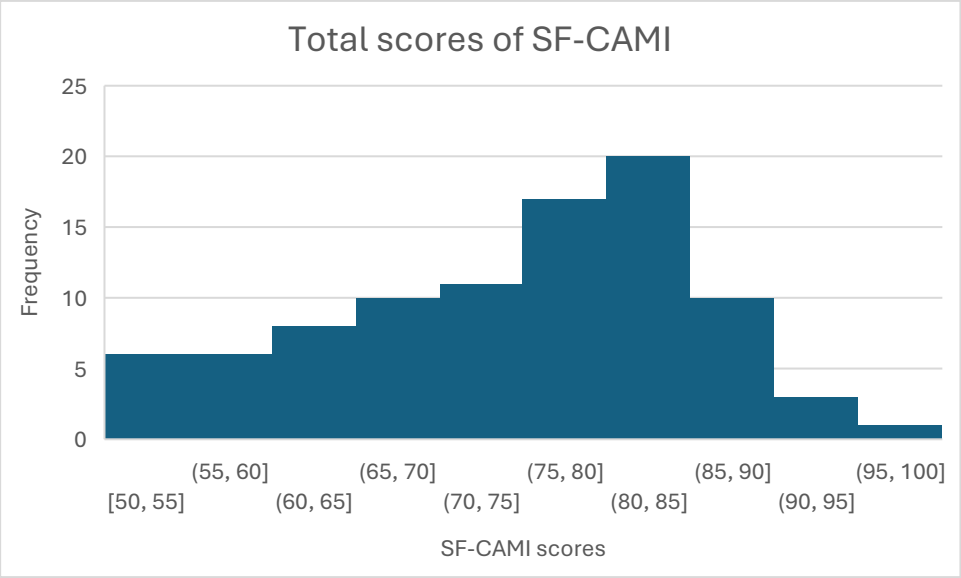
1 2 3 4 5 6 7 8 9

none at all very much

Appendix 7

Figure 1

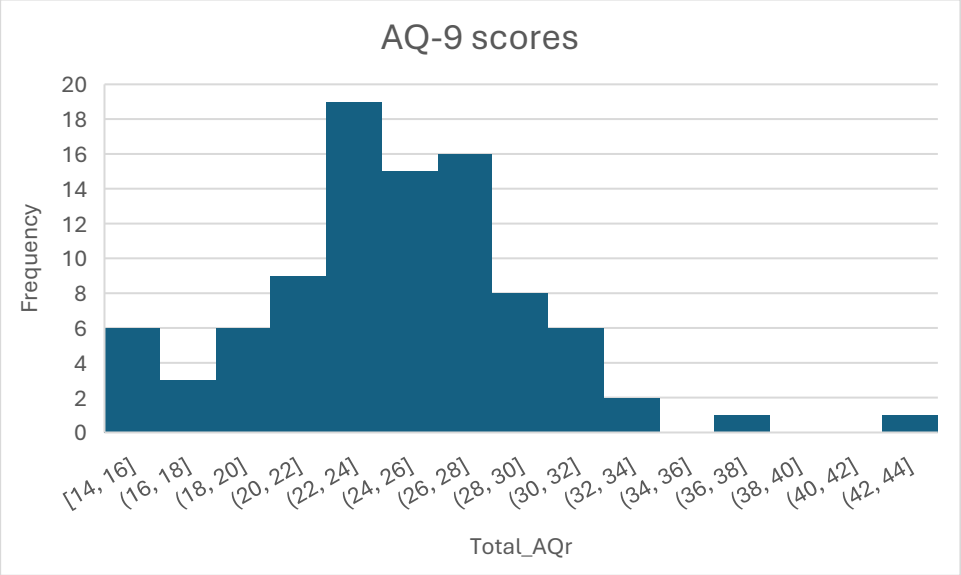
Histogram of SF-CAMI score



Appendix 8

Figure 3

Histogram of AQ-9 score



Appendix 9

Figure 4

Histogram of the level of contact scale