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Differences in Mental Health Education Across Baby Boomers, Generation X, and Millennials

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in the Department of Sociology and Anthropology.

By
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Under the mentorship of Dr. Nancy Malcom

ABSTRACT

There is no denying that mental illness has gained a strong prevalence in the United States. According to the National Alliance on Mental Illness, approximately one in five adults in the United States experiences a mental illness in any given year. Although mental health stigmas have played a role in the past, it does not mean they must continue to play the same role in the future. Research is now looking toward ways to decrease mental health stigma through increasing mental health knowledge. This study examines the starting point for which a society becomes literate in mental health. Using a quantitative online survey questionnaire with quantitative data analysis, participants' self-assessed and demonstrated ability to identify mental illness was tested across three generations – Baby Boomers, Generation X, and Millennials. In addition to the generational cohort, educational experience with mental illness and personal contact with mental illness were also examined against the dependent variables. For this study, 250 participants across the three generations were recruited ranging in age from 18 to 74. Data was analyzed using IBM SPSS Statistics. In conclusion, generational differences and the closest proximity of oneself to mental illness proved to be significant points in participants' demonstrated ability to identify mental illness, while age, frequency of contacts, and education did not weigh in as significant points. This study was approved by the Georgia Southern University Institutional Review Board.

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MENTAL HEALTH PREVELANCE

There is no denying that mental illness has gained a strong prevalence in the United States. According to the National Alliance on Mental Illness (NAMI), approximately 1 in 5 adults in the U.S. experiences a mental illness in any given year. This can be estimated at roughly 43.8 million people – or 18.5% of the adult population. What is more, roughly 1 in 25 adults, or 4.2% of the adult population, experience a serious mental illness that substantially interferes with major life activities (NAMI). With such a high probability of experiencing a mental illness, the education on the symptoms of different mental illnesses must become a vital part of the American educational system.

This research examines the extent to which the population has an accurate understanding on mental illness and symptoms that correlate with certain disorders. To educate a population, one must first locate the general baseline to determine where to begin. This study aims to do this. Through a series of questions, the researcher will test participants' knowledge of nine different mental illnesses and symptoms of these illnesses. From this study, different educational facilities will have the knowledge of what areas of mental illness need to be focused on more heavily, which misconceptions need to be reversed, and how the population views the need for this education.

Mental Illness Stigma

In 2013, Bernice Pescosolido set out to investigate the public stigma of mental illness. She inquired about three things: What do we think? What do we know? What can we prove? One finding was set on “good news.” Between the years of 1950 to 2000, the public had become more sophisticated and open to recognizing, discussing, and

responding over the topics concerning mental health problems (Pescosolido 2013).

However, even with this exciting finding, her research also showed that stigma against mental health problems held constant during that fifty-year span with surprising adult-child comparisons (Pescosolido 2013).

Other research has been done considering the changes in public perception of stigma toward mental illness. Lisa Wood and colleagues researched the differences in public perceptions of different psychiatric diagnoses (Wood et al. 2014). The general trend that was found was a slight decrease in the negative stigma since 1998; however, since 2003, rates of negative stigma have begun to rise once more to the levels they were at in 1998. Wood and her team speculate that this shift can be seen from the entry of *The Changing Minds* campaign, that promoted positive attitudes toward psychiatric diagnoses beginning in 1998. However, this campaign came to an end in 2003 (Wood et al. 2014). Wood suggests that to “promote a positive perception of psychiatric diagnoses” (Wood et al. 2014:606) public stigma campaigns need to continue for a long-term basis through social contact and public education. As other research will show, public stigma can be internalized by the person with a mental illness which then leads to numerous detrimental effects on the individual.

Studies done by Roger Vilardaga and colleagues considered the effects that experiential acceptance and cognitive reappraisal had on individuals with serious mental illnesses. They examined two psychological strategies: experiential acceptance, which “refers to the non-reactive and mindful awareness of our ongoing stream of consciousness” (Vilardaga et al. 2013:426), and cognitive reappraisal, which is a form of cognitive change that involves interpreting a potential emotion fueling situation in a way

that changes its emotional impact on one's life. Vilardaga and colleagues found that behavioral regulation of experiential acceptance had a stronger and more positive impact on the individual's quality of life over cognitive reappraisal (Vilardaga et al. 2013). With these high levels of association between engagement in social interactions/activities and the individual's quality of life, their study supports the assertion that someone with a mental disorder should continue to engage in a generally active and social life style (Vilardaga et al. 2013). However, to continue gaining a positive impact in an individual's life, research must consider the negative aspects that need to be abandoned to make room for the more positive aspects, such as social interaction.

Effects of Discrimination and Stigma

A common factor among individuals with mental illness is the ability for anticipated discrimination in a certain setting to lead them toward a greater chance of isolation and social marginalization (Farrelly et al. 2014). Farrelly and colleagues investigated the associations between anticipated and experienced discrimination among those diagnosed with severe mental illnesses, such as schizophrenia, bipolar, and major depressive disorders. In this study, 87% of participants reported having experienced discrimination based on their mental disorder, and 92% reported having anticipated discrimination in at least one area of life (Farrelly et al. 2014). However, these percentages do not seem to have changed much in the past several years. In 2007, Behavioral Risk Factor Surveillance System found that only 25% of adults with a mental illness believed that people are sympathetic to individuals with a mental illness (BRFSS). Farrelly et al. also found associations between education and experienced discrimination. Those with a mental illness who had higher levels of education were more susceptible to

experiencing discrimination (Farrelly et al. 2014). They hypothesize this to be the case as “education may lead individuals to have greater expectations or to be more critical of their experiences” (Farrell et al. 2014:6). In relation to anticipated discrimination, females were more highly associated to it than their male counterparts were.

These rates of experienced and anticipated discrimination can lead to many consequences with negative outcomes for the individual’s overall well-being. Some of these negative outcomes were identified by Jason Randall et al. in their study of acute risk of suicide and suicide attempts associated with recent diagnosis of mental disorders. The results show that an individual is most likely to attempt or commit suicide within the first 90 days of the initial diagnosis (Randall et al. 2014). They suspect that it is possible for a recent diagnosis to make the individual feel hopeless expecting their quality of life to decrease with the stigma of mental illness.

Internalizing the stigma of mental illness is associated with lower levels of self-esteem, self-efficacy, and recovery orientation (Drapalski et al. 2013). In this study of internalized stigma and its effects on individuals with mental illness, over one-third of the participants reported experiencing moderate to severe levels of self-stigma and 46% reported experiencing mild levels of self-stigma (Drapalski et al. 2013). These self-stigmas arise from the perception of the individual taking on the image that society projects toward a person with mental illness. Also, the fear or concern of rejection of others “leads to poorer self-concept and disengagement from others” (Drapalski et al. 2013:268). Their study states that to reduce the internalized stigmas regarding mental illness, society must first understand the process by which it develops and maintains.

Using Education and Connection to Shift Gears

Although mental health stigmas have played a role in the past, it does not mean they must continue to play the same role in the future. Research is now looking toward ways to decrease mental health stigma through increasing mental health knowledge. This can be seen in A. F. Jorm's research on ways to introduce the concept of mental health literacy to a wide audience by a narrative review (2000). Within his research, he sees that "many members of the public cannot correctly recognize mental disorder and do not understand the meanings of psychiatric terms" (Jorm 2000:396). He states that these misunderstandings can cause problems in communication with health practitioners as well as in differences in methods of help and care, as many members of the public avoid seeking help due to fear of possible negative impacts on their employment situation (Jorm 2000). Jorm advocates for an increase in education of mental health literacy within society but without the confines of mental health professionals. He states that if "there are to be greater gains in prevention... we need a 'mental health literate' society which basic knowledge and skills are more widely distributed" (Jorm 2000:399) among the whole instead of only the professionals.

In addition to Jorm's research, one other indicates the importance of mental health education. In Bamgbade, Ford, and Barner's study in 2016, they found that a brief anti-stigma intervention was effective in reducing the stigma and increasing the knowledge of mental health among third-year pharmacy students. The beliefs and perceptions regarding the stigma of mental health were categorized into five subdomains of stigma including: recovery, safety, disclosure, separation, and comfort. Recovery refers to the possibility that a person with a mental illness can recovery and live a fulfilling life; safety refers to

the danger that someone with a mental illness poses to society; disclosure refers to the willingness a person has in revealing their personal mental illness; separation refers to the willingness to interact with a person with mental illness in a social setting; and comfort refers to feeling comfortable being around a person with a mental illness (Bamgbade, Ford, and Barner 2016). These subdomains of stigma decreased as the knowledge of mental health increased (Bamgbade, Ford, and Barner 2016). A major contributing factor was the process in how the education on mental health was presented to the pharmacy students. As opposed to simply providing a list of symptoms and definitions, video clips of actual patients were provided during the time of learning. Bamgbade, Ford, and Barner predict that “helping students connect abstract concept (e.g. stigma related to mental illness) to a lived experience” (p. 9) increases the capability to gain a knowledge and understanding of mental illness while decreasing the mode of stigma (2016).

Those video clips presented a more personal way to learn about mental health; they gave a deeper connection between the pharmacy students and those with a mental illness. Research conducted by Gordon Allport suggest that “prejudice may be reduced by equal status contact between majority and minority groups in the pursuit of common goals” (1954:281), an idea more commonly known as the contact hypothesis. He goes on to explain that this reduction of prejudice is strengthened when institutional factors, such as law, custom or local atmosphere, support such interactions. However, these interactions must be of common interest and humanity between the two groups wishing to come together to lower prejudice (Allport 1954). Allport’s research supports the influence that a personal connection can have upon stigma.

Mental Health Education

This study examines the starting point for which a society becomes literate in mental health. Using a quantitative survey questionnaire with quantitative data analysis, the accuracy of mental illness symptoms will be tested across three generations – Baby Boomers, Generation X, and Millennials. Although stigmas for mental health have slowly begun to increase again, evidence on the current state of mental health education needs to be assessed before an accurate fight against the stigma comes back into play. This study will conduct a current assessment of mental health education within Georgia in the United States.

My primary hypothesis is that participants within Generation X will have the most accurate knowledge of mental health than those within the Baby Boomers generation and those within the Millennial generation. Based off the contact hypothesis, I also hypothesize that those who have a close relationship to someone with a mental illness will have the most accurate knowledge of mental health as opposed to someone with no personal experience or prior educational knowledge. However, a participant who has a higher educational knowledge over mental health will have more accurate knowledge of mental illnesses than someone with only personal experience.

METHODOLOGY

As this study measures the accuracy of the knowledge of mental illness symptoms, it will be carried out in a quantitative method through means of an online survey specifically via Qualtrics with respondents recruited through social media. This method is appropriate as it will reach the most amount of people to have the largest

sample to draw conclusions from. The survey will allow for participants to be tested over nine different mental illnesses in roughly ten minutes. An online survey also allows for convenience to the research participant as it can be completed on any device with internet access – such as a cell phone, tablet, or computer. A copy of the survey has been provided in Appendix A. This study was approved by the Georgia Southern University Institutional Review Board.

Survey Outline

The survey begins with demographic information for the research participant such as: year of birth, sex, race/ethnicity, religious beliefs, gross annual income, and highest education level. After demographics, two questions are posed that will provide the basis for the hypothesis. The first question asked states, “When did you first learn about mental illness in an educational/school setting?” Answer choices provided for this question range from no prior educational experience to having learned about mental health for the first time in a doctoral or professional course. This ensures that all educational levels and possibilities are accounted for. The second question asks, “Do you personally know someone with a mental illness? If so, what is their relation to you? Check all that apply.” The answer choices branch out from those of closest relation to those of distant relation. They also include “Myself” as well as “Do not know someone with a mental illness.”

The following sections test the participant’s knowledge over mental health. The mental disorders that participants will be tested over include: anorexia nervosa, bipolar I disorder, generalized anxiety disorder, major depressive disorder, obsessive compulsive disorder, panic disorder, posttraumatic stress disorder, schizophrenia, and social anxiety phobia.

The first section of this testing contains a list of 18 symptoms – nine of which are symptoms of mental illnesses drawn from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) by the American Psychiatric Association while the other nine are common misconceptions. Participants are asked to decide if these symptoms are accurate symptoms of a mental disorder. The second section asks the participants directly if they believe that they would be able to recognize the symptoms of the nine mental illnesses the survey is testing them over. The last section then includes 18 symptoms – two accurate symptoms from each of the nine mental illnesses – all pulled from the DSM-V. Participants are asked to choose which mental disorder they believe the symptom relates to. The survey ends with asking participants to what degree, in general, they believe five different treatment methods are beneficial to those with a mental illness.

Participants

For this study, I recruited 250 participants across three generations – Baby Boomers, Generation X, and Millennials. One participant was excluded from the survey due to opting out on the consent form; therefore, 249 participants completed the survey. The subjects ranged from ages 18 to 74, having been born between the years 1943 and 1998. Generations were broken up based on a prior generational study by Andre A. Pekerti and Denni Arli (2017). In their study, four generations were represented: The Maturers (1929-1945), Baby Boomers (1946-1964), Generation X (1965-1976), and Millennials (1977-2000). The same four generations were represented in this particular research; however, only four participants were found to be in The Maturers generation (born between 1943-1945). In order to keep their data while also having large enough groups for analyzing, these four participants were placed into a Baby Boomer/Maturers

generation category.

Subjects were recruited via Internet through Facebook. The survey was created through Qualtrics, so the IP Address of the participants was not collected. I contacted ten people – five men and five women – from each generation from my friend list to ask if they would share the link to the survey on their profile. This was drawn from a random sampling as well as nonrandom sampling. The nonrandom sampling includes the people selected from my personal friends list, while the random sampling includes the greater Facebook community. For those selected to share the link of their personal profile, I provided them with the recruitment information on their personal page for their friends to participate. This was done in hopes that the greatest number of people in each generation would have the opportunity to participate in the survey. There were no incentives used for this survey.

Variables and Measurement

The six independent variables used in this study include the participants' generational grouping, their age, the number of contacts they have with mental illness, their closest contact proximity to mental illness, the presence or not of a formal education over mental illness, and their first formal educational encounter over mental illness.

These will be measured categorically as each variable has varying levels within it.

The dependent variable is the accuracy of responses during the testing of the nine different mental illnesses. The three dependent variables include the participants' self-assessed ability to identify mental illness in others; their ability to correctly identify behaviors that are symptoms of mental illness; and their ability to correctly match symptoms to their corresponding mental illness.

Data Analysis Plan

The statistical software, IBM SPSS Statistics, was used to analyze the data. Within this system, the one-way analysis of variance (ANOVA) was used to determine whether there were any statistically significant differences between the means of the three dependent groups in relation to four of the independent variables tested. These four different tests looked at the independent variables of the participants' generational grouping, number of contacts with a mental illness, closest contact proximity to mental illness, and first encounter with a formal education over mental illness.

An independent samples t-test was used to compare the means of two normally distributed interval independent variables for the three dependent groups. In this test, the independent variable of whether the participant had a formal education on mental illness or whether the participant did not have a formal education on mental illness was examined against the three dependent variables. Lastly, a SPSS correlation test, which is a procedure used for testing whether two metric variables are linearly related in some population, was used to see whether there was a correlation between the three dependent variables and the increase in the numerical age of the participants.

RESULTS

Generation and Age

The respondents in my sample felt confident that they could identify mental illness in others and their confidence did not significantly vary by either their age or by the generation they were a part of. As Table 1.1 demonstrates, 84.5% of Millennials, 88.1% of Generation X, and 77.5% of Baby Boomers said they believed they could

correctly identify people experiencing mental illness. However, the respondents' self-assessed abilities greatly surpassed their demonstrated ability to accurately identify symptoms of mental illnesses and match symptoms to their corresponding mental illness. On average, 55.9% of Millennials, 55.3% of Generation X, and 50.4% of Baby Boomers correctly identified whether a given behavior was a symptom of a mental illness. Millennials had the most success (77%) at matching symptoms with their corresponding mental illnesses; followed by respondents from Generation X (75.6%) and Baby Boomers (63.4%). Baby Boomers, compared to both Millennials and people from Generation X, were significantly less able in both identifying symptoms of a mental illness and correctly matching symptoms to their corresponding mental illness. Looking at Table 1.2, we see that age is negatively correlated with both a respondent's self-assessment of their ability to identify mental illness and their actual ability to do so.

With the analysis between the groups, statistical significance was found between the groups in their ability to correctly identify behaviors that are symptoms of mental illness and their ability to correctly match symptom to their corresponding mental illness. No variation was found between the groups in participants' self-assessed ability to identify a specific mental illness. There was also no variation found between Millennials or Generation X in their self-assessed and demonstrated ability to identify mental illness. However, statistical significance was found between the Baby Boomers and the other two generations in their ability to correctly identify behaviors that are symptoms of mental illness and in their ability to correctly match symptoms to their corresponding mental illness.

Table 1.1: Self-Assessed and Demonstrated Ability to Identify Mental Illness by Generation

	Total Sample (n=249)		Millennials (n=164)		Generation X (n=43)		Baby Boomers/Maturers (n=42)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Self-assessed ability to identify mental illness in others	.84	.22	.84	.21	.88	.21	.78	.26
Correctly identified behaviors that are symptoms of mental illness	.55	.09	.56 ^a	.09	.55 ^b	.09	.50 ^{ab}	.10
Correctly matched symptoms to their corresponding mental illness	.74	.15	.77 ^a	.13	.76 ^b	.11	.63 ^{ab}	.20

Note: ^aBaby Boomers/Maturers vs. Millennials means significantly different ($p < .05$); ^bBaby Boomers/Maturers vs. Generation X means significantly different ($p < .05$)

Table 1.2: Correlation Matrix Between Self-Assessed & Demonstrated Ability to Identify Mental Illness and Age

	Self-Evaluation		Identify Symptom		Matching Symptom		Age	
	Correlation	Correlation	Correlation	Correlation	Correlation	Correlation	Correlation	Correlation
Self-assessed ability to identify mental illness in others	1		-.02		.13**		-.05	
Correctly identified behaviors that are symptoms of mental illness	-.02		1		.16**		-.22*	
Correctly matched symptoms to their corresponding mental illness	.13**		.16**		1		-.31*	
Age	-.05		-.22*		-.31*		1	

Note: *= $p < .05$, **= $p < .01$

When looking at the age of the participants in the Pearson correlation displayed in Table 1.2, there is significance in correlation between each year of life gained and a decreased ability in correctly identifying behaviors that are symptoms of mental illness and in correctly matching symptoms to their corresponding mental illness.

Personal Contact

Table 1.3 displays the results from the ANOVA test between the three dependent variables and the independent variable of the number of contacts the participant had with mental illness. There is a statistically significant difference in the means between those who only had one contact with a mental illness and those who had either three or four contacts with mental illness. However, there was only significance within participants' ability to correctly match symptoms to their corresponding mental illness. On average, 69.3% of people who only had one contact correctly answered these questions while on average 79.1% and 80.1% of those who had three and four contacts, respectively, answered the questions correctly. With few significant results from this grouping, it is uncertain to say whether the amount of people one knows with mental illness affects the accuracy of his or her knowledge of mental illness.

The next area of personal contact is shown in Table 1.4 looking at the closest contact proximity a participant had to mental illness. The original answers were condensed to three categories: myself, family, or others. If someone listed themselves as well as a family member, they were placed in the "Myself" category as that would be their closest proximity. However, if someone did not list themselves, and only listed those in family and out of family, they were placed in the "Family" category as that would be their closest proximity. The two participants who chose to not answer the

Table 1.3: Self-Assessed & Demonstrated Ability to Identify Mental Illness by Number of Contacts with Mental Illness

	Total Sample (n=247)		0 Contacts (n=10)		1 Contact (n=98)		2 Contacts (n=39)		3 Contacts (n=42)		4 Contacts (n=26)		5 Contacts (n=18)		6 Contacts (n=8)		7 Contacts (n=6)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Self-assessed ability to identify mental illness in others	.84	.22	.73	.23	.83	.22	.81	.27	.88	.19	.87	.17	.84	.22	.88	.20	.91	.15
Correctly identified behaviors that are symptoms of mental illness	.55	.09	.50	.09	.54	.09	.56	.08	.55	.10	.55	.09	.59	.05	.55	.12	.54	.11
Correctly matched symptoms to their corresponding mental illness	.74	.15	.72	.09	.69 ^a	.17	.75	.17	.79 ^a	.10	.80 ^b	.09	.80	.12	.78	.12	.80	.18

Note: ^a1 Contact vs. 3 Contacts means significantly different ($p < .05$); ^b1 Contact vs. 4 Contacts means significantly different ($p < .05$)

Table 1.4: Self-Assessed & Demonstrated Ability to Identify Mental Illness by Closest Contact Proximity to Mental Illness

	Total Sample (n=238)		Myself (n=70)		Family (n=121)		Others (n=47)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Self-assessed ability to identify mental illness in others	.84	.22	.89 ^b	.18	.85	.23	.78 ^b	.24
Correctly identified behaviors that are symptoms of mental illness	.55	.09	.58 ^{ab}	.08	.54 ^a	.09	.54 ^b	.10
Correctly matched symptoms to their corresponding mental illness	.75	.15	.80 ^{ab}	.11	.73 ^a	.15	.70 ^b	.18

Note: ^aMyself vs. Family means significantly different ($p < .05$); ^bMyself vs. Others means significantly different ($p < .05$)

question and the nine participants who answered, “I do not know anyone with a mental illness” were not placed in any of the three categories. There is a statistically significant difference in the means between those in the “Myself” category and those in the other two categories. The difference between the “Myself” and “Others” category is significant across participants’ self-assessed and demonstrated ability to identify mental illness. On average, those in the “Myself” category scored 11%, 4.4%, and 10.5% better than those in the “Other” category across all three dependent variables, respectively. On average, those in the “Myself” category scored 3.9% and 6.9% better than those in the “Family” category across their ability to correctly identify behaviors that are symptoms of mental illness and their ability to correctly match symptoms to their corresponding mental illness, respectively. There was no significant difference between those in the “Family” category in relation to the “Other” category.

Formal Education

Lastly, two tests were run in relation to formal education and the accuracy of responses over mental illness. The first test, Table 1.5, looked at the presence of a formal education over mental illness in the participants’ lives, and the second test, Table 1.6, looked at the level of education when the participant first encountered a formal education over mental illness. However, neither test produced any statistically significant data. Whether or not one had been taught in an educational setting, or at what level one had been taught, it did not impact the answers on the survey and did not create any relationship between the variables. Being exposed to mental illness in a formal educational setting had no impact in participants’ self-assessed and demonstrated ability to identify mental illness.

Table 1.5: Self-Assessed & Demonstrated Ability to Identify Mental Illness by Exposure to Formal Education on Mental Illness

	Mental Health Education (n=204)		No Mental Health Education (n=43)	
	Mean	S.D.	Mean	S.D.
Self-assessed ability to identify mental illness in others	.84	.22	.81	.23
Correctly identified behaviors that are symptoms of mental illness	.55	.09	.54	.08
Correctly matched symptoms to their corresponding mental illness	.75	.15	.72	.15

Note: * = $p < .05$

Table 1.6: Self-Assessed & Demonstrated Ability to Identify Mental Illness by First Exposure Formal Education on Mental Illness

	Total Sample (n=247)		No Encounter (n=43)		Elementary School (n=13)		Middle School (n=30)		High School (n=77)		Higher Education (n=84)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Self-assessed ability to identify mental illness in others	.84	.22	.81	.23	.91	.13	.82	.24	.87	.21	.83	.23
Correctly identified behaviors that are symptoms of mental illness	.55	.09	.54	.08	.56	.09	.56	.08	.55	.08	.55	.11
Correctly matched symptoms to their corresponding mental illness	.75	.15	.72	.15	.74	.12	.74	.12	.76	.16	.75	.15

Note: * = $p < .05$

DISCUSSION AND CONCLUSION

With six independent variables, each fitting into one of three categories, each part of the hypothesis has been analyzed. First, in relation to the primary hypothesis that Generation X would fair more accurately than Millennials or Baby Boomers, this was half-correct. In fact, neither Generation X nor Millennials scored significantly better than the other; however, Baby Boomers showed a significantly worse score than either of the other two categories. This goes to show that generation does have an impact on one's accuracy of mental health when comparing older adults to middle-aged and younger adults; however, age itself does not. While Table 1.2 at first gives the appearance that with age comes a decrease in knowledge of mental health, due to a lack of significance found between Generation X and Millennials in Table 1.1, there is reason to believe that the Baby Boomers performed poorly enough on the survey causing the correlation of each additional year of life to appear significant. In other words, a Millennial or someone from Generation X will likely not decrease in their knowledge as they become the age of present-day Baby Boomers. Generational differences, as opposed to ageing, is what has an impact on mental health knowledge.

For the second hypothesis on personal relation to mental illness, results show that the closest proximity to mental illness, i.e. yourself, provides a more accurate knowledge over mental health. However, only in relation to oneself did there appear to be significance. Data does not prove that a closer proximity means a greater understanding as no significance was found between the "Family" grouping and the "Other" grouping. However, due to a smaller sample size and few participants noting that they had no personal contact with mental illness, tests were not run between those in the "Family" or

“Other” group in relation to a “No Contact” group. As such, the hypothesis that a person with some contact proximity would have a greater knowledge over mental health than a person with no contact with mental illness will still need to be examined. To expand upon the contact hypothesis, it is not a matter of how many people one knows with a mental illness, as the frequency did not have enough significance across the board to give leeway in that direction.

For the third hypothesis over education, data does not support a significant relationship between education over mental health and an accurate knowledge over mental illness. While knowledge must come from somewhere, data from this research does not suggest that it is coming from a formal educational setting. As this finding may come as a shock, it is important to remember what Bamgbade, Ford, and Barner predicted: “helping students connect abstract concept to a lived experience” (p. 9) increases the capability to gain a knowledge and understanding of mental illness (2016). Although most of the participants (almost 83%) had received a formal education over mental health at one point during their life, this does not account for the method of teaching that may or may not have been most useful. For future research, different educational experiences and modes of teaching and learning could be tested against the participants’ mental health knowledge. From this, possible policy can be implemented for the specific ways in which to better educate the population over mental health.

In conclusion, generational differences and the closest proximity of oneself proved to be significant points in mental health education in this research, while age, frequency of contacts, and education did not weigh in as significant points.

For further research, I would suggest enlarging the sample size to include more Generation X and Baby Boomers into the survey. Also, I would recommend examining education level of participants without the contingency that mental health be involved in education. Lastly, a larger number of males could bring about the potential in seeing discrepancies between gender.

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Appendix A.

Mental Health Education

COLLEGE OF LIBERAL ARTS AND SOCIAL SCIENCES DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY

To Whom It May Concern:

My name is Ashlyn Avera, and I am a senior undergraduate student at Georgia Southern University studying sociology and psychology. I have been a part of the University Honors Program since my freshman year. To graduate through this program, all seniors must complete an individual, original thesis/capstone project. I have chosen to do my project over Mental Health Education using a survey method.

The purpose of this research is to compare the knowledge and understanding of Mental Health and the knowledge and understanding of Mental Illness symptoms across three generations: Baby Boomers, Generation X, and Millennials.

Participation in this research will include the completion of an online survey lasting no longer than ten minutes. The survey will inquire about general demographic information, educational experience, then lastly knowledge over mental health. Personal information about your health will not be asked about.

You understand that medical care is available in the event of psychological discomfort resulting from this research; however, neither financial compensation nor free medical treatment is provided to you. If you wish to seek assistance, you may contact the National Alliance on Mental Illness hotline at (800) 950-6264 or may visit their website at <http://www.nami.org/>

Although no direct benefit will come to you as the participant, this research will benefit the societal whole by allowing the education systems to see ways they are succeeding in education about mental health and ways in which to improve. This research hopes to lend an incentive for more in depth education with future generations over mental health to decrease stigma regarding those who have mental disorders.

Deidentified or coded data from this study may be placed in a publically available repository for study validation and further research. You will not be identified by name in the data set or any reports using information obtained from this study, and your confidentiality as a participant in this study will remain secure. All data will be reported in a group form so individual answers will not be identifiable. Due to the nature of the survey processor, Qualtrics, the IP address of any device used to take this survey will not be recorded in any way and will not be accessible to the primary researcher or any subsequent researcher.

As a participant, you have the right to ask questions and have those questions answered. If you have questions about this study, please contact the researcher named above or the researcher's faculty advisor. Both of whose contact information is located at

the end of this informed consent. For questions concerning your rights as a research participant, contact Georgia Southern University Office of Research Services and Sponsored Programs at 912-478-5465.

You do not have to participate in this research, and there is no penalty for deciding to withdraw participation before or during the completion of the survey. You may decide at any time you do not want to participate further and may withdraw without penalty or retribution. To do so, you may simply exit out of the survey without returning to submit your questions. There is also an option in every question to “Skip This Question,” in such case that you wish to continue the survey but do not wish to answer a certain question. If necessary, participants may exit out of the survey and return later to complete the survey. However, if after 48 hours from beginning the survey and it has not been completed, the survey will immediately close and all answers will be disregarded.

You must be 18 years of age or older to consent to participate in this research study. If you consent to participate in this research study and to the terms above, please check the consent box at the end of this page to continue with the survey. Checking the box and clicking continue implies that you agree to participate and your data may be used in this research.

You will be given a copy of this consent form to keep for your records. To contact the Office of Research Integrity for answers to questions about the rights of research participants or for privacy concerns please email IRB@georgiasouthern.edu or call (912) 478-5465. This project has been reviewed and approved by the GSU Institutional Review Board under tracking number H17305.

Title of Project: Mental Health Education

Principal Investigator: Ashlyn M. Avera, (762) 207-6552, aa05087@georgiasouthern.edu

Faculty Advisor: Dr. Nancy Malcom, (912) 478-5168, nmalcom@georgiasouthern.edu,
PO Box 8051 Statesboro, GA 30460

Yes, I consent to participating in the survey over Mental Health Education.

No, I do not consent to participating in the survey and would like to exit.

Condition: No, I do not consent to par... Is Selected. Skip To: End of Survey.

Q1 What year were you born in?

Q2 What is your sex?

Male

Female

Other

Q3 What is your race/ethnicity. Check all that apply.

- Hispanic or Latino
- Not Hispanic or Latino
- American Indian
- Alaska Native
- Asian
- African American
- Pacific Islander
- White/Caucasian
- Other

Q4 What religious belief do you identify with?

- Protestant Christian
- Catholic Christian
- Jewish
- Muslim
- Buddhist
- Hindu
- Atheist
- Agnostic
- Unaffiliated/Nothing in Particular

Q5 What is your gross annual income? (If you are a dependent, what is your family's gross annual income?)

- Less than \$20,000
- \$20,000 through \$39,999
- \$40,000 through \$59,999
- \$60,000 through \$79,999
- \$80,000 through \$99,999
- \$100,000 or greater

Q6 What is your highest education level?

- GED
- High School Diploma
- Associates Degree or Pursuing
- Bachelors Degree or Pursuing
- Masters Degree or Pursuing
- Doctorate Degree or Pursuing
- Professional Degree

Q7 In what state did you attend high school?

Q8 What type of high school did you attend? Check all that apply.

- Public
- Charter
- Magnet
- Military Academy
- Private
- Other

Q9 Did you attend - or are currently attending - college for a bachelor's degree?

- Yes
- No

Display This Question:

If Did you attend college? Yes Is Selected

Q10 Where did you attend college for your bachelors degree? List all institutions attended for this degree.

Display This Question:

If Did you attend college? Yes Is Selected

Q11 What was your bachelors degree in?

Q12 To what degree is mental illness a concern in the United States?

- No Concern
- Slight Concern
- Mild Concern
- Serious Concern
- Severe Concern
- Skip This Question

Q13 When did you first learn about mental illness in an educational/school setting?

- Did not learn about mental illness in an educational setting
- Elementary School Course
- Middle School Course
- High School Course
- Undergraduate Course
- Graduate Course
- Doctorate Course
- Skip This Question

Q14 Do you personally know someone with mental illness? If so, what is their relation to you? Check all that apply.

- Do not know someone with mental illness
- Myself
- Immediate Family (e.g. parent, child, sibling, spouse)
- Extended Family (e.g. grandparent, aunt/uncle, cousin, niece/nephew)
- Other Family Member
- Close Friend or Romantic Partner
- Coworker, Classmate, Teammate, etc.
- Other Acquaintance
- Skip This Question

For the following questions, please answer whether you believe the following constitute a person as having a mental illness or not.

[Answer Choices Include: Yes; No; Skip This Question.]

Q16 Having a conversation with yourself and/or having an imaginary friend

Q17 Intense fear of gaining weight

Q18 Loss of interest or pleasure in activities that were once enjoyable

Q19 Inability to control actions, behaviors, or conversations

Q20 Continuous thoughts and desires to have things neatly organized

Q21 Heightened sensitivity to potential threats and/or very reactive to unexpected stimuli

Q22 Having romantic feelings for someone of the same sex

Q23 Reckless involvement in activities that are unusual for individual, even though activities are likely to have catastrophic consequences

Q24 Anticipatory anxiety of a social event far in advance of the situation

Q25 Prone to violent, unexpected, and hostile behavior

Q26 Mild or sub-threshold forms, hallucinations, or delusions

Q27 Individual inability to take care of themselves or contribute to society

Q28 Chemical imbalance in the brain

Q29 Excessive anxiety and worry about several activities or events

Q30 Actions or thoughts that are time consuming or cause significant distress or impairment

Q31 Feelings of paranoia

Q32 Unexpected abrupt surge of intense fear or intense discomfort that reaches a peak within minutes

Q33 Suicidal thoughts or desires to hurt oneself

For the following questions, please answer whether or not you believe you would be able to recognize the symptoms of the mental illnesses listed.
[Answer choices include: Yes; No; Skip This Question.]

Q34 Anorexia Nervosa

Q35 Bipolar I Disorder

Q36 Generalized Anxiety Disorder (GAD)

Q37 Major Depressive Disorder

Q38 Obsessive Compulsive Disorder (OCD)

Q39 Panic Disorder

Q40 Post-Traumatic Stress Disorder (PTSD)

Q41 Schizophrenia

Q42 Social Anxiety Phobia

Without consulting any educational material, please select which mental illness you believe these symptoms correlate with.

[Answer choices include: Anorexia Nervosa; Bipolar I Disorder; Generalized Anxiety Disorder; Major Depressive Disorder; Obsessive Compulsive Disorder; Panic Disorder; Post-Traumatic Stress Disorder; Schizophrenia; Social Anxiety Phobia; Skip This Question.]

Q44 Distress due to constant worrying and impairment in social, occupational, or other important areas of functioning

Q45 Repetitive behaviors or mental acts

Q46 Abnormally, persistently elevated, expansive, or irritable mood

Q47 Recurrent thoughts of death or suicidal ideation/plans/attempts

Q48 Behavior changes such as reorganizing daily life or restricting usual daily activities to minimize attacks

Q49 A variety of unusual or odd belief that are expressed but are not of delusional proportions, such as magical thinking.

Q50 Development of symptoms after exposure to a traumatic event either directly, indirectly, or by witnessing

Q51 Fear or anxiety of social events judged to be out of proportion to actual risk with overestimate of negative consequences

Q52 Weight loss viewed as achievement of self-discipline while weight gain viewed as unacceptable failure of self-control

Q53 Difficulty in controlling worry and keeping worrisome thoughts from interfering with attention to other tasks

Q54 Clear presence of delusions, hallucinations, or disorganized speech

Q55 Intrusive and unwanted repetitive and persistent thoughts, images, urges

Q56 Body weight below minimal normal level for age, sex, developmental trajectory, and physical health

Q57 Dissociative states that may last from a few seconds to hours or days when components of an event are relived

Q58 Manic episodes commonly accompanied by a major depressive episode

Q59 Intense fear of social situation in which one may be scrutinized by others

Q60 Guilty preoccupations or ruminating over minor past failings

Q61 Panic attack that occurs out of the blue, such as when the individual is relaxing or emerging from sleep

For the following questions, please rate how effective, in general, you believe the following treatments are in relation to mental illness.

[Answer choices include: Not effective at all; Slightly effective; Moderately effective; Very effective; Extremely effective; Skip This Question.]

Q63 Psychotherapy, or therapy provided by a mental health professional

Q64 Medication

Q65 Hospitalization

Q66 Support Group

Q67 Electroconvulsive Therapy, or use of electric stimuli on the brain

Q68 Solitary Confinement

Thank you for participating in this survey over Mental Health Education. If you wish to seek assistance, you may contact the National Alliance on Mental Illness hotline at (800) 950-6264 or may visit their website at <http://www.nami.org/>