Exploring differences in attitudes towards mental health between British South Asians and White British individuals using the opinions about mental illness scale

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ABSTRACT

This study aimed to explore if individuals form a British South Asian cultural background have a more positive or negative attitude and perception of mental illness and the mentally ill compared to White British individuals by using the Opinions about Mental Illness scale which was developed by Cohen & Struening (1962) and explores attitudes to mental health across 5 attitudinal dimensions. The questionnaire was posted online and data was collected using an opportunity based sample by recruiting participants using social media. An Independent samples *t*-test revealed that British South Asians have a significantly more negative attitude and perception towards mental illness than their White British counterparts. Results and findings are discussed.

KEY WORDS:	ATTITUDES TO MENTAL ILLNESS	BRITSH SOUTH ASIAN	WHITE BRITISH	CULTURE	OMI SCALE

Introduction:

According to various epidemiological studies conducted to assess the prevalence of mental illnesses and disorders in the U.K, Europe and the United States, it has been found that they are a common phenomenon in various societies. According to these studies, approximately one fourth of the population in these countries are suffering, or have suffered, from a mental disorder or illness of some form during their lifetimes, with the prevalence rate of psychotic disorders found to be at 3% in the general population and anxiety and mood disorders found to be the most common of the mental disorders. (Alonso et al. 2004; Perala et al. 2007). Although wide-ranging research has been conducted regarding the stigma of mental illness and how to reduce it, as well as the outstanding advances in psychotherapy and psychiatry research and interventions over the last decade aimed at reducing and preventing the effects of mental disorders and increasing the understanding of their aetiology, negative attitudes towards individuals who suffer from mental illness, however, are still widespread (Health Service Executive, 2012). The perception of mentally ill individuals as being dangerous mad men who are aberrant and unsafe are some of the more frequent themes found in accounts of the mentally ill (Elbogen & Johnson, 2009).

There are various factors that have been found to shape and influence the attitudes and beliefs that individuals have regarding mental illness and the mentally ill. Some of these factors are as follows; knowing or interacting with an individual who has a mental illness or disorder, the level of personal knowledge and experience regarding mental illness, stories in the mass media related to mental illness and the mentally ill, level of familiarity with institutional practices for dealing with and treating the mentally ill and cultural backgrounds and influences which can lead to the formation of cultural stereotypes about mental disorders and illnesses as well as of the mentally ill (Corrigan, Markowitz & Watson 2004; Wahl, 2003).

Culture and Mental health:

Of the various factors mentioned above, cultural background has been found to have a profound influence on various issues related to mental health. It can influence the propensity of individuals accessing mental health services, the treatment methods they implement and utilise to help treat or cope with a specific mental disorder and, most importantly, it can influence the attitudes and beliefs of a specific community towards mental illness and the mentally ill in general, which can potentially lead to discriminatory and stereotyping behaviours (Office of the Surgeon General, U.S., 2001; Link et al., 1999). It is for these reasons that researchers have long been interested in attempting to further explore and understand how individuals from various cultural backgrounds view the issue of mental health (Abdullah & Brown, 2011). Although there have been various studies to explore this issue, exploration of cultural influences on individuals form ethnic minority cultures in the U.K has been given very little and very basic attention by researchers. Some of the research studies that have been conducted have been very limited in their scope and somewhat general in nature as they tend to focus only on general attitudes towards mental illness and do not give attention to specific areas or dimensions (Schefer et al,. 2013). The vast majority of the studies which have explored the issue of attitudes towards mental health among ethnic-minority cultures and groups in the U.K have tended to mainly concentrate on and explore how there is a perception among

ethnic-minority groups in the U.K of being discriminated against and stigmatised by the medical establishment and authorities and how this negative perception they have can potentially act as a barrier to them accessing and approaching mental health services and specialists (Karlsen et al,. 2005). According to Shefer et al., (2013), in recent years this has become the main area of focus with regards to research in this area. From among the various ethnic minority groups in the U.K, this study will focus on exploring the attitudes and beliefs of individuals from a British South Asian cultural background towards mental illness and the mentally ill.

British South Asians & attitudes to Mental Health:

According to the 2011 U.K. Census, 4.9% of the U.K population identified themselves as being from a South Asian (India, Pakistan and Bangladesh) background (ONS, 2011). People began to arrive in the U.K from various parts of South Asia during the 1950s and 60s. The mass immigration of individuals from these countries to the U.K was as a result of post war labour shortages which opened up job opportunities for individuals' from the various Commonwealth nations (Visram, 2002). The individuals who migrated from these nations brought with them their own cultural beliefs, practices and attitudes. Rait & Burns (1997) state that early theories of migration and acculturation postulated that migrants coming from the Commonwealth countries would assimilate and embrace the new culture that is around them in their host nation and society and that they would, eventually, become entirely absorbed into their new communities. These theories were, however, unfounded and as time went by this became more evident. Later theories of acculturation now instead postulate that, although there may be a slight shift in cultural behaviour and practices, a vast amount of the cultural attitudes, beliefs and behaviours are retained by the migrant communities from their countries of origin, whilst only a small amount of the ideals and traditions of the host community are incorporated. Therefore, the cultural beliefs, attitudes, ideals and practices of the migrant communities are then passed on to their offspring and are, thus, perpetuated into the later generations (Rait & Burns., 1997; Rudmin., 2003).

According to Lopez et al., (2006) neuro psychiatric disorders, which includes depressive disorders, anxiety disorders, dementias, neurological disorders and mental retardation account for 11.1 % of the total burden of disease in low and middle income countries, which include the South Asian countries of India, Pakistan, Bangladesh and Sri Lanka. This is one of the main reasons why various studies have been conducted to explore the attitudes and beliefs towards mental illness and the mentally ill in these South Asian countries and they have found that the predominant beliefs and attitudes individuals from these nations have are mostly negative. Lauber & Rossler (2007) found that, compared to many Western nations, there is a higher propensity to stigmatise and discriminate against individuals who are suffering from a mental illness in Asian countries. They found that people with mental illnesses are considered to be aggressive and dangerous. They also found that there is a prevalence among these communities to explain mental health problems as having originated or being caused by either supernatural or religious influences rather than having biological or medical causes which, in turn, leads to individuals regarding mental health services with contempt and scepticism. Individuals with mental illnesses are also more likely to face stigmatisation from their own families in these communities. All of this in turn has led to individuals suffering from mental illnesses and disorders, as well as their families, being socially excluded

and ostracised in their communities. These findings are further supported by Patel (2007) who further states that the social exclusion and stigmatisation of mentally ill individuals that is caused by the high prevalence of negative attitudes and perceptions of mental illness and the mentally ill leads to the development of further and more severe mental disorders in such societies. There is also further support from Karim et al., (2004) and Khandelwal et al., (2004) for the finding that mental illnesses and disorders are believed to have mainly supernatural or religious causes and not as having biological or medical causes. They state that, as these are regarded to be the main causes of these illnesses and disorders, mentally ill individuals and their families turn towards spiritual healers (Amils and Hakims) for treatment, rather than approach mental health specialists and services or utilise medical or pharmacological treatments.

Studies have also been conducted to explore the issue of attitudes towards mental illness and the mentally ill among British South Asian communities. They have found that, like the attitudes of those who reside in South Asian countries, British South Asian individuals also have fairly negative beliefs and attitudes regarding mental illness and the mentally ill. According to Sheikh & Furnham (2000), these negative beliefs, attitudes and ideals are usually perpetuated by family members and can be traced back to the earlier generation of migrants from South Asian countries. Tabassum et al., (2000) conducted a qualitative research study using family group interviews to explore the attitudes towards mental illness amongst a British South Asian community and their sample comprised of both first and second generation individuals. One of the main findings they made was that the first generation migrant community had made very little effort to assimilate and interact with the culture of their host society and had instead remained rigidly adhered to their original South Asian peasant culture. The interviews were conducted with all members of the families present and were made up of both first and second generation individuals. When asked regarding what they believed to be the causes of mental illness and disorders, 27% of the sample stated that they believed mental illness was mainly caused by supernatural influences. They were also asked regarding the level of interaction they would be willing to have with an individual who was suffering from a mental disorder. Although there was an overall willingness to have superficial contact with mentally ill individuals, none of the sample were willing to even consider the concept of marriage to a mental health patient. As well as this, less than 25% were willing to consider having a close relationship with a mental health patient, whilst less than 50% were willing to socialise with them. Some individuals from the sample also stated that they would be reluctant to allow their children to even converse with an individual who had a mental illness.

A more recent study was conducted in 2010 by the anti-stigma and anti-discrimination charity Time to Change which supports the findings of the previous study. A report was commissioned by this charity which aimed to explore the attitudes towards mental illness among individuals from a South Asian cultural background living in London. They conducted a qualitative research study by using consultation groups, focus groups and interviews with various members of the community with the aim of understanding the stigma and discrimination that mentally ill individuals and their carers or families experience, as well as aim to understand and explore the attitudes of the wider community towards mental illness and mental health in general (Time to change, 2011). They made some key findings across the research groups which highlighted the types of stigma and discrimination mentally ill

individuals experienced as well as how individuals from this community viewed mental health issues. They found that mental illness is a taboo subject amongst members of this community and is not an issue which is discussed or spoken about for fear of bringing shame on the family. Mentally ill individuals also stated that they were forced to keep their problems a secret from their family members for fear of discrimination, similar to those who reside in South Asian countries, with one individual stating they had kept their illness a secret from their spouse for 20 years. They also found that, due to the culture of secrecy that surrounds the issue of mental health, there is a severe lack of understanding regarding the causes of mental health problems and several misconceptions are prevalent which have grown over several years. Much like individuals who reside in South Asian countries, the causes of mental illness were attributed to supernatural or religious causes such as black magic or as being the will of God, as well as having entirely genetic causes or as being the result of bad parenting. As a result of such beliefs, the likelihood of accessing mental health services is very low, even among individuals who do recognise the biological and medical causes of mental illness as they have a tendency to believe that the cause of mental illness is entirely genetic and, therefore, it cannot be cured or treated. Such beliefs also act as barriers to reducing negative perceptions and attitudes regarding mental illness. A further finding from this research sates that the family plays a significant role in perpetuating negative attitudes and stereotypes towards individuals with mental health problems (Time to change, 2011).

Research rationale:

Although the above mentioned studies have explored the issue of attitudes towards mental illness among British South Asian communities, they have done so from a very general perspective and have not explored specific areas or dimensions. This current study will explore attitudes towards mental illness among individuals from a British South Asian cultural background (those who were born and/or raised in Britain and belong to a South Asian culture) using The Opinions about Mental Illness scale (OMI) which was developed by Cohen & Struening (1962). The reason for using this scale is that it has a long history of usage among various different populations (Todor, 2013) and it explores and investigates attitudes towards mental illness across five main attitudinal dimensions which are; Authoritarianism, which can be understood as representing individuals beliefs regarding how mentally ill individuals are inferior or different compared to those who are not mentally ill. It contains items which asses the belief that mentally ill individuals should be restrained, kept secure and locked in in-patient facilities. It also contains the belief that talking and thinking about ones problems should be avoided as it is unhelpful. The second dimension is Benevolence, which can be understood as being a moral kindness towards mentally ill individuals, an attitude towards them that is between tolerance, compassion and pity. The third is Mental Hygiene Ideology, which can be defined as being the opinion that there is a difference between mental illness and other ailments and also that mental illnesses should be treated specifically by mental health specialists only. The forth is Social Restrictiveness, which refers to the belief that mentally ill individuals should be restricted in certain social domains. It contains the belief that parental rights should be removed, employment choices and areas should be restricted and even the notion of forced sterilisation. The final attitudinal dimension is Interpersonal Etiology (sic), which can be understood as being the

belief that mental illnesses are caused, mainly, by problematic interpersonal relationships (Todor, 2013; Cohen & Struening, 1962).

Using this scale will allow for a better understanding of the underlying attitudes towards mental illness and the mentally ill among members of the British South Asian community which will, in turn, allow for the development of more culture specific educational interventions which will help to dispel some of the negative thoughts and perceptions that may be present among members of this community. This will then help to reduce the levels of stigma and discrimination that mentally ill individuals who live among members of the British South Asian community experience.

As well as exploring attitudes towards mental health among the British South Asian community, this study will also explore attitudes towards mental health among individuals who come from a White British cultural background. The reason for this is based on the findings of Angermeyer & Dietrich (2005) who carried out a literature review of all the available literature pertaining to population based attitude research in Psychiatry over a period of 15 years and they found that negative perceptions, attitudes and misconceptions towards mental illness and the mentally ill were still very prevalent among the general public in the time period between 1990 and 2005. However, they also found that there were inter-cultural variations in these attitudes and that there had been a change in attitudes over time, with individuals form certain cultures having a more positive perception of mental illness and the mentally ill compared to others. This finding is further supported by a report released by the mental health charity MIND, (2014) which explored attitudes towards Mental Illness among adults in the U.K using a survey that was made up of 27 statements regarding mental illness with respondents required to indicate to what level they agreed or disagreed with these statements on a 5 point Likert scale. The aim of the survey was to monitor possible changes in public perceptions and attitudes towards mental illness over time. They found that attitudes towards individuals with a mental illness had generally become more favourable between 2008 and 2014. The 27 statements were grouped into 4 categories. The first was ‘Fear and Exclusion of people with mental illnesses. Items in this category portray mostly negative attitudes towards mentally ill individuals and the findings indicate that levels of agreement with these statements was low and had fallen between 2008 and 2014. The second category was ‘Understanding and Tolerance of mental illnesses. Levels of understanding regarding the causes of mental illness as well as tolerance of those who are mentally ill was found to be high and had increased between 2008 and 2014. The third category was ‘Integrating people with mental illness into the community’. Levels of agreement to statements in this category were mixed but were found to have become significantly more positive between 2008 and 2014. The final category was ‘Causes of mental illness and the need for special services’. Items in this category explore the causes of mental illness as well as whether or not there are sufficient services available in the community for mentally ill individuals. There was an increase in the percentage of individuals disagreeing that mental illness was caused by a lack of will power between 2008 and 2014 (from 62% to 68%). Also, in the same time period, there was an increase in the percentage of people disagreeing that there were sufficient services available for the mentally ill in the community (from 44% to 49%).

Aims and hypotheses:

Based upon the findings of the above mentioned study and report, this study aims to establish if there is a difference in attitudes towards mental illness and the mentally ill based upon an individuals' cultural background. Therefore, attitudes towards mental illness and the mentally ill will be explored among individuals from a British South Asian cultural background and individuals from a White British cultural background using the OMI which will explore their attitudes in 5 specific attitudinal dimensions (Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness & Interpersonal Etiology).

H1: It is hypothesised that individuals from a British South Asian cultural background will have an overall more negative perception of mental illness and the mentally ill and will have a lower overall score on the OMI.

H2: It is hypothesised that British South Asians will score less than their White British counterparts on the 5 attitudinal sub-scales of the OMI.

Methodology:

Design:

The current research is of an independent measures design which used a questionnaire to explore attitudes towards mental illness and the mentally in 5 attitudinal areas. The independent variable is the cultural background of the participants (White British or British South Asian). There are 6 dependent variables in this study which are the overall score of the participants on the OMI as well as their scores on each of the 5 sub-scales of the OMI used to explore attitudes in these specific areas.

Participants:

There was a total of 69 participants who responded to the questionnaire. Of these participants 22 were male and 42 were female with the remaining 5 participants choosing not to disclose their gender. 24 of the participants were from a White British Cultural background and 30 were from a British South Asian cultural background. The remaining 15 participants either responded to their cultural background as being 'other' or chose not to disclose their cultural background and were, therefore, not included in the analysis as they did not fulfil the required criteria for inclusion in this study. The total number of participants for this study is 54 ($N = 54$).

Materials:

An application for ethical approval form (AEAF) (Appendix 1) was filled in and submitted to gain ethical approval for this study. A questionnaire (Appendix 2), was used to explore participants' attitudes to mental illness and the mentally ill. An information sheet (Appendix 3) and debrief sheet (Appendix 4) were the other materials used and were administered electronically and online to participants.

Measures:

Questionnaire, Opinions about Mental Illness scale:

In this research, an established questionnaire known as the Opinions about Mental Illness scale (OMI) (Cohen & Struening, 1962) was used by the researcher as it has been found to have satisfactory psychometric properties as well as having a long history of being used to explore attitudes towards mental illness in various populations (Todor, 2013; Kazantzis et al. 2009). Permission to use this questionnaire was gained from the American Psychological Association (Appendix 5). The questionnaire was developed by Cohen and Struening in 1959 in order to assess the attitudes of health care personnel towards mental illness. According to the authors, responses to the items on the OMI scale give an insight into attitudes and opinions regarding the treatment, prognosis and aetiology of mental illness (Cohen & Struening, 1962). Construct validation of the OMI was conducted from a pool of 200 items which were analysed by 8000 individuals who were experienced in the field of mental health. After extensive factor analysis, a 51 item scale was developed which provides opinion statements that are responded to using a 7 point Likert scale ranging from 1 = Strongly Agree to 7 = Strongly Disagree, a higher score is indicative of a more positive attitude. The authors conducted a further factor analysis of the remaining 51 items which revealed 5 sub-scales; Authoritarianism (11 items), Benevolence (14 items), Mental Hygiene Ideology (9 items), Social Restrictiveness (10 items) and Interpersonal Etiology (9 items).

Procedure:

Participants for this study were recruited using an opportunity sampling method. The questionnaire (Appendix#) was uploaded to the online survey tool Qualtrics. A link to the website was then sent to participants via social media website Facebook inviting them to complete the questionnaire. Upon following the provided link, participants were brought to the questionnaire where the information sheet (Appendix 3) was provided which gave details regarding the researcher as well as some brief information regarding what the study and questionnaire entail. On the next page, participants were asked to read through a statement and click the box to confirm that they are consenting to take part in the study. Upon giving their consent, participants were taken to the next page to begin responding to the questionnaire (Appendix 2). Upon completing the questionnaire, participants were provided with a debrief sheet (Appendix 4).

Data Analysis:

Data obtained from the questionnaire was analysed using the software SPSS.

Independent *t*-test:

In order to establish if the mean differences in the scores attained by participants from the 2 cultural backgrounds (White British and British South Asian) were statistically significantly different, an independent samples *t*-test was conducted on the data. According to research, *t*-tests are extremely useful for highlighting the similarities or differences between 2 groups (Watkins, Scheaffer & Cobb, 2004).

Results:

In order to establish if the data was normally distributed, a Shapiro-Wilk test ($p > 0.05$) was conducted which showed that the data is approximately normally distributed for both White British participants and British South Asian participants, with a skewness of - 0.909 (SE = 0.564) for White British individuals and a skewness of - 0.003 (SE = 0.472) for British South Asian participants.

Descriptive Statistics.

Table 1:

Table presenting the means and standard deviations for the scores of White British and British South Asian participants on the 5 sub-scales of the OMI (Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness and Interpersonal Etiology):

	White British N=24		**British South Asian N=30**	
OMI Subscales	*M*	*SD*	*M*	*SD*
Authoritarianism.	96.25	6.66	82.68	11.40
Benevolence.	32.43	4.12	28.00	4.37
Mental Hygiene Ideology.	19.05	4.69	21.33	3.70
Social Restrictiveness.	32.90	3.16	29.19	4.40
Interpersonal Etiology.	40.67	5.62	39.33	6.19

The descriptive statistics reveal that for the attitudinal dimension of Authoritarianism, both White British and British South Asian participants gained a significantly high score, with White British Participants scoring higher (M = 96.25, SD = 6.66) than British South Asians (M = 82.68, SD = 11.40). Both groups of participants gained significantly low scores for the attitudinal dimension Mental Hygiene Ideology, with British South Asians scoring slightly higher (M = 21.33, SD = 3.70) than White British participants (M = 19.05, SD = 4.69). For the dimension Interpersonal Etiology, White British participants scored slightly higher (M = 40.67, SD = 5.62) than their British South Asian counterparts (M = 39.33, SD = 6.19). For Social Restrictiveness, again White British participants scored higher (M = 32.90, SD = 3.16) than British South Asians (M = 29.19, SD = 4.40). For the factor of Benevolence, White British participants also scored higher (M = 32.43, S = 4.12) than British South Asians (M = 28.00, SD = 4.37).

Inferential Statistics:

Overall OMI score:

As the data was approximately normally distributed, a parametric analysis was conducted of the results to establish if the results were statistically significantly different from one another. An independent-samples *t*-test was used to compare the scores of the participants from the 2 cultural backgrounds (White British and British South Asian). The results indicate that there was a significant difference in between White British participants (M = 221.00, SD = 15.28) and those from a British South Asian cultural background (M = 203.38, SD = 16.27) in the overall OMI scores they attained $t(38) = 3.44$, $p = .001$. This finding supports H1 which hypothesised that British South Asians would score lower than White British participants indicating that they had over all more negative attitudes towards mental illness and the mentally ill.

Scores on the 5 subscales measuring attitudinal areas:

Independent sample *t*-tests were also conducted on the scores attained by the 2 cultural groups (White British and British South Asian) on each of the 5 subscales of the OMI to compare the levels on which they differed from one another.

The calculations indicate that there was a significant difference between White British participants and British South Asians in the scores attained in the attitudinal dimension subscales of the OMI for Authoritarianism $t(44.51) = 5.18$, $p < .001$, Benevolence $t(46) = 3.57$, $p = .001$ and Social Restrictiveness $t(45) = 3.20$, p .002. There was no significant difference between the scores of the cultural groups for the remaining 2 attitudinal subscales of Mental Hygiene Ideology $t(45) = -1.87$, $p = 0.07$ and Interpersonal Etiology $t(40) = 0.718$, $p = 0.48$. This finding contradicts H2 which hypothesised that participants from a British South Asian cultural background will gain lower scores in all 5 of the subscales of the OMI compared to participants from a White British cultural background.

Discussion:

This study aimed to establish if there is a difference in attitudes towards mental illness and the mentally ill based upon an individuals' cultural background. Attitudes towards mental illness and the mentally among White British and British South Asians were explored using the OMI scale which explores attitudes in 5 specific attitudinal dimensions. As stated earlier, the findings indicate that individuals from a British South Asian cultural background have an overall more negative attitude towards mental illness and the mentally ill compared to their White British counterparts which confirmed H1. As for the scores on each of the 5 subscales of the OMI which measure attitudes in the 5 specific attitudinal dimensions, a significant difference was found between the cultural groups in 3 of the dimensions; Authoritarianism, Benevolence and Social Restrictiveness, whereas there was a non-significant difference in Mental Hygiene Ideology and Interpersonal Etiology.

The findings of this study are consistent with previous research which has explored the issue of attitudes towards mental illness among individuals from a British South Asian cultural background which found that a negative perception and attitude towards mental illness was prevalent amongst members of this community

(Tabassum et al. 2000; Time to Change, 2011). This study can add to such research as it explored 5 specific attitudinal areas

5 attitudinal dimensions:

Authoritarianism:

This factor of the OMI assesses the opinion that individuals who are suffering from a mental illness are inferior and different from those who are not suffering from a mental illness. In this subscale, the lower score was attained by individuals from a South Asian cultural background which is reflective of a more negative attitude towards the mentally ill. This negative attitude can be linked to previous research which found that the stereotypical view of mentally ill individuals as being people who are dangerous is somewhat prevalent among British South Asians (Lauber & Rossler, 2007; Time to Change, 2011). White British participants attained a much higher score in this subscale which is indicative of a more positive attitude towards mentally ill individuals as being the same and equal to those who are not suffering from a mental illness.

Benevolence:

This subscale reflects a moral kindness, the level of compassion, pity and tolerance individuals have towards the mentally ill. In this subscale, there was also a significant difference between the mean scores of the 2 cultural groups. British South Asian participants were found to have a lower score which indicates that their level of moral kindness towards individuals who are mentally ill is less than that of their White British counterparts.

Mental Hygiene Ideology:

This subscale measures the belief that there is a distinction between mental illness and physical ailments as well as the belief that only mental health specialists should treat mentally ill individuals. There was no significant difference in the mean scores attained by participants from the 2 cultural groups for this subscale.

Social Restrictiveness:

This subscale aims to explore the belief that mentally ill individuals should be kept away from certain parts of society. On this subscale, there was a significant difference between the mean scores attained by each cultural group, with British South Asians once again scoring lower than White British participants which indicates a more negative attitude.

Interpersonal Etiology:

This subscale aims to explore the belief that mental illnesses are caused by problematic interpersonal relationships. In this subscale, there was not a significant difference in the mean scores of the 2 cultural groups.

The findings of 3 of the 5 subscales give support to the findings of Angermeyer and Dietrich (2005) who stated that, although more positive perceptions and attitudes of

mental illness were increasing in certain societies, there were certain cultural variations in the attitudes towards mental illness and the mentally ill.

Evaluation:

There were numerous limitations in this study. The opportunity sampling method that was utilised to recruit participants for this study by inviting them to complete the questionnaire via social media limited the amount of responses that were gained to the questionnaire which means that the findings of the study cannot be generalised to the wider population. A suggestion for future research would be to use a wider ranging sampling method which will allow for the recruitment of a greater number of participants, thus, allowing for a greater generalisation of the research findings.

Another limitation of this study is that it did not take into account the effect of gender on attitudes towards mental illness and the mentally ill. A suggestion for future research would be to include gender in the research analysis in order to establish if it has an effect on the development of positive or negative attitudes towards mental health. A further suggestion for a future study would be to include a question asking participants what level of knowledge or experience they have of mental illness, as well as what generation participants belong to (2^{nd}, 3^{rd}, 4^{th} generation migrants etc.) as these factors can have an effect the attitudes that individuals may have towards mental illness and the mentally ill.

Implications for future research:

The topic of exploring attitudes towards mental illness and the mentally ill among individuals from various cultural backgrounds is extremely important as it allows for a deeper understanding of cultural influences that have been proven to have an effect on the formation of beliefs and attitudes. A deeper understanding of these cultural influences will allow for the development of culture specific educational programmes to help tackle and reduce the misconceptions that such influences can perpetuate in certain communities. Such community based approaches aimed at tackling stigma can be more valuable and effective than top down public education programmes (Knifton et al. 2009). Researchers may want to conduct more direct ethnographic and emplaced studies with individuals from a British South Asian cultural background, as well as other ethnic minority cultures within the U.K., in order to get a deeper understanding of which facets of these various cultures influence the attitudes that they develop towards mental illness and the mentally ill.

Conclusion:

Overall, this study has provided evidence that individuals from a British South Asian cultural background have a more negative perception and attitude towards mental illness and the mentally than those who belong to a White British cultural background. It is important to conduct a more deeper and wide-ranging study into the specific cultural beliefs and ideals that are possibly responsible for the continuous perpetuation of these negative attitudes in order to help create a greater understanding regarding mental illness and, thus, create a more harmonious and understanding society for all.

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