Mental health literacy: Public knowledge and beliefs about mental disorders

A. F. JORM


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Mental health literacy
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A. F. JORM

Background Although the benefits of public knowledge of physical diseases are widely accepted, knowledge about mental disorders (mental health literacy) has been comparatively neglected.

Aims To introduce the concept of mental health literacy to a wider audience, to bring together diverse research relevant to the topic and to identify gaps in the area.

Method A narrative review within a conceptual framework.

Results Many members of the public cannot recognise specific disorders or different types of psychological distress. They differ from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments. Attitudes which hinder recognition and appropriate help-seeking are common. Much of the mental health information most readily available to the public is misleading. However, there is some evidence that mental health literacy can be improved.

Conclusions If the public’s mental health literacy is not improved, this may hinder public acceptance of evidence-based mental health care. Also, many people with common mental disorders may be denied effective self-help and may not receive appropriate support from others in the community.

Declaration of interest None.

Health literacy has been defined as “the ability to gain access to, understand, and use information in ways which promote and maintain good health” (Nutbeam et al, 1993). In the area of physical health, examples of health literacy would include knowledge and use of a healthy diet, taking actions to prevent skin cancer, performing breast self-examination, having first aid skills and knowing how to look up health information in a library or on the internet. While the importance of health literacy for physical health is widely acknowledged, the area of mental health literacy has been comparatively neglected. The purpose of this review is to introduce the concept to a wider audience, to bring together diverse research relevant to mental health literacy and to identify gaps in the area.

DEFINITION AND CONCEPTUAL FRAMEWORK

Jorm et al (1997a) introduced the term ‘mental health literacy’ and have defined it as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. Mental health literacy consists of several components, including: (a) the ability to recognise specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information.

If people experience disabling psychological symptoms or have close contact with others who have such problems, they will attempt to manage those symptoms. People’s symptom-management activities will be influenced by their mental health literacy. If successful, these symptom-management activities may lead to a reduction in disabling symptoms and also a change in mental health literacy. In this framework, the person affected by the symptoms (either personally or through close contact) is seen as the primary agent in symptom management, with professional help being one of a range of strategies he or she might try. This perspective is important because it leads to a greater emphasis on increasing public (rather than professional) knowledge and skills about mental health and on empowering the person experiencing disabling symptoms. The need for the public to have greater mental health literacy is highlighted by the high lifetime prevalence of mental disorders (up to 50%, according to Kessler et al, 1994), which means that virtually everyone will either develop a mental disorder or have close contact with someone who does.

RECOGNITION OF MENTAL DISORDERS

Many members of the public cannot correctly recognise mental disorders and do not understand the meanings of psychiatric terms. For example, when a representative sample of the Australian public was shown vignettes of a person suffering from major depression or schizophrenia, most recognised that there was some sort of mental health problem but depression was correctly used as the label by only 39% and schizophrenia by 27% (Jorm et al, 1997a). For the depression vignette, 11% thought the person had a physical disorder. Similarly, European surveys have found lack of understanding of the terms schizophrenia and mania to be common (Brandli, 1999; Hillert et al, 1999) and that ‘schizophrenia’ is commonly associated with a split personality (Angermeyer & Matschinger, 1999). A US study found that the public are reasonably knowledgeable about the mood symptoms of depression, but less likely to know about somatic changes (Regier et al, 1988).

Is the inability to use a correct psychiatric label and lack of knowledge of symptomatology of any significance? These failures of mental health literacy may cause problems of communication with health practitioners. It is well known that patients with mental disorders are often missed by general practitioners (GPs). Aspects of the GP interviewing style are known to be associated with rate of detection (Goldberg & Huxley, 1992), but the patient’s mode of
interacting with the GP is also important. Detection of a mental disorder is greater if the patient presents his or her symptoms as reflecting a psychological problem (Herran et al., 1999; Kessler et al., 1999) and explicitly raises the problem with the GP (Bowers et al., 1990; Jacob et al., 1998). Although GP recognition may not be sufficient in itself to benefit the patient (Goldberg et al., 1998; Simon et al., 1999), it is a first step towards effective action.

**KNOWLEDGE AND BELIEFS ABOUT CAUSES**

In Western countries depression and schizophrenia are most often seen by the public as caused by the social environment, particularly recent stressors (McKeon & Carrick, 1991; Matschinger & Angermeyer, 1996; Priest et al., 1996; Jorm et al., 1997b; Link et al., 1999). While psychiatric epidemiologists would concur about the importance of stressful life events in depression, in schizophrenia life events are more of a trigger than a cause. Biological factors are seen by the public as less important than environmental ones (McKeon & Carrick, 1991; Matschinger & Angermeyer, 1996; Wolff et al., 1996; Jorm et al., 1997b; Link et al., 1999), although relatives of people with schizophrenia are more likely to see biological factors as important (Angermeyer & Matschinger, 1996a). Providing the label ‘schizophrenia’ to a vignette has also been found to increase the likelihood that biological rather than psycho-social causes are seen as responsible (Angermeyer & Matschinger, 1996b). In some non-Western cultures, supernatural phenomena, such as witchcraft and possession by evil spirits, are seen as important causes of mental disorders (Razali et al., 1996), although this is uncommon in the West (Angermeyer & Matschinger, 1999; Brändli, 1999).

Beliefs about causes may alter patterns of help-seeking and response to treatment. For example, in Malaysia belief by psychiatric patients in supernatural causes was associated with greater use of traditional healers and poorer compliance with medication (Razali et al., 1996). In a US controlled trial of psychotherapy for depression, belief in relationship causes was associated with a better outcome in behavioural therapy, while belief in existential causes was associated with a better outcome in cognitive therapy (Addis & Jacobson, 1996).

**KNOWLEDGE AND BELIEFS ABOUT SELF-HELP**

Given that only a minority of people who meet diagnostic criteria for a mental disorder seek professional help (Regier et al., 1993; Lin et al., 1996; Andrews et al., 1999), self-help skills are of great importance. When the public were asked to rate a range of interventions for likely helpfulness, self-help interventions were found to be at the top of the list in both Australia and the UK (Rippere, 1979; Parker & Brown, 1982; Jorm et al., 1997a). Among the most popular self-help interventions are seeking support from family and friends, engaging in pleasurable activities, taking up new activities and physical exercise. Unfortunately, there is much less evidence on the effectiveness of self-help interventions than on that of professional ones, making it difficult to say which are likely to work. However, for milder states of depression, there is evidence for the effectiveness of social support (Goldberg & Huxley, 1992), physical exercise (Martens et al., 1994), self-help books based on cognitive-behavioural therapy (Cuijpers, 1997) and for the herb St John’s wort (Linde et al., 1996). *Rauwolfia serpentina* is a traditional herbal remedy known to have an antipsychotic effect (Bhatara et al., 1997). There is a clear need for further evaluation of self-help interventions, so that the public can be given appropriate advice.

Knowledge of how to help others is a related component of mental health literacy. Very little research has been done on the topic, but a Swiss survey found that the public have difficulty in dealing with mental disorders, saying they do not know how to behave, are afraid of making mistakes and do not have sufficient knowledge (Brändli, 1999).

**KNOWLEDGE AND BELIEFS ABOUT PROFESSIONAL HELP**

A number of surveys have asked the public about various helping professions. General practitioners are rated very highly in many countries, particularly for depression (Priest et al., 1996; Wolff et al., 1996; Jorm et al., 1997a; Bradli, 1999). The strong endorsement of GPs is not, however, universal (McKeon & Carrick, 1991; Jorm et al., 2000a). For depression, psychiatrists and psychologists are rated less highly than GPs, but are more likely to be seen as helpful for schizophrenia (Jorm et al., 1997a; Angermeyer et al., 1999). These results come from developed countries. Beliefs about professional help may be very different in developing countries. For example, in Ethiopia traditional sources of help, such as witchcraft, holy water and herbalists, were preferred over medical help for a range of mental health problems (Alem et al., 1999). By contrast, medical help was overwhelmingly preferred for physical health problems. When the public are asked about various therapies, a strikingly consistent finding across many countries is very negative beliefs about medication for a range of mental disorders (Regier et al., 1988; Angermeyer et al., 1993; Priest et al., 1996; Jorm et al., 1997a; Fischer et al., 1999; Hiller et al., 1999; Jorm et al., 2000a). The public’s belief about medication is in sharp contrast to both the evidence from randomised controlled trials and the views of mental health professionals that antidepressant and antipsychotic medications are effective (Jorm et al., 1997c; Caldwell & Jorm, 2000). The public’s negative views about psychotropic medication also contrast with their own positive views about medication for common physical disorders (Hillert et al., 1999). The reasons given by the public for their negative views of psychotropic medication are perceived side-effects, such as dependence, lethargy or brain damage, and the belief that the treatments deal only with the symptoms and not the causes (Angermeyer et al., 1993; Priest et al., 1996; Fishcher et al., 1999). One interpretation of these findings is that the negative attributes of benzodiazepines have become generalised to all types of psychotropic medication (Angermeyer et al., 1993). Indeed, the public do not seem to discriminate between different types of psychotropic medication, in contrast to mental health professionals who are quite specific in their recommendations (Jorm et al., 1997c). An Australian survey found that other treatments specifically associated with psychiatrists, such as electroconvulsive therapy (ECT) and admission to a psychiatric ward, are also viewed very negatively by the public, with more people believing they are harmful than helpful (Jorm et al., 1997a). Anecdotal evidence would support the conclusion that such
beliefs are widespread in other countries as well.

‘Natural’ remedies, such as vitamins and herbs, are viewed much more positively by the public (Angermeyer & Matschinger, 1996c; Jorm et al., 1997a) and are not generally seen as sharing the negative attributes of psychotropics (Fischer et al., 1999).

Another consistent finding across a range of countries is very positive views about psychological treatments such as counselling (McKeon & Carrick, 1991; Priest et al., 1996; Jorm et al., 1997a, 2000a) and psychotherapy (Angermeyer & Matschinger, 1996c; Hillert et al., 1999). Indeed, the public’s views tend to be more positive than those of professionals (Furnham et al., 1992; Jorm et al., 1997c). What is most surprising is that psychological interventions are seen by the public as highly effective for psychotic disorders (Angermeyer & Matschinger, 1996c; Jorm et al., 1997c, 2000a) and even, according to an Austrian survey, for dementia (Jorm et al., 2000a).

What are the consequences of the public’s beliefs about treatment? The most obvious is that negative beliefs about medication may lead to failure to seek medical help and lack of compliance with any medication recommended (Fischer et al., 1999). It has been proposed that greater account should be taken of patients’ views in negotiating the treatment approach. In this regard, the term ‘concordance’, which implies a two-way negotiation between doctor and patient, is more appropriate than ‘compliance’ (Mullen, 1997). Public beliefs about professional help may also affect the help-seeking of others. It has been found that professional help for depression is more likely to occur when another person recommends that help be sought (Dew et al., 1991), so the views of significant others about treatment may also be influential.

ATTITUDES THAT FACILITATE RECOGNITION AND HELP-SEEKING

There is a stigma associated with mental disorders and this may hinder seeking help. For example, the German public report much greater reluctance to discuss mental disorders with relatives and friends than to discuss physical disorders (Hillert et al., 1999), while in the USA many members of the public reported an unwillingness to seek treatment for depression because they feared a negative impact on their employment situation (Regier et al., 1988). Stigmatising attitudes also extend to approaching professionals. In the UK, a majority of the public reported that they would be embarrassed to consult a GP for depression, primarily because the GP would see them as unbalanced or neurotic (Priest et al., 1996), and in India patients with stigmatising attitudes have been found to present their distress in somatic rather than psychological terms (Raguram et al., 1996).

KNOWLEDGE OF HOW TO SEEK MENTAL HEALTH INFORMATION

We know very little about how people acquire knowledge and beliefs about mental health. It is likely that personal experiences and anecdotal evidence from family and friends are an important source. A UK study found that 33% of respondents cited personal experience of someone with a mental disorder as their main source of information, while a further 10% cited friends and relatives (Wolff et al., 1996). Indeed, personal experience or contact has been found to be associated with beliefs about causes (Angermeyer & Matschinger, 1996b), with more favourable attitudes (Angermeyer & Matschinger, 1996d; Wolff et al., 1996), with treatment preferences (Angermeyer & Matschinger, 1996a) and with greater understanding of the term schizophrenia (Hillert et al., 1999).

Other important influences are journalists’ reports and television and cinema dramas depicting mental disorders. In the UK, 32% cited the media as their main source of information (Wolff et al., 1996). Unfortunately, these media often tend to report on the negative aspects. In a survey of the German public, 64% said that they had read about a person with a mental illness who had committed a violent crime and 50% about someone who became addicted to prescribed drugs, but only 17% had read about persons with mental illnesses who became able to lead a normal life by taking their medication (Hillert et al., 1999). It is clear that such negative reporting has an impact. Another German study was able to show that two attempts on the lives of prominent politicians by persons with a mental disorder led to a marked increase in negative attitudes (Angermeyer & Matschinger, 1995).

People with mental disorders are also frequently portrayed as violent or having other undesirable characteristics in fictional accounts in the cinema and on television (Hyler et al., 1991; Wilson et al., 1999). Although violence is a problem in a small proportion of people suffering from severe mental disorders (Torrery, 1994), the public clearly overestimate this risk, on the basis of media reports and dramatic portrayals (Wolff et al., 1996; Link et al., 1999).

Finally, there are sources of knowledge, such as books, libraries, the internet and courses of study, available to those with better education and resources. While it is known that some self-help books are best-sellers and that some mental health websites receive a large number of hits, the overall impact of such sources on mental health literacy is unknown. There is a need for greater quality control of such sources to ensure that the public gets accurate information. For example, a recent study of the top 20 depression websites found the overall quality of the information was poor when evaluated against clinical practice guidelines (K. Griffiths, personal communication, 2000; further details available from the author upon request).

COGNITIVE ORGANISATION OF MENTAL HEALTH LITERACY

There is a clear gulf between public and professional beliefs about mental disorders (Jorm et al., 1997c). One interpretation of this finding is that there is a continuum of mental health literacy running from lay beliefs to professional knowledge. The professionals have expert knowledge which is to a large extent based on scientific evidence and expert consensus, while the public have a range of beliefs based on personal experience, anecdotes, media reports and more formal sources of knowledge. However, factor analysis of public beliefs reveals not a general factor corresponding to mental health literacy, but a number of factors representing general belief systems that illness is best handled by medical, psychological or lifestyle interventions (Jorm et al., 1997d). It may be that when people are confronted by a health problem they know little about, they fall back on their general belief systems about health (Jorm et al., 2000b). For example, if a person has no specific knowledge about depression, they might fall back on a general belief system that health problems
are caused by lifestyle and that the solution is to be found in natural remedies and lifestyle changes. These general belief systems then become a scaffold onto which specific knowledge (mental health literacy) is grafted.

IMPROVING MENTAL HEALTH LITERACY

Efforts to improve public knowledge of mental disorders have been much less common than for cancer and heart disease. Nevertheless, a number of approaches have been tried. One is an information campaign targeted at the general population. In the late 1980s, the Americans instituted the Depression Awareness, Recognition and Treatment Program, which aimed to inform both the public and health professionals that depressive disorders are common, serious and treatable (Regier et al, 1988). This campaign involved a broad range of educational materials, including television, radio and print advertisements, bookmarks and brochures. This national campaign was coordinated with action in local communities. Its effects are unknown. Another US campaign, begun in the early 1990s, is the National Depression Screening Day (Jacobs, 1995). The aims of this day are to call public attention to depression, to educate the public about symptoms and treatments and to identify individuals who may be unaware they are clinically depressed. This day has resulted in widespread media publicity and screening of a large number of people.

In the UK there was the Defeat Depression Campaign run by the Royal College of Psychiatrists and the Royal College of General Practitioners from 1992 to 1996 (Paykel et al, 1998). This campaign aimed to educate the public about depression and its treatment, to encourage earlier treatment-seeking and to reduce the stigma of depression. It included use of radio, television and print media. National surveys carried out at the beginning, middle and end of the campaign showed small but significant changes in the percentage of the public who believe that antidepressants are effective and who would be willing to seek professional help. It is impossible to say whether these changes were solely due to the campaign, but the results are certainly encouraging.

In Norway, there has recently been a campaign in one county aimed at reducing the duration of untreated psychosis by encouraging early help-seeking (Johannesen, 1998). As well as targeting the public, this campaign was aimed at health care providers, educators and treatment centres. It involved radio, newspaper, cinema and television advertisements. Public surveys carried out before and after the campaign showed a large increase in knowledge of the terms psychosis and schizophrenia. There is also early evidence that help-seeking behaviour has changed and that the duration of untreated psychosis has decreased.

Another approach is to target specific subgroups of the public. This approach is exemplified by the work of Wolff et al (1999), who educated the public in a neighbourhood where a group house for those with mental illnesses was being established. In this study, one such neighbourhood received an education campaign, while another acted as a control. The campaign consisted of an educational package with information sheets and a video, social events to establish contact with the group house, a formal reception and informal discussion sessions. Pre- and post-surveys in the experimental and control neighbourhoods showed only a small effect on public knowledge, but revealed less fear and more social contact with the group house residents in the experimental neighbourhood. Another targeted population subgroup is high-school students. Fairly brief classroom instruction has been found to improve willingness to seek professional help (Battaglia et al, 1990; Esters et al, 1998).

Finally, there are attempts to improve the quality of information presented in the media through expert input. Although mental health experts frequently make themselves available for media comment, there is virtually no research on the effects of doing so. However, in an analysis of four media items derived from lay sources and three from psychiatrists, Nairn (1999) found that the psychiatrists presented mental disorders in a less negative manner, but the journalists tended to undermine their message to produce a more newsworthy story.

IMPlications FOR mental health care

The evidence reviewed here makes it clear that the public in many countries have poor mental health literacy. There are a number of important consequences of this poor knowledge. First, it may place a limit on the implementation of evidence-based mental health care. Attempts to make clinical practice more evidence-based, such as the Cochrane Collaboration (Adams, 1995), are founded on the assumption that meta-analyses of randomised controlled trials and the dissemination of clinical practice guidelines are sufficient to improve clinical practice. This approach is very much a top-down one in which it is assumed that the benefits of research will be realised if clinicians can be won over to use evidence-based treatments. However, this approach fails to take account of the views of the public, who are the potential consumers of services. If evidence-based treatments do not accord with public views, people who develop mental disorders may be unwilling to seek those treatments or to adhere to advice given by clinicians (Jorm et al, 2000a). Furthermore, they may burden the health care system by seeking inappropriate services and unnecessary investigations.

A second consequence of poor mental health literacy is that the task of preventing and helping mental disorders is largely confined to professionals. However, the prevalence of mental disorders is so high that the mental health workforce cannot help everyone affected and tends to focus on those with more severe and chronic problems. If there are to be greater gains in prevention, early intervention, self-help and support of others in the community, then we need a ‘mental health literate’ society in which basic knowledge and skills are more widely distributed.

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REFERENCES


CLINICAL IMPLICATIONS

■ The public does not share many of the core beliefs of clinicians with regard to treatment and aetiology of mental disorders.

■ Clinicians may have difficulty in implementing evidence-based mental health care if patients do not believe in the interventions offered.

■ An increase in mental health literacy in the population may assist prevention, early intervention, effective self-help and support of others in the community.

LIMITATIONS

■ The concept of mental health literacy assumes the superiority of expert psychiatric knowledge over lay beliefs.

■ The concept could be criticised for seeing the sufferer’s interpretation of his or her condition as less valid.

A. F. JORM, DSc, Centre for Mental Research, The Australian National University, Canberra 0200, Australia

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