

PROJECT TITLE

Attitudes In The UK Towards Mental Illness As Seen Over Three Family Generations And How These Are Affected By Personal Exposure To Mental Illness

BACKGROUND

Efforts have been made over recent years to reduce the stigma associated with mental illness, however, much remains unknown about how, when and why stigma develops (Jorm and Wright, 2008). This research project proposes to gather information from three generations of family members – children, parents and grandparents – to compare attitudes both across generations and amongst peers. An additional element of participants' previous exposure to mental illness will be considered as an additional factor.

In 2008, a study was conducted in Australia with young people and their parents to explore what influences young people's stigmatising attitudes towards mental illness (Jorm and Wright, 2008). This study found that personal experiences and parental attitudes both affect a young person's attitude. It showed that parental attitudes, particularly regarding personal responsibility, dangerousness and perceived stigma, affected the beliefs of their children, who often followed in similar beliefs. Other studies have been conducted with adult participants using vignettes to explore social distance and beliefs around mental illness (Link, Cullen, Frank and Wozniak, 1987; Link, Phelan, Bresnahan, Stueve and Pescosolido, 1999; Penn et al, 1994). These studies have shown that public understanding of mental illness is different to that of professionals and that these beliefs strongly impact feelings towards individuals with a mental illness and lead to social distance and continued stigmatisation. These studies have also shown that exposure to mental illness tends to make adults more sympathetic. However, according to one study, familiarity could have the opposite effect on adolescents (Corrigan et al, 2005).

For this study, an Attribution Questionnaire (Corrigan et al, 2002) will be used rather than vignettes as it shows attitudes towards mental illness in general rather than certain illnesses or scenarios. By analysing similar questions, relationships between attitudes can be explored. Some additional questions will be included after the questionnaire regarding exposure to mental illness.

METHOD

INTENDED PARTICIPANTS

The study population will be heterogeneous in socio-economic status and ethnicity. The intended participants are three generations of family members comprising a child, their parent and their grandparent. Children will be defined as individuals aged between 10-19 years in accordance with the World Health Organisation's definition for 'adolescent' (World Health Organization, n.d.). In place of 'adolescent' this study will use the term 'child' to also incorporate and clarify the relational aspect. To compare and contrast family attitudes which may be passed on through upbringing, this study will use immediate family members rather than those related by marriage. Children related through adoption will be included if they have been with the family continuously since the age of 4.

DESIGN

This study will use a between subjects design to compare attitudes towards mental illness between members of the same family (child, parent and grandparent) as well as comparing attitudes between peers (child to child, parent to parent, grandparent to grandparent).

MATERIALS

This study will use an Attribution Questionnaire (Corrigan et al, 2002) to determine the attitudes of participants towards mental illness. The Attribution Questionnaire is made up of twenty questions related to attitudes towards mental illness with results being collected on a 9-point Likert scale. The questionnaire focuses on views regarding anger, fear, dangerousness, pity, personal responsibility, helping behaviours and avoidance (Corrigan et al, 2002). Results will be calculated to give an overall

score (a low score indicating a generally open and positive attitude toward mental illness, a high score indicating a generally closed and negative attitude). Data will also be broken down to group together results of questions analysing similar attitudes (anger = questions 1, 4, 8; fear = questions 2, 3, 10, 11, 16; dangerousness = questions 5, 9; pity = questions 6, 14, 17, 19; personal responsibility = questions 7, 15; helping behaviour = questions 12, 13, 20; avoidance = question 18). An additional element to determine exposure to mental illness will ask participants if they know someone with a mental illness. Participants answering positively will then be asked to further identify their level of intimacy by checking all that apply: i.e. self, immediate family member (please specify), distant family member (please specify), friend, acquaintance.

All participants will complete the same questionnaire. This questionnaire was selected as other questionnaires examining similar attitudes were too long for younger participants or contained language that was too complex. Data will be collected face-to-face with the questionnaire being completed on a computer using a specially designed animated interface to make the task clear and engaging for participants of all ages.

RECRUITMENT PLAN

Recruitment will be done through schools, colleges and medical centres. An invitation to take part in the study along with relevant information will be sent to prospective participants via email, text and post. The study will also be advertised in school, college and medical centre newsletters, on bulletin boards and on websites and social media.

ETHICAL CONSIDERATIONS

This study will follow the guidelines laid out in the British Psychological Society Code of Human Research Ethics (BPS, 2014) at every stage.

Prior to making contact with prospective participants, contact will be made with schools, colleges and medical centres in selected areas. To ensure anonymity, no names will be taken as part of the data

collection, but each family unit will be assigned a pseudonym to ensure data from each family is able to be compared to fulfil the purpose of the study.

Prospective participants will be invited to a neutral location such as a school, college or medical centre to take part in the study. On arrival they will be issued an information sheet detailing the aims of the study, how data will be collected and subsequently used, a confidentiality statement, compliance with the General Data Protection Regulation, the right to withdraw and the name and contact details of the researcher conducting the study (BPS, 2014). They will also be given two copies of a consent form to complete should they wish to participate in the study (BPS, 2014). As stipulated by the BPS Code of Human Research Ethics (2014), an additional consent form will be given to any parent who has a child under 16 to consent to their child's participation. The assent of the child will also be given due consideration (BPS, 2014).

Once all consent forms have been signed by the researcher, each participant and parent, one copy of each will be collected and stored securely in line with GDPR. Participants will be given a code to log into the digital portal, with each family unit receiving a different code. Upon logging in, each participant will be asked to give their age, gender and whether they are a child, parent or grandparent. To be able to compare data given by family members, each participating family will then be assigned a pseudonym by which they will be known. Participants will then complete all 20 questions followed by the additional exposure questions. On completion of the questionnaire, each participant will be given a debrief form thanking them for their participation, restating the aims of the study and reiterating their right to withdraw. They will also be given an opportunity to ask any questions they may have.

STUDY OUTCOMES

A small number of studies have looked at the attitudes of young people towards mental illness (Corrigan et al, 2005; Jorm and Wright, 2008) with fewer exploring attitudes throughout family generations (Jorm and Wright, 2008). Evidence is limited on this topic, making it hard to draw firm

conclusions. Therefore further research is necessary, especially given the prevalence of mental illness amongst young people (Office for National Statistics, 2017). Given the lack of literature to be found, this study would provide beneficial research in this area.

The expected outcomes for this study include finding common themes in the attitudes of family members as attitudes are often passed down from generation to generation. The added element of determining exposure to mental illness could also provide valuable insights into trends amongst family generations or if any outliers are present in the data. It is also expected that trends will be found amongst peers. This data would provide a basis for exploring whether attitudes are more similar amongst families or amongst peers. Such insights will then help to shape how best to educate people in matters concerning mental illness.

There are some limitations to be taken into account regarding exposure as, beyond asking the nature of the relationship and categorising the mental illness, this study will not consider the nature of the exposure, i.e. if it has been positive or negative. This would be worth exploring in subsequent studies as it could give insights into why and how stigma develops. Another limitation is that this study will only require data from one member of each family generation. Were additional family members included, it would produce a wider picture.

Being a relatively unexplored area, this study would be part of paving the way for further research into changes in attitude toward mental illness as well as those that have persisted over time, which could lead to insights into ways to change stigma.

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