



Investigating the Effect of Gender differences and Socioeconomic Status on the Willingness to Access Mental Health Services.

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ABSTRACT

Research conducted previously assessed the effect of gender and socioeconomic status (SES) on the willingness to access mental health services, however these factors were measured independently. Despite Denton et al. (2004) suggesting that females have an increased association with lower SES and therefore display an increased willingness to access mental health services, there is a gap in research that fails to effectively measure this claim. The current study therefore aims to measure the effect of gender and SES on the willingness to access mental health services. An online survey was distributed to 165 participants, however due to incomplete responses and identified outliers, 39 responses were removed. The final sample consisted of 126 participants, 53 males and 73 females and in terms of SES: 66 working-class, 50 middle-class and 11 upper-class. The data underwent a two-way ANOVA. The findings demonstrated that gender alone effected willingness to access mental health services, with males being more willing than females. Additionally, no difference was found in SES and willingness. Despite this, a significant interaction between gender and SES was found. Further research should be conducted to determine the different aspects of SES and their effect on willingness to access mental health services.

KEY WORDS:	GENDER	SOCIO-ECONOMIC STATUS	MENTAL HEALTH	WILLINGNESS	TWO-WAY ANOVA
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Introduction

One of the largest challenges that public health faces today is the mental health treatment gap (Evans-Lacko et al., 2018). The mental health treatment gap refers to the large deviation between the need for treatment of mental disorders and the provision of that treatment (Patel et al., 2016). The term mental disorder refers to a broad range of psychological conditions that impair everyday functioning and cause distress to the individual experiencing the condition (Hayden and Vandermeer, 2018). Mental disorders may also be referred to as a mental illness, and the terms are often used interchangeably by researchers. Therefore, throughout this study both the terms mental disorder and mental illness will be used. 'Good' mental health refers to a state of wellbeing where there is an absence of a mental disorders, and where the individual is aware of their abilities, allowing them to: adapt to normal life stressors, form and maintain affectionate relationships, work productively and contribute to social roles and their surrounding community (World Health Organisation, 2018; Bhugra, 2013).

Mental illness is a widespread issue, with 1 in 6 individuals in England alone living with a mental illness (Stansfeld et al., 2016). In 2014, only 39.4% of individuals with a mental illness received any form of treatment (Lubian et al., 2016). Even though, this is a vast improvement since 2000; where only 23.1% received treatment, there is still a concern as to why 61.6% have received no treatment (Lubian et al., 2016). An avoidance or failure to treat mental illness can lead to vulnerabilities and often causes the individual to experience a range of internal factors, including: poor self-esteem, lack of emotional resilience, isolation and poor integration with society (Bhugra et al., 2013).

Availability of Mental Health Services

In the last 30 years, the UK has witnessed drastic changes in the treatment of mental disorders (O'Brien et al., 2009). Treatments for an individual with a mental disorder previously consisted of institutionalisation to a psychiatric facility, however after the recent development of treatments made accessible within the community, there is a variety of more appropriate treatments available (O'Brien et al., 2009). The most common types of services currently available in the UK include: therapy, pharmacotherapies, counselling, self-help groups, crisis teams and hospital/psychiatric facilities (Shepley and Pasha, 2017; Committee on School Health, 2004). Despite the substantial range of facilities that are available within the community, not every individual with a mental illness decides to utilise these services. There are a number of factors that could be taken into consideration that could influence their decision, including: social class, level of education, location, gender, availability of services, financial costs and national beliefs towards mental health (Davies, 2001; Buffel et al., 2014). However, for the purpose of this research only the two factors of gender and socioeconomic status (SES) will be investigated.

Gender influence on the utilisation of mental health services

Throughout psychological research, it has been assumed that gender differences may play a significant role in the participation and outcomes of an individual's experiences in accessing mental health services (Gleason et al., 2014). Research tends to suggest that females have an increased likelihood and willingness to access mental health services when compared to males (Kovess-Masfety et al., 2014). One justification for the reduced usage of mental health services by males, is

due to the fear of being stigmatized (Chen and Dagher, 2016). According to Pattyn et al. (2015) Westernised cultures tend to perceive males as 'strong' individuals due to their levels of masculinity, resulting in their reduced needs to access help, as they are expected to deal with their own emotions; without the assistance of others. Whereas, females are viewed as more willing to adopt the sick role, and therefore have a higher acceptance to seek help through accessing mental health services (Green and Pope, 1999). Despite the significance of this research, the application of their findings is questioned when taking into account methodological considerations. The heavy reliance of self-report measures in healthcare research can result in an over-representation of a particular type of respondent (Short et al., 2009). Consequently, to avoid this it is important that the study obtains a varied sample that displays a range of personalities, but is also equal in terms of the independent variables, this is possible to obtain due to the larger sample sizes research is able to obtain through self-reported measures.

Gender differences in mental health care utilisation can also be a result of gender specific patterns of pathology. Buffel et al. (2014) discovered that males are more susceptible to inheriting impulsive and addictive disorders, whereas females are more prevalent to acquiring mood and anxiety disorders. Therefore, research implies males are more willing to rely more on specialised mental health services as they specifically target the treatment of addictive and impulsive disorders (Kovess-Masfety et al., 2014). Alternatively, females show increased association with the usage of General Practitioners (GP's) in order to treat their more familiar anxiety and mood disorders (Buffel et al., 2014). In spite of the extensive psychological research that establishes an association between increased utilisation of mental health services by females compared to males, there is also research contradicting this finding and

therefore weakening this claim. Gagné et al. (2014) discovered an increased usage in GP services over the past year by males when compared to females, thus suggesting that males are more willing to access mental health services than females. Hence why, it is now essential to further investigate which gender is more willing to access mental health services.

Impact of SES on mental health care utilisation

SES is also an important factor to consider due to its impact on the frequency of accessing mental health services. It is especially important due to the relationship between the mental health care available in societies infrastructure and other sociocultural factors throughout the country (Cummings, 2014). Socioeconomic status (SES) is defined as a multidimensional construct that doesn't just include the measure of wealth (Jednorog et al., 2012) but is in fact assessed by three aspects: education attainment, income and social status (Kong et al., 2014). Subjective social status (SSS) is defined as 'the individual's perception of his/ her own position in the social hierarchy' (Jackman and Jackman, 1973: 569). Therefore, it can be argued that SSS is a better indication of an individual's social position in society, in comparison to the more traditional SES indicators (Honjo et al., 2014).

Kong et al. (2014) established that populations from lower SES had an increased frequency in accessing mental health services, and the level of intensity for these services was greater than the requirement necessary for individuals from a higher SES. Individuals living in low SES often face a lack of economic materials and psychological resources in respect of healthcare (Honjo et al., 2014). Research has discovered that being from a disadvantaged background has a relation to increased stressors caused by issues with: finances, relationships, transportation, job loss/

employment issues and having a lack of education (Businelle et al., 2014; Samari et al., 2018). Exposure of these stressors therefore leads to an increase in mental health problems, common examples include: depression, anxiety and mood disorders (Businelle et al., 2014) and thus leads to the increased utilisation of mental health services from individuals with lower SES.

Additionally, an individual's perceived judgement of their position in the social hierarchy impacts their positivity or negativity towards the usefulness of mental health services (Honjo et al., 2014). For example, Honjo et al. (2014) found that individuals who rated their SSS as middle-class had the lowest association with using mental health services in comparison to individuals who rated themselves as working-class who displayed the highest association. As well as an individual's SSS and the increased stressors associated with low SES, the availability of services in the different areas of society also impacts the frequency of accessing mental health services. In areas of higher SES, there is a heightened availability of services due to the location (Cummings, 2014) and the increased awareness of these services increases their utilisation (Gonzalez et al., 2011). Although, the majority of psychological research implies that those with lower SES are more willing to access mental health services, the extent to which this can be attributed to real life is restricted, as there is no clear measurement of SES, thus making it difficult to apply the magnitude of all findings to make this assumption. Consequently, it is important to ensure the three main factors of SES (SSS, level of education and income) are measured separately, to establish which aspect is directly affecting the dependant variable.

Additionally, some psychological research challenged this argument by suggesting that those from a higher SES are more willing to access and use mental health services than individuals from a lower SES. Post traumatic growth theory claims

that significant life events that cause disruption, threat and distress for an individual promotes cognitive and behavioural processes (Andrykowski et al., 2013). Thus, suggesting individuals living in low SES can benefit from greater positive mental health outcomes following the 'growth' of experiencing the trauma. As a result of this 'growth' individuals from a lower SES will need less support, suggesting that those from a higher SES are more likely to utilise mental health services.

The impact a relationship between Gender and SES has on the accessibility of mental health services

After deliberating how both gender and SES impact the frequency of utilising mental health services, we have established the reasoning for these factors independently, however it is important to look at the factors in relation to one another. The exploration of gender and SES attitudes and stereotypes has an increased importance, in order to target specific subgroups of the population who may have a higher demand to access mental health services, as this could be influential on their usage (Gonzalez et al., 2011; Rhodes et al., 2002). Ross and Bird (1994) explained in their differential exposure hypothesis that females generally tend to live in lower SES, as they are more likely to be: unemployed, live in poverty, be single parents and have lower incomes when compared to males. Research from Denton et al. (2004) suggests that due to these additional demands and obligations that females tackle as a result of their social position, females tend to be willing to access mental health services more than males.

Therefore, the aim of this research is to gain a further insight into the limited existing literature exploring the effects of both gender differences and SES, on an

individual's willingness to access mental health services. Aside from this study, there is a lack of evidence that looks at both factors in association with one another, this is an important gap in the research that is necessary to explore. Exploring this association allows specific subgroups of the population who have a higher need to utilise mental health services to be targeted. Due to the extensive amount of psychological research (Kovess-Masfety et al., 2014; Buffel et al., 2014) measuring mental health care utilisation through self-report methods, this seemed an appropriate method to use in this study in order to gain larger sample sizes. Consequently, this research aims to establish if gender and SES influence an individual's willingness to access mental health services. The current study therefore expects to find the following:

Hypothesis 1: Females will be more willing to access mental health services than males.

Hypothesis 2: There will be a difference in the socioeconomic status of individuals who are more willing to access mental health services and those who are less willing.

Hypothesis 3: There will be a relationship between the gender of the participant and their socioeconomic status, and this will affect their willingness to access mental health services.

Null hypothesis: There will be no difference in the gender and SES of an individual's willingness to access mental health services.

Method

Design

The current study followed a between-subjects design, in which all participants completed a 28-item online survey. This survey assessed the independent variables (IV's) of gender, with two levels (female, male) and SES with 3 levels (working-class, middle-class, upper-class) and the dependant variable (DV) of willingness to access mental health services. There were no control groups or further conditions.

Participants

165 adults ranging from ages 18-55 participated in this study. The sample were recruited via opportunity sampling (See Appendix 1), through the use of Manchester Metropolitan University internal participation pool and the researcher's social media platforms, mainly through the social media site Facebook. Social media was used as a sampling method to ensure a broader distribution of participants from various backgrounds. Thirty seven data sets had to be removed from the data set due to incomplete data. As a result, there was 128 responses left to be used in the main analysis. However, after conducting the tests for normality (See Appendix 2), participants 11 and 116 were removed for being extreme outliers, leaving 126 responses.

The final sample being used for analysis comprised of 53 males and 73 females, and in terms of groups of social class, 66 participants classified themselves as working-class, 50 as middle-class and 10 as upper-class. Additionally, for income groups: 21 participants belonged to the £0- £10,000 income group, 38 to the £10,000- £25,000 group, 32 to the £25,000- £40,000 group, 12 to the £40,000- £50,000 group and 23 to the group of £50,000+. Furthermore, in terms of level of education attained: 17 participants stated they achieved a high school level, 31 stated college, 71 stated bachelor's degree and 7 said they had a masters/ doctorate level of education.

Furthermore, demographics revealed that 36.5% of the participants had been diagnosed with a mental health disorder, thus meaning 64.5% of the sample did not have a mental health disorder. Within the group of participants who stated they had been diagnosed with a mental health disorder, 28.6% were male and 71.74% were female.

Data sets that were removed due to their incomplete data were securely destroyed.

Measures

The survey consisted of a range of demographics and scales measuring willingness to access mental health services (See Appendix 3). The willingness scale consisted of 8 statements, measured using a 5-point Likert scale. Examples include 'How likely are you to use medication to treat a mental health illness?' and 'To what extent do you believe that: mental health services are useful?'. The 8 statements were provided in questions 21- 28 of the survey, to measure the DV by providing an overall willingness score. This willingness score will be measured using a total score of 35, therefore a score of 17.5 or above, would indicate a willingness to access mental health services. The IV's of gender and SES were measured within the demographic questions.

The survey was generated upon gathering ideas from research measuring similar variables. For example, the generation of a number of the statements were gathered from the General Help Seeking Questionnaire (Wilson et al., 2005). The General Help Seeking Questionnaire (GHSQ) measured how likely an individual is to use a range of sources to deal with an emotional problem. The following categories were acquired from the GHSQ to use in this current study, in regard to the types of mental health services the respondent may use: GP's, mental health professionals, therapists and those around you, including: an intimate partner, friends or family. This study differs from the GHSQ which uses a 7-point Likert scale, compared to this study which uses a 5-point Likert scale. This survey (See Appendix 3) was then added to the online software Qualtrics.

Ethics

Ethical Approval was obtained (See Appendix 1) from Manchester Metropolitan University Psychology department, it was essential that the ethical guidelines met The British Psychological Society (2018) Code of Ethics and Conduct. Participants were required to read and sign the consent form (See Appendix 4) presented to them online, prior to them filling out the survey. Participants were also required to create a unique code using the last two digits of their postcode and the last two digits of their date of

birth, ensuring their data was kept anonymous. Data was secure on a password protected computer, only accessible to the researcher. Participants were made aware that they could withdraw their data from the study if they wished to do so and were provided the researchers contact details in the information sheet (See Appendix 5) and debrief form (See Appendix 6).

Procedure

Once ethical approval was granted by Manchester Metropolitan University (See Appendix 1), data collection began. After creating the survey on Qualtrics, it was distributed, and participants responses were acquired through social media platforms or the internal participation pool. Participants clicked on to the link which directed them to the survey, where they were then required to read the necessary consent form (See Appendix 4) and information sheet (See Appendix 5) prior to completing the survey. Once all 28 questions are completed, they were provided with an online debrief sheet (See Appendix 6).

Results

Preparation of Data

The survey was subjected to internal consistency analysis, using Cronbach's alpha. Results indicated the reliability for the 'willingness' scale was good but just below average, $\alpha = .674$ (See Appendix 2). Removing items from the scale could improve the Cronbach's alpha value, however this would only make a minor improvement, therefore the decision was made to remove zero of the items from the scale.

Data was checked to see if parametric assumptions were met. Shapiro-Wilk's test of normality discovered a normal distribution for both males and females (See Appendix 2). Additionally, both working-class and middle-class groups displayed a normal distribution, the only group that did not follow a normal distribution were upper-class participants. Data was also checked for outliers by reviewing the box plots (See Appendix 2), two outliers were discovered, therefore these responses had to be removed prior to analysis. Homogeneity of variance was also measured. It was established that the first IV of gender had homogeneity of variance. Whereas, for the second IV of social class, lacked homogeneity of variance when comparing working-class and middle-class groups to upper-class groups. The only variance that can be found between the social class groups was between the working-class and middle-class.

Analysis

The results for the willingness scores were analysed using an independent measures two-way Analysis of Variance (ANOVA) test and further post-hoc Tukey HSD tests. Both IV's were between-subjects: gender and SES. The DV for this study was the participants 'willingness' to access mental health services score.

Descriptive statistics for this data set are presented in Table 1. Overall the data reveals the mean willingness scores for males were slightly higher (M= 19.51, SD= 5.21) than willingness scores for females (M= 17.51, SD= 4.91). Additionally, the mean willingness scores for working-class participants (M= 18.02, SD= 4.66) were the lowest in comparison to the upper-class participants (M= 20.70, SD= 9.02) who showed slightly higher scores when compared to both working-class and middle-class groups.

Table 1.

Descriptive Statistics for Gender and Social Class

Gender	Social Class	N	M	SD
Male	Working Class	21	18.71	3.72
	Middle Class	24	18.88	4.98
	Upper Class	8	23.50	7.69
	Total	53	19.51	5.21
Female	Working Class	45	17.69	4.69
	Middle Class	26	17.81	4.37
	Upper Class	2	9.50	2.12

	Total	73	17.51	4.91
Total	Working Class	66	18.02	4.66
	Middle Class	50	18.32	4.66
	Upper Class	10	20.70	9.02
	Total	126	18.35	5.12

Note: M= Mean; SD= Standard Deviation

A two-way ANOVA was conducted to examine the effect of gender and SES on 'willingness' scores to access mental health services. The main effect of gender on willingness scores was significant, $F(1,120) = 14.00, p < .001, \eta^2 = .104$. On the contrary, no main effect was found between social class on willingness scores, $F(2,120) = .41, p = .667, \eta^2 = .007$. Furthermore, a significant interaction between gender and social class was found, $F(2,120) = 5.31, p = .006, \eta^2 = .081$. Figure 1 illustrates this interaction.

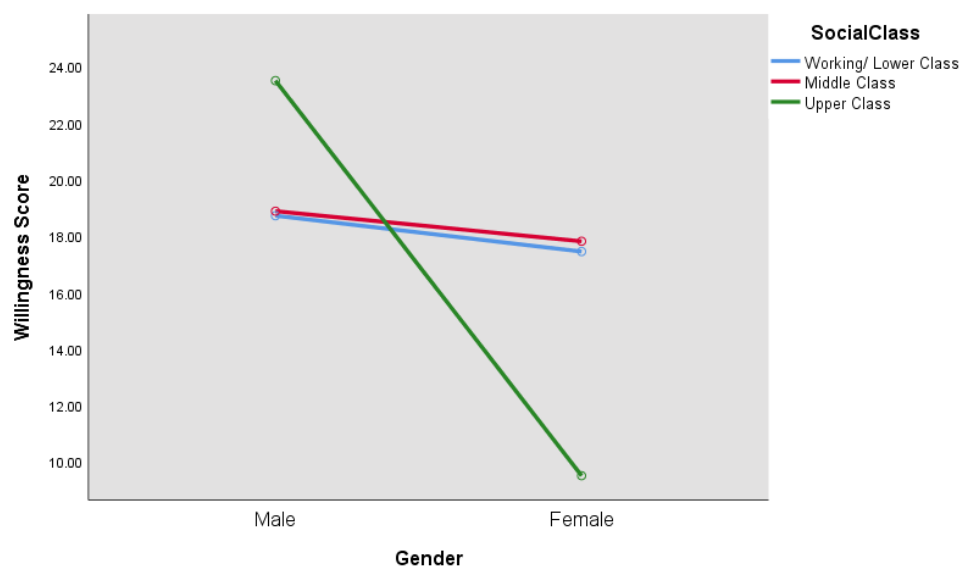


Figure 1. A graph to show the mean scores for willingness to access mental health services in relation to gender and SES.

In order to interpret the significant interaction between gender and social status on the willingness score, a further post-hoc Tukey HSD test was conducted (See Appendix 2). The analysis showed the smallest difference in willingness scores appeared between working-class and middle-class for both males $p = .964$ and females $p = .997$. Whereas the largest differences in willingness scores for both males $p = .066$ and females $p = .053$ were found between working-class and upper-class groups. For all SPSS Output, see Appendix 2.

After taking into consideration the findings from this ANOVA in relation to the SSS component of SES, it seemed appropriate to explore the two other factors of SES: income and level of education, which were measured demographically. The study found that 56.3% of individuals in the income group: £25,000- £40,000 had accessed mental health services previously, in comparison to the £0- £10,000 income group, where only 33.3% had accessed a service. In relation to level of education, those who had attained a 'Master's/ Doctorate degree' level were found to be most likely to access mental health services, with 57.1% of this group stating they had accessed a mental health service previously. Compared to only 41.9% of individuals with a 'college' education level who had accessed mental health services before.

In order to examine this further, an additional two-way ANOVA (Appendix 2) was conducted between income, gender and willingness to access mental health services. The descriptive statistics for this analysis, can be demonstrated in Table 2. Moreover, the second ANOVA discovered the mean willingness scores for the income group of £40,000- £50,000 were the highest ($M = 20.58$, $SD = 4.17$) compared to the

income group of £25,000- £40,000 ($M= 17.44$, $SD= 3.91$). Thus, demonstrating that those with a higher income were less willing to utilise mental health services.

Table 2.

Descriptive Statistics for Gender and Income

Gender	Income	N	M	SD
Male	£0- £10,000	5	20.40	4.04
	£10,000- £25,000	13	17.46	4.45
	£25,000- £40,000	13	19.08	3.88
	£40,000- £50,000	7	20.00	5.29
	£50,000+	15	21.13	6.85
	Total	53	19.51	5.21
Female	£0- £10,000	16	18.06	5.93
	£10,000- £25,000	25	17.48	5.11
	£25,000- £40,000	19	16.32	3.61
	£40,000- £50,000	5	21.40	2.07
	£50,000+	8	16.88	5.62
	Total	73	17.51	4.91
Total	£0- £10,000	21	18.62	5.54

£10,000- £25,000	38	17.47	4.83
£25,000- £40,000	32	17.44	3.91
£40,000- £50,000	12	20.58	4.17
£50,000+	23	19.65	6.65
Total	126	18.35	5.12

Note: M= Mean; SD= Standard Deviation

Firstly, there was a non-significant main effect of income on willingness scores, $F(4,116) = 1.23$, $p = .301$, $\eta_p^2 = .041$. Additionally, a non-significant effect of gender on willingness scores, was found, $F(1,116) = 2.39$, $p = .125$, $\eta_p^2 = .020$. Furthermore, a non-significant effect was discovered between gender and income on the willingness to access mental health services, $F(4,116) = .97$, $p = .429$, $\eta_p^2 = .032$. As a result, it was not necessary to conduct any further post hoc tests.

Additionally, a third ANOVA was conducted to measure the third aspect of SES: the effect of level of education and gender on willingness to access mental health services. The descriptive statistics for this analysis are displayed in Table 3. The mean willingness scores for level of education were found to be highest in those individuals with a 'Master's/ Doctorate Degree' ($M = 20.71$, $SD = 6.68$), whereas those with a 'Bachelor's degree' level of education displayed the lowest scores for willingness to access mental health services ($M = 17.51$, $SD = 5.08$). Thus, demonstrating the higher the level of education attained by the individual the less likely they are willing to utilise mental health services.

Table 3.

Descriptive Statistics for Gender and Level of Education

Gender	Level of Education	N	M	SD
Male	High School	8	20.50	4.28
	College	16	19.81	4.09
	Bachelor's Degree	27	18.30	5.49
	Master's/ Doctorate Degree	2	29.50	.71
	Total	53	19.51	5.21
Female	High School	9	16.00	4.00
	College	15	19.93	5.61
	Bachelor's Degree	44	17.02	4.82
	Master's/ Doctorate Degree	5	17.20	3.56
	Total	73	17.51	4.91
Total	High School	17	18.12	4.62
	College	31	19.87	4.80
	Bachelor's Degree	71	17.51	5.08
	Master's/ Doctorate Degree	7	20.71	6.68

Total	126	18.35	5.12
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Note: M= Mean; SD= Standard Deviation

In summary, there was significant main effect of gender on willingness scores, $F(1,118) = 12.16, p = .001, \eta^2 = .093$. Also, there was a significant main effect of level of education on willingness to access mental health services, $F(3,118) = 3.40, p = .020, \eta^2 = .080$. Finally, a significant interaction was established between gender and level of education in relation to willingness scores, $F(3,118) = 3.13, p = .028, \eta^2 = .074$.

In order to interpret this significant interaction, further post-hoc Tukey HSD tests were conducted (See Appendix 2). The analysis showed that the smallest differences in willingness to access mental health services were exhibited between college and high school education levels for males, $p = .988$. Whereas the smallest differences found for females were between bachelor's degree and masters/ doctorate degree groups, $p = 1.00$. Moreover, a significant difference between the bachelor's and masters/ doctorate level of education for males was found, $p = .015$. Additionally, the biggest difference in females was established between college and high school groups, however this difference was not significant, $p = .194$. Without regards to gender, the biggest difference was found between college level of education and bachelor's level, $p = .113$, although this difference was not significant.

In conclusion, the results have revealed there is a link between gender and SES when comparing willingness scores to access mental health services. Moreover, a significant main effect was established between gender, thus showing there was a difference in willingness to access mental health services between males and females.

However, no significant main effect was found between social class groups, suggesting that the willingness to access mental health services does not differ between social classes. After conducting pairwise comparisons in the post-hoc tests, the largest difference between willingness scores were discovered between working-class and upper-class females.

Due to the non-significant main effect established in social class, two further ANOVA's were conducted to measure income and education level, the two other factors associated with SES. The second ANOVA established a non-significant main effect between income on willingness scores, as well as a non-significant interaction between gender and income. However, the third ANOVA established both a significant main effect of level of education and willingness to access mental health services, as well as a significant main interaction between gender and level of education on willingness. After further post-hoc tests on this significant interaction, the biggest difference in willingness scores were established between master's and bachelor's level of education, for males only.

Discussion

This research aimed to assess the effect of gender and SES on willingness to access mental health services. In summary the results established a gender difference in willingness to access mental health services, but no difference in SES. An overall interaction between gender and SES was also established in this research.

Hypothesis One: Gender

The first hypothesis proposed that females would be more willing to access mental health services than males, however this is not supported by the results, consequently this hypothesis was rejected. The findings from this study, displayed that there was a significant main effect of gender on willingness scores. However, the difference displayed in these findings, shows males had higher willingness scores ($M=19.51$) than females ($M=17.51$), thus demonstrating the opposite of what the study expected to find. Previous research suggested that females were more likely to be willing to access mental health services than males (Kovess-Masfety et al., 2014; Chen and Dagher, 2016; Pattyn et al., 2015). However, research from Gangé et al. (2014) did demonstrate an increased utilisation of GP services from males over females, thus suggesting that males could be more willing to access mental health services than females. However, this is not a clear measurement of the usage of mental health services as it only focuses on the use of GP services. Consequently, as findings from this study; in relation to hypothesis one, are not consistent with previous research. It is important that future research focuses on the idealisation that males could be more willing to access mental health services than females.

Hypothesis Two: SES

The second hypothesis proposed there would be a difference in the SES of an individual and their willingness to access mental health services. In contrast to this expectation, the results actually exhibited there was no overall difference in the SES of the individual and their willingness to access mental health services, therefore hypothesis two was rejected. Previous research established a wide range of findings, the first found individuals with lower SES have an increased willingness to access mental health services (Kong et al., 2014; Honjo et al., 2014; Businelle et al., 2014). On the other hand, Steele et al. (2007) suggests those from lower SES are less willing to access mental health services, due to the cost and transportation issues they face, as well as the lack of services available, that are needed to meet the increasing demands for services in their areas. Andrykowski et al. (2013) also demonstrates through their post-traumatic stress theory, those from a lower SES are less likely to use mental health services, due to 'growth' and positive mental health outcomes they experience following the distress associated with lower SES.

Due to the lack of an association that was found between social class and willingness to access mental health services, two further ANOVA's were conducted in order to measure the two other aspects of SES: level of education and income. The findings from the second ANOVA, showed there was no difference between the income of the individual and their willingness to access mental health services, as well as a non-significant interaction between gender and income. Despite this, the third ANOVA conducted which measured level of education found a significant interaction between gender and education level on willingness to access mental health services. Following pairwise comparisons from the post-hoc tests the biggest difference was found between college and bachelor's degree level. This difference established that

those with a college education were more willing to access services ($M= 19.87$) in comparison to those with a bachelor's degree ($M= 17.51$). Thus, suggesting that those with a lower SES; in terms of education, were more likely to access mental health services and therefore displays consistency with previous research. This finding is supported by the social causation theory (Giddings, 1904), which hypothesises the stressors associated with living in low SES; including a lower level of education, increase the risk of mental illness, therefore suggesting their increased willingness to utilise mental health services.

In conclusion, hypothesis two was rejected due to the non-significant main effect that was reported from this study. However, after further analysis it can be argued that the educational aspect of SES can be associated with the presumption of those from a lower SES showing an increased willingness to access mental health services, thus supporting this hypothesis.

Hypothesis Three: Gender and SES

Hypothesis three proposed the gender of the individual would display a relationship with SES and this would affect their willingness to access mental health services. This hypothesis was accepted, as findings revealed a significant interaction between gender and SES. However, the findings from the two additional ANOVA's did not add any significant or relevance in terms of this interaction so these findings were not considered in respect of this hypothesis. Additionally, through post-hoc analysis this effect was found to be the most significant between working-class and upper-class females. Previous research does support this hypothesis, for example Denton et al. (2004) proposed that females tend to live in lower SES and are therefore more willing to access mental health services due to the additional demands they face as a result

of their social position. Thus, suggesting that males would be less willing to utilise mental health services as a result of their higher SES. However, the extent to which the findings from Denton et al. (2004) study can be applied to the current findings from this research are limited, as countries tend to vary massively in the types of services they provide and their costs, so the relevance of SES in Canada when compared to the UK could differ. Therefore, suggesting why this study may have not followed the same result pattern.

Overall, previous research suggested there would be a relation between gender and SES on an individual's willingness to access mental health services, however this relation needs to be explored further, as despite the significant interaction that was discovered, the pairwise comparisons did not allow an in-depth insight in to the comparison of females in lower SES compared to males in higher SES.

Limitations and Future research

Various limitations need to be addressed when considering the findings of this study. One limitation of this study is the use of self-report measures. Even though the use of self-reports are effective in measuring the variables, they can also cause issues in this research. Participants are likely to under-report utilisation of mental health services, due to motivational and cognitive reasons (Golding et al., 1988), also known as social desirability bias. The participants were recruited through opportunity sampling which could also affect the social desirability of this study. Participants from this sample demonstrate a willingness to fill in the survey and this therefore could be attributed to a biased sample who may also show overall willingness to access mental health services. Thus, meaning those who show a decreased willingness are not being represented in this study. If participants are subject to social desirability, the results

could lack validity, as the true representation of the samples willingness to access mental health services could be inaccurate. To overcome this issue in future research the use of mental health services records could be used for an accurate representation of the utilisation of these services.

Additionally, as the IV of social class requires the participant to decide on their own categorisation of social class, this could create an inaccurate representation of this variable due to the varying views on the participants subjective social status (SSS). Research by Diemer et al. (2012) has shown that a more appropriate way of measuring SSS in self-report methods is to use the ladder measure, where the respondents are asked to rate their level of status from 1 'low' to 10 'high' in comparison to society. This is therefore a more accurate representation of SSS than the respondent's selecting the category they belong to as the participant is more likely to be honest when using a scale, thus reducing the chance of social desirability bias. Alternatively, if SES is being measured as a whole it maybe suggested that income and level of education are more appropriate measures in comparison to SSS. This is due to level of education and income being categorical variables, that cannot be changed as a result of the participants perception of their place in society, so are therefore more valid measures of SES.

Finally, the last limitation that can be attributed to the findings of this research is the unrepresentativeness of the sample recruited for this study. Even though there is a slight difference in size of gender groups, with there being 53 males and 73 females, this is unlikely to affect the accuracy of the data. However, due to the larger differences in the groups for SES, with the working-class group having 66 participants and only 10 participants in the upper-class group, this could make the data skewed due to the overrepresentation of one group of social class. To overcome this issue in

future research it is important to find a more representative way of accessing responses from upper-class participants. One suggestion could be distributing paper copies of the survey to those from an upper-class group by visiting an area of high wealth.

Practical Implications

As discussed previously, there was a non-significant main effect found of SES; particularly social class, on willingness to access mental health services. This present study therefore demonstrates the importance of all aspects of society having an increased accessibility to mental health services, with the long-term goal of ending the mental health treatment gap (Evans-Lacko et al., 2018). However due to the differences in needs for mental health services, it could be suggested that the approach that is taken to promote mental health services differs. For example, those living in lower SES need the mental health services in their area to be made more accessible, by making more services available. This is something that could be used and implemented by the NHS or government. In order to promote willingness of mental health services for those from a higher SES, it may be more appropriate to focus on types of services that are available, in contrast to the location and amount of services needed. This could require promotion of more specialised private services, thus leading to an increased availability of mental health services in the community for those with a lower SES, who are unable to access specialised services due to financial barriers.

However, due to the additional analysis revealing that those from a lower level of education being more willing to access mental health services, in particular those from a 'college' level of education showing increased willingness over those with a

bachelor's degree. As a result of these findings from this study, it is important to focus the promotion of mental health towards those in university level of education compared to those in college. This could entail visiting more university lectures and finding more effective ways to reach out to students and increase their willingness to utilise the mental health services that are available to them throughout the university.

Conclusion

In conclusion, the current study found that the effect of gender and SES did effect willingness to access mental health services. The results suggested that hypothesis one and two should be rejected. This is a result of the gender differences found in this study, displaying that males were more willing to access mental health services than females, showing the opposite to what the study hypothesised. Additionally, the differences in SES, in particular when measuring SSS demonstrated that SES did not affect the individual's willingness to access mental health services. However, after further analysis it was found that the higher the level of education the individual has attained predicts less willingness to access mental health services. Despite this, hypothesis 3 was accepted due to the significant interaction that was found between gender and SES on the individual's willingness to access mental health services, specifically finding that the biggest difference was found between upper-class and working-class males. Further research should be conducted to fully understand the relationship between SES and willingness to access mental health services, in addition to the increased willingness to access services displayed by males in contrast to females.

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