CHAPTER 7

Mental Health Literacy and Stigma in Participants of a Self-help Program

Submitted:

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ABSTRACT

Background: Low levels of mental health literacy and stigma may contribute to delayed treatment seeking and poorer outcomes in people with mental disorders. The present study investigates mental health literacy in relation to mental disorders in general and depression in particular, in people experiencing psychological distress.

Methods: Volunteers consented to a mental health program participated in the study. Respondents' mental health literacy and attitudes towards psychiatric disorders were investigated using two vignettes portraying depression with subtle or obvious symptoms. The *'Community Attitudes to Mental Illness' scale (CAMI)* was used to measure attitudes about mental illness in general.

Results: Psychosocial and intrapsychic factors were more frequently reported as possible causes of depression than biological causes. Psychological (e.g. psychologist and social worker) and lifestyle (e.g. close family/friends, physical activity) interventions were most often endorsed as effective treatment options than pharmacological treatments (e.g. antidepressants). More stigma was expressed towards people with severe depressive symptoms than with mild symptoms.

Conclusion: Knowledge of psychobiological causes for depression and of available effective treatment was limited. These results indicate that psycho-education should be incorporated into interventions for psychological distress.

INTRODUCTION

Low levels of mental health literacy and stigma may contribute to delayed treatment seeking and poorer outcomes in people with mental disorders. A nationally representative household survey reports that approximately 30% of adults in South Africa have experienced a common mental disorder in their lifetime (1). Only 25.1% reported they received treatment in the year preceding the interview (2), leaving 74.9% of people with such a condition not receiving any help for their psychological problems. Despite the high worldwide prevalence and associated burden of common mental disorders, the need for treatment is not always met (3;4). The World Health Organization (WHO) indicates that the treatment gap for mental disorders in developed countries is 30-50% and in low- and middle-income countries (LAMIC) 76-80%.

A scarcity of human, mental health and financial resources are reported as the predominant cause of the treatment gap in South Africa (5-8). Besides structural barriers, like the cost and availability of services, attitudinal barriers are also important in determining people's help-seeking behaviour. A recent study in South Africa indicated that a low perceived need for treatment was the most common reason for not accessing mental health services (93%) (9). Respondents who did recognize the need for treatment but did not seek help reported more psychological barriers than structural barriers. The main psychological barriers cited were stigma, negative beliefs about the effectiveness of treatment and the desire to tackle the problem themselves. An earlier study amongst people suffering from a mental disorder in a mental health advocacy group indicated that not knowing where to go for help and the idea to handle issues on their own were the main barriers for seeking help (10). A review of help-seeking behaviour in young people also found perceived stigma, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance were the most important barriers to help-seeking (11).

Thus, it is not only the accessibility of mental health services, but also patients' knowledge and attitudes towards psychiatric disorders and their ability to recognize mental health issues that are important barriers to receiving care (12). The concept of 'mental health

literacy', developed by authors such as Jorm, is defined as "the knowledge and beliefs about mental illness that aid their recognition, management or prevention"(13). Mental health literacy may vary across different mental disorders. For example, symptoms of schizophrenic are more often viewed as a mental illness than depressive symptoms (14;15). Psychosocial factors, particularly psychosocial stress, are viewed by the public as more important than biological factors in the cause of mental illness. Most studies find that the public prefers psychological interventions over pharmacological treatments for mental disorders (14). Mental health literacy could potentially influence help-seeking behaviour and adherence to treatment. Stigma of mental health problems could be one of the detrimental effects of inaccurate beliefs hold about mental health disorders. Low mental health literacy and high stigma in relation to a mental health condition may result in a lower level of help-seeking (13;16;17). Therefore, in addition to tackling economic and resource barriers, improving mental health literacy is important in improving mental health practice.

Very little is known about the mental health literacy and attitudes of people who themselves appear to be struggling with a mental health problem. Relatively few studies have explored whether severity of symptoms impacts on knowledge and attitudes. In South Africa studies have investigated mental health literacy in community samples (15;18) and in a sample of people living with HIV (19), but not in a population with mental health problems. This study attempts to look at the ability of people with psychological distress to recognize depression, their attitudes towards mental illnesses and stigma they hold against people suffering from depression.

METHODS

Participants

The participants were people with reported mental health problems who consented to participate in a problem solving therapy pilot program in deprived communities around Cape

Town, South Africa. The inclusion criteria were; being over 18 years of age and experiencing mental health problems. They were excluded from participation if they: 1. had suicide plans, as opposed to just suicidal thoughts; 2. had severe mental health problems- these were referred to their local community day hospital, in line with the Western Cape's mental-health-referral guidelines; 3. were illiterate, as participants were expected to read through the booklet's self-help text in English, Afrikaans or Xhosa.

Measures

Psychological distress

The severity of psychological distress was evaluated using the K-10 questionnaire (Kessler et al 2002), a scale that has been used to screen for mental disorders.

Mental health literacy

The questionnaire used to evaluate mental health literacy was an adapted version of a measure developed by Hugo et al (2003). Participants were randomly presented with a vignette (case study) of either mild or severe depression in line with the DSM-IV diagnostic criteria. The mild and severe vignettes respectively read:

"*Carl is described by his fellow-workers as someone who doesn't seem to have much fun in life. Although he gets his work done, he usually seems gloomy and irritable. He hardly ever has lunch with his fellow-workers even when invited, saying that he simply doesn't enjoy company. Carl also seems to have a very low self-esteem, and often says that he is incapable of doing even the simplest of tasks, even though others have a high opinion of his work. When a supervisor once asked if something was bothering him, he replied that he has always been this way*"

"*Brenda started feeling increasingly sad after her sister died in a motorcar accident. Of course, the whole family had been affected by this tragic loss, but Brenda's sadness seemed to last the*

longest. Some six months after her sister's death, she was still unable to keep thoughts about this loss out of her mind. She continuously questioned the value of life. She found that she had difficulty falling asleep, lost 10kg in weight, had very little energy, and she had trouble concentrating. At work, she found herself crying without reason."

After reading the vignette, mental health literacy was evaluated by 23 questions about the aetiology and 21 questions about the treatment of the symptoms presented in the vignettes, which had to be rated on a 5-point likert scale. Participants were asked to indicate their view on the possible cause of Carl's or Brenda's behaviour by checking yes, maybe, no boxes for all the presented possible causes. Psychosocial (e.g. work difficulties), biological (e.g. brain disease), intrapsychic (e.g. lack of willpower), socialization (e.g. growing up in a broken home), state of society (e.g. loss of traditional values in society) and supernatural (e.g. witchcraft) causes were listed. They were thereafter asked to indicate what in their view would be appropriate treatments for Carl or Brenda by ticking helpful, harmful or neither boxes for the listed treatment options. Treatments listed were psychological (e.g. counsellor, psychiatrist), lifestyle (e.g. naturopath, get out more) and medical (e.g. antidepressants, electro-convulsive therapy) interventions.

Stigma

The *Attribution Questionnaire* (short form) was conducted after the vignettes to record levels of stigma. Respondents were asked to fill out a list of statements addressing 8 stereotypes about people with mental illnesses, including blame, anger, pity, help, dangerousness, fear, avoidance and segregation. Their opinions had to be coded on a 9 point scale ranging from 'not at all' to 'very much'. The *'Community Attitudes to Mental Illness' scale (CAMI)* consists of 40 items covering 4 sub-scales (*Community Mental Health Ideology*, *Benevolence* , *Social Restrictiveness* , and *Authoritarianism)* and measures attitudes about mental illness on a 5 point Likert-scale

(Taylor and Dear, 1981). The psychometric properties have been tested in different samples and were found to be adequate. The higher one scores on the scales, the more stigma one holds towards the mentally ill. The subscale 'Benevolence' refers to paternalistic and sympathetic views of mentally ill people. 'Authoritarianism' covers views of mentally ill people being inferior and requiring coercive handling. The 'Social Restrictiveness' subscale assesses the view that mentally ill people are a threat to society and should be avoided. The 'Community Mental Health Ideology' subscale assesses acceptance of mental health services and the mentally ill in the community.

Procedure

Recruitment for the intervention was done by: posting pamphlets and posters on notice boards of community libraries, community centres and public health facilities and by giving short talks on the program in community settings and NGO's.(20) Participants were recruited from different communities representing the majority of deprived communities around Cape Town that lack access to mental health care. Volunteers at the different sites who felt that they had mental health problems were invited to participate with the intervention program. Prior to the start of the program the K-10, CAMI, AQ-SF and mental health literacy questionnaires were administered in English, Afrikaans or Xhosa.

Analysis

Data were analysed using the Statistical package for the Social Sciences 17.0 The responses to the aetiology and treatment were explored using chi-square calculations. A multiple logistic regression model was developed to investigate the association between demographic variables and whether or not people could correctly identify the behaviour in the vignettes as depression. The distribution of the stigma scores was tested for normality using the Kolmogorov-Smirnov test. The scores were not normally distributed and therefore the Mann-Whitney test was used

to compare the responses on the mild and severe vignettes. Finally a Pearson's correlation was conducted to evaluate the correlation between psychological distress and stigma.

RESULTS

Respondents

A total of 56 respondents filled out the questionnaires. The mean age of people who completed the questionnaire was 31; 38% were male; 51% were African black and 49% coloured (mixed race); 74% were Christians and 26% Muslim. Most lived in Manenberg (50%) and Khayelitsha (28%), 61% were unemployed and 33% were married. Regarding education, nobody had completed tertiary education, 42% had finished high school, and 18% had not finished primary school.

Mental health literacy

Despite all vignettes being constructed according to DSM IV criteria, only 37.5% reported that the case study presented to them was typical of a mental illness, while 44.6 % thought the vignette represented a normal response. Over half of the respondents indicated they believed the described behaviour was typical of weak character (55.4%). Stress (64.8%) and lack of willpower (57%) were most often mentioned as causes for the described behaviour. Psychosocial stressors were most often reported as causes (between 33.3% and 64.8%), followed by intrapsychic factors (31.5% and 57.4%), biological causes (between 29.6% and 44.4%), socialization (22.2-29.6%), supernatural powers (9.3%-27.8%) and state of society (13-16.7%).

TABLE 1 Mental health literacy-causes of depression

Causes of depression	Severe depression	Mild Depression	Overall	
	% Yes (n)	*% Yes (n)*	*% Yes (n)*	p-value
Behaviour is normal response	57.1 (16)	32.1 (9)	44.6 (25)	P<0.05
Behaviour is typical of weak character	60.7 (17)	50.0 (14)	55.4 (31)	0.296
Typical mental illness	28.6 (8)	46.4 (13)	37.5 (21)	0.269
Typical of general medical problem	21.4 (6)	39.3 (11)	30.4 (17)	0.122
Psychosocial stress				
Difficulties in partner or family Relationships	28.6 (8)	38.5 (10)	33.3 (18)	0.315
Work difficulties	53.6 (5)	23.1 (6)	38.9 (21)	P<0.05
Stress	82.1 (23)	46.2 (12)	64.8 (35)	P<0.01
Biological				
Brain disease	50.0 (14)	19.2 (5)	35.2 (19)	P<0.05
Hereditary/genetics	42.9 (12)	15.4 (4)	29.6 (16)	P<0.05
Weakness	64.3 (18)	23.1(6)	44.4 (24)	P<0.01
Intrapsychic factors				
Lack of willpower	67.9 (19)	46.2 (12)	57.4 (31)	0.168
Expecting too much from oneself	53.6 (15)	30.8 (8)	42.6 (23)	0.107
Unconscious conflict	42.9 (12)	19.2 (5)	31.5 (17)	0.082
Socialization				
Growing up in a broken home	14.3 (4)	46.2(12)	29.6 (16)	P<0.05
Lack of parental affection	14.3 (4)	34.6 (9)	24.1 (13)	0.114
Overprotective parents	17.9 (5)	26.9 (7)	22.2 (12)	0.520
State of society				
Los of traditional values in society	17.9 (5)	15.4 (4)	16.7 (9)	1.0
Decays of natural ways of life	10.7 (3)	15.4 (4)	13 (7)	0.699
Exploitation of people in industrial Society	3.6 (1)	23.1 (6)	13 (7)	0.47
Supernatural powers				
Will of God	21.4 (6)	34.6 (9)	27.8 (15)	0.366
Witchcraft	7.1 (2)	19.2 (5)	13.0 (7)	0.243
Sign of the Zodiac	3.6 (1)	15.4 (4)	9.3 (5)	0.184

The causes attributed to the described behaviour varied between the mild and severe depression vignette. Work difficulties (χ =5.28, df=1, p<0.05) , stress (χ =7.66, df=1, p<0.01) , brain disease (χ =5.597, df=1, p<0.050, weakness (χ =9.27, df=1, p<0.01) and genetics (χ =4.88, df=1, p<0.05) were more often mentioned as causes for severe depression compared to mild depression. Growing up in a broken home, on the other hand, was mentioned more as a cause for mild depression than for severe depression (χ =6.57, df=1, p<0.05).

Treatments described as helpful were mostly psychological or lifestyle interventions, e.g. counsellor (98.2%), psychologist (92,7%), close family (89.3%), social worker (89.1%), psychotherapeutic treatment (87.3%), physical activity (86.8%) and close friends (83.9%). The most frequently reported medical treatment for depression was spending time in a psychiatric ward (71.7%) and electro-convulsive therapy (55.8%). (see Table 2).

TABLE 2 Mental health literacy-treatment of depression

Treatment of depression	**Severe depression**	**Mild depression**	**Overall**	
	% yes (n)	***% yes (n)***	***% yes (n)***	***p-value***
Psychological				
Counsellor	100 (28)	96.4 (27)	98.2 (55)	1.00
Social worker	92.9 (26)	85.2 (23)	89.1 (49)	0.422
Telephone counselling	67.9 (19)	44.4 (12)	56.4 (31)	0.106
Psychiatrist	85.7 (24)	67.9 (19)	76.8 (43)	0.205
Psychologist	96.4 (27)	85.7 (24)	92.7 (51)	0.352
Psychotherapy	89.3 (25)	85.2 (23)	87.3 (48)	0.705
Hypnosis	17.9 (5)	36.0 (9)	26.4 (14)	0.212
Lifestyle				
Close family	92.9 (26)	85.7 (24)	89.3 (50)	0.669
Close friends	89.3 (25)	78.6 (22)	83.9 (47)	0.469
Naturopath	39.0 (11)	37.0 (10)	38.2 (21)	1.00
Vitamins	71.4 (20)	48.1 (13)	60 (33)	0.102
Physical activity	96.4 (27)	76.0 (19)	86.8 (46)	P<0.05
Get out more	75.0 (21)	70.4 (19)	72.7 (40)	0.768
Medical				
Pain relievers	25 (7)	30.8 (8)	27.8 (15)	0.764
Antidepressants	14.3 (4)	39.3 (11)	26.8 (15)	0.068
Antibiotics	17.9 (5)	38.5 (10)	27.8 (15)	0.131
Sleeping pills	25.0 (7)	28.0 (7)	26.4 (14)	1.000
Antipsychcotics	17.9 (5)	20.0 (5)	18.9 (10)	1.000
Tranquilisers	28.6 (8)	12.0 (3)	20.8 (11)	0.183
Psychiatric ward	82.1 (23)	60.0 (15)	71.7 (38)	0.126
Electro-convulsive therapy	71.4 (20)	37.5 (9)	55.8 (29)	0.240

Physical activity was more frequently viewed as an appropriate intervention for the treatment of severe depression than for mild depression (χ =4.81, df=1, p<0.05). There was a trend for antidepressants to be viewed as more useful in the treatment of mild depression compared to severe depression (χ =4.46, df=1, p=0.068). Both vitamins and electro-convulsive therapy were reported by 71.4% of the respondents as an appropriate treatment for someone with severe

depressive symptoms. None of the demographic characteristics were predictors of mental health literacy.

Stigma

The levels of dangerousness, fear, segregation, anger and help differed significantly between the mild depression vignette compared to the severe depression vignette. People indicated to hold less stigmatizing attitudes and being more helpful to people with symptoms of mild depression than for severe depression. (see table 3).

The highest reports of stigma on the 1-5 CAMI scale were for the factors Benevolence (*m* = 3.39, SD = 0.569) and Social Restrictiveness (*m* = 3.31, SD = 0.582). Lower scores of stigma were reported on Community Mental Health Ideology (*m* = 3.28, SD = 0.512) and Authoritarianism (*m* = 2.953, SD = 0.438). The extent of stigma reported on the CAMI was significantly correlated with psychological distress, r= .329, p<0.05.

TABLE 3 Scores on Attribution Questionnaire measuring feelings towards individuals with depression

Item	Mild depression		Severe depression		*Comparison of means P*
	Mean	*SD*	*Mean*	*SD*	
Pity	4.61	2.455	5.21	1.663	0.213
Dangerousness	3.64	2.264	4.75	1.578	0.034
Fear	3.11	1.685	4.36	1.638	0.010
Blame	3.07	2.64	3.57	1.20	0.156
Segregation	2.64	1.948	3.86	1.957	0.015
Anger	2.32	1.657	3.29	1.761	0.039
Help	6.89	2.89	4.61	2.409	0.002
Avoidance	2.64	2.004	2.86	1.604	0.266

DISCUSSION

This study found that the majority of people participating in our program did not consider DSM-IV symptoms of depression as typical of a mental illness, and over half reported these symptoms as typical of a weak character. This finding is consistent with earlier studies conducted in South Africa with community samples (15;18) and a sample of people living with HIV/AIDS (19). Stress and lack of willpower were most often endorsed as possible causes for depressive symptoms. Psychological and life-style interventions were far more often endorsed as useful treatments for the depressive symptoms described in the vignettes than medical treatments. These data are consistent with studies in South Africa and elsewhere, which report that psychological treatments are viewed more favourably than psychopharmacological treatments (15;16;18).

Relatively few studies have explored whether severity of mental health symptoms impacts on knowledge and attitudes. It is notable that many of the answers regarding possible causes of the mild and severe depression varied significantly, while the answers regarding treatment possibilities did not. The symptoms of severe depression were more often viewed as a normal response than symptoms of mild depression. This finding could reflect a problem in the questionnaire. Biological causes, work difficulties and stress were more often rated as possible causes for symptoms of severe depression than for symptoms of mild depression.

Overall, the level of stigma reported in relation to mental disorder in general was mild, with all the CAMI subscale scores indicating moderately negative attitudes in our population. The results show that although people hold paternalistic and sympathetic views of people with a mental illness they also consider them as threats to society. In addition they view themselves as slightly superior to mentally ill people and have some resistance to having people with mental illness and health services in their communities. Since many of the participants did not view depression as a mental disorders it is perhaps not surprising that the stigma attributed to the symptoms of depression expressed in the vignettes was very mild. Overall people expressed pity towards those with mental health symptoms and low levels of blame and avoidance.

The attitudes expressed after reading the vignette of depression, differed significantly depending on the severity of symptoms. Respondents indicated severe depression was more dangerous and were more fearful of them. They also expressed higher levels of fear and segregation and less willingness to help towards severe depressive symptoms than for mild symptoms. Respondents indicated to be less stigmatizing, and more helpful to people with symptoms of mild depression compared to symptoms of severe depression.

The extent of stigma reported on the CAMI was significantly correlated with psychological distress. This indicates that people with a high level of psychological distress had a tendency to stigmatize mental illnesses more. This is not consistent with earlier findings indicating a positive association between familiarity with mental illness and acceptance of people with mental illnesses (21;22). A recent review indicates that half of the studies that evaluated this association found a positive association while the other half did not (14). As mentioned earlier stigma may vary across different mental illnesses. For example people with schizophrenia and alcoholism are seen as more dangerous and unpredictable than people with depression and anxiety disorders (23-25). It is also plausible that people who attribute more stigma towards the mentally ill, encounter more distress when experiencing mental issues themselves. Literature indicates 'self stigma' to have negative effects on the psychological well being of people (26;27).

This study has several limitations that deserve emphasis. The psychological distress was administered by self-report but no diagnostic interviews were conducted so that the effect of clinical status is unknown. The vignettes used in our study only represented mild or severe depressive symptoms. Therefore, the results found with regards to the reported causes, treatment and stigma towards the behaviour cannot be generalized to other mental illnesses.

Despite these limitations, the findings of this study can hold implications for addressing mental health care in South Africa. The inability of people to recognize a mental illness in others may be associated with an inability to recognize one's own symptoms and to communicate these to a health practitioner. Additionally, since higher levels of stigma is associated with more

psychological stress, stigma may also be a barrier to accessing treatment. Literature reports the chances of detecting mental disorders in primary care to be greater if patients indicate their symptoms to be a reflection of a psychological problem when seeing a general practitioner (28-30). However, a positive finding of the present study was the acceptability of psychotherapy as a treatment option for depression. What the results of the present study reveal is the need to increase the understanding of the biological causes of mental illness and the value of pharmacotherapy. Improving mental health literacy could assist the process of early recognition, in turn reducing the burden associated with untreated common mental disorders.

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