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Adolescent Mental Health Literacy: Young People's Knowledge of Depression and Social Anxiety Disorder

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A B S T R A C T

Purpose: Understanding why nearly 80% of youth ages 6–18 years with a mental disorder fail to receive treatment represents an important public health priority. International data suggest that underrecognition of mental illness and the need for treatment are barriers to service utilization. This study extends work to a U.S. sample of 1,104 adolescents.
Methods: High School students were invited to participate in a self-report study assessing knowledge and beliefs regarding mental illness. Participants completed the survey in groups at school and read vignettes portraying peers experiencing major depression, social anxiety disorder, and a situation where the individual has to cope with a common life stressor followed by a series of questions in reference to each vignette.
Results: Adolescents had better recognition of depression than social anxiety disorder and were more likely to recommend seeking help for it. However, <50% of youth recognized depression. Family, friends, and counselors were recommended as sources of help. Differences according to the sex of the respondent and person in the vignette were observed.
Conclusions: These data are among the first to provide information regarding the mental health literacy of American adolescents and suggest potential points for intervention. Pending replication of the findings herein, efforts to help adolescents recognize mental health problems and to increase the likelihood of recommending professional help will be important.

IMPLICATIONS AND CONTRIBUTION

Poor recognition of mental illness may prevent treatment seeking. In this study involving more than 1,000 adolescents, the majority did not recognize depression or social anxiety disorder. Frequent recommendations for help included approaching family, friends, or counselors. Interventions targeting mental health literacy of adolescents in the United States may facilitate treatment seeking.

Eighty percent of American youth fail to obtain needed mental health services [1]. Increasing mental health literacy (MHL) may increase service utilization [2]. MHL is "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" [3]. Limited MHL is associated with lower rates of recognition and treatment for mental illness [4,5].

Many youth have poor MHL. Youth from Australia, Sweden, and Portugal have been shown to have difficulty recognizing depression, psychosis, and schizophrenia [6–11]. Recognition of social anxiety disorder is low in the UK (19%) [12] and Australia (3%–16%) [9,13,14]. In the United States, 28% of youth identified social anxiety disorder as mental health problem [15]. However, respondents were only asked to identify if symptoms constituted a disorder and do not tell us what percent can name it. In the U.S. study, recognition of depression was better but not universal, with 42% of youth identifying depression as a disorder. Finally, previous studies suggest potential sex differences in MHL that

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could inform future interventions. For example, Australian adolescent females were almost twice as likely to identify depression compared to males [6,8], and in the UK, females were more likely than males to recommend professional help [12].

More data are needed documenting adolescent knowledge and beliefs regarding mental health interventions [3]. Many Australian youth report that they would recommend that someone with depression speak to a counselor (58%) and talk to friends (42%) or with family (41%), whereas few recommend seeking help from a psychologist (6%), psychiatrist (4%), or another type of doctor (1%–2%) [8]. In Sweden, 20% of youth said they would recommend a mental health professional for depression [10]. Finally, youth in England report that they would suggest a psychologist or psychiatrist, followed by family and friends [12].

The present study replicated and extended prior work examining MHL for major depression [8,15] and social anxiety in U.S. adolescents [13,15]. Depression and social anxiety disorder are among the most common forms of mental illness in youth [16,17]. In addition to being among the initial studies of American youth, we included vignettes depicting both disorders and presented both male and female versions of each [8,15]. Based on prior data from youth samples [8,13,15] and our work with adults [18–20], we hypothesized that (1) consistent with international samples and one U.S. sample, identification of disorders would be relatively poor (i.e., <50%); (2) replicating prior studies, females would demonstrate greater accuracy [6,8]; (3) consistent with prior findings, disorder recognition would be higher for female characters [8]; (4) participants would express more concern related to depression versus social anxiety; and (5) participants would predict longer recovery time from depression and social anxiety compared to a control vignette. (6) Based on prior findings [8,15], it was predicted that recommendations to talk with friends, family members, and therapists/counselors would be common, but specific hypotheses regarding proportions were not made. Finally, (7) based on previous work [8], we tested the hypothesis that higher MHL would statistically predict individuals' recommendations for help seeking for both disorders.

Before testing the primary aims, we briefly examined the psychometric properties of our MHL measure. Based on our conceptualization of MHL and the findings of Reavley, Morgan, and Jorm [21], we hypothesized that being female, being older, and having more years of education would be associated with better MHL than being male, younger, or having less years of education. In addition, we also hypothesized that higher levels of mental health symptom would be associated with better MHL.

Methods

Participants

Totally 1,104 high school students (313 9th graders, 271 10th graders, 251 11th graders, and 268 12th graders) in a public high school in upstate New York participated. Participants were aged 14–19 years (mean, 16.05 years; standard deviation, 1.27) and 51.6% were male. Eighty-five percent of the eligible students participated. Eighty-five percent of participants reported being Caucasian, 4.9% African-American, 2.4% Asian or Asian American, 3.0% Hispanic, 1% Native American, and 4.3% reported another race.

Procedure

All students were invited to participate (N = 1,305) via a letter to parents with a study overview. A copy of the questionnaires was available at the school. Parents could choose to have their child not participate ("opt out"), and students could also decline participation. Students completed the questionnaires in their classroom or the school auditorium during the school day. Students who were absent on testing days participated within 1 week. Two versions of the packet were used to counterbalance the vignette order and include male and female versions of each disorder. The packets were counterbalanced such that 53% of the students were presented with a vignette portraying a depressed male first and a socially anxious female last, whereas 47% of the students completed a vignette portraying a socially anxious male first and a depressed female last. Our University's Human Subjects Research Review Committee, the district superintendent, and the school board all approved all study procedures, and all procedures were in accordance with the ethical standards delineated in the 1964 Declaration of Helsinki and its later amendments.

Measures

Friend in Need Questionnaire–Revised. A modified version of the Friend in Need Questionnaire developed by Burns and Rapee was used [8]. Clinical vignettes, presenting individuals with major depression and social anxiety disorder, were presented in a counterbalanced order (either first or third) and portrayed each sex one-half of the time. The depression vignette was based on the "Tony" vignette used by Burns and Rapee [8], and the social anxiety disorder vignette was drawn from Jorm et al. [13]. The second vignette was based on Burns and Rapee [8] and portrayed an adolescent girl coping with the death of her grandmother. Participants read each vignette and then answered questions assessing their recognition of the disorder ("In five words or less, what do you think is the matter with name?"), their degree of concern for the person portrayed ("If name was your friend, how worried would you be about his/her overall emotional well-being?" Rated from 1 = I would not be at all worried about his/her emotional well-being through 4 = I would be extremely worried about his/her emotional well-being), their perception of the chronicity of symptoms ("How long do you think it will take for name to feel better again?" Rated from 1 = 1–2 days through 4 = longer than a few months), and whether they recommended help seeking ("Do you think name needs help from another person to cope with his/her problems? Yes, no, or do not know) and who from ("who do you think s/he needs help from"). Participants were also asked to identify what parts of the vignette they used to label the disorder. The "cues" were then coded based on the categories in Table 1 and prior work [8,13]. Three coders were trained using exemplars and then by coding a subset of responses that were reviewed for accuracy. Agreement between the coders exceeded 93% for all categories. The vignettes presented symptoms that clearly met Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria [22] and are available on request.

Strengths and Difficulties Questionnaire

The youth self-report Strengths and Difficulties Questionnaire (SDQ) is a 25-item measure of MH symptoms for ages ≥11 years [23]. The SDQ yields a total score and subscale scores (e.g., conduct