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Research report

Beliefs about depression—Do affliction and treatment experience matter? Results of a population survey from Germany

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ABSTRACT

Background: There is not much known about the associations of beliefs about depression (depression literacy) with a history of depression and treatment experience.
Methods: Analyses were based on a telephone survey in two large German cities (Hamburg and Munich). Written vignettes with typical signs and symptoms suggestive of a depression were presented to 1293 respondents. Respondents were then asked about beliefs about causes, symptoms, prevalence, and treatment using a standardized questionnaire. For the analysis respondents were divided into three groups: (1) people who never had a depression, (2) people who had a depression but were not treated and (3) people with treatment experience.
Results: Respondents with experience in treatment for depression were more likely to correctly recognize the disorder, to positively evaluate treatability and to favor external factors (adverse conditions in childhood and psychosocial stress) as potential causes of depression compared to those who never were afflicted. There were no significant differences between these two groups regarding beliefs about the effectiveness of treatment options. There were only few significant differences in depression literacy between respondents who have a history of depression but have not sought help and those who never were afflicted.
Limitations: The three groups were constituted on the basis of respondents' self-reports, not medical diagnoses.
Conclusions: Our findings only partly support the general assumption that being afflicted and having sought help is associated with beliefs closer to those of professionals.

1. Introduction

Public knowledge and beliefs about mental disorders can be conceptualized as 'mental health literacy'. According to Jorm (2000) mental health literacy consists of several components, including the ability to recognize specific disorders, knowledge and beliefs about risk factors and causes, about self-help interventions and about professional help. Although there is a general trend of increasing mental health literacy (Schomerus et al., 2012), there are still deficiencies in the public knowledge about depression ('depression literacy') (Gabriel, 2010; Jorm, 2012). As a consequence, many members of the public do not know what they can do for prevention, people often delay or avoid seeking treatment, view recommended treatments with suspicion or they are unsure how to assist people afflicted by depression (Jorm, 2012).

In terms of factors associated with depression literacy, results concerning gender and age are inconsistent (Angermeyer and Dietrich, 2006; Holzinger et al., 2012). Knesebeck et al. (2013a) found that education is positively associated with illness recognition and a realistic estimation of the lifetime prevalence. Moreover, people with high education were more likely to believe that medication is effective in treating depression and less likely to agree with the statement that a weak will is a potential cause. Furthermore, previous contact to mentally ill had a positive influence on the correct recognition of a depression vignette (Lauber et al., 2003).

Only a few studies examined the effect that experiencing depression and receiving treatment might have on depression literacy. Comparing individuals with major depression with people with other depressions and those who were not depressed, Goldney et al. (2001) found few significant differences between the groups in terms of mental health literacy. In a study from

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Austria, respondents familiar with the treatment of depression tended to be more ready to recommend to seek help from mental health professionals and to endorse various treatment options, particularly medication. In this study, being familiar with depression meant either respondents who had been in treatment for depression themselves or who had such a person among their family or friends (Holzinger et al., 2011). Other studies found that people with exposure to depression were less likely to believe that antidepressants are harmful (Jorm et al., 2005; Reavley and Jorm, 2012). Beliefs about the helpfulness of diverse medical, psychological and lifestyle interventions were studied by Jorm et al. (2000). They found few significant associations with history of depression and help-seeking beliefs. In sum, results seem scarce and partially inconsistent and most studies did not cover different components of mental health literacy.

Against this background associations of beliefs about depression with history of depression and treatment experience were analyzed. To this end, we examined several aspects of depression literacy among three groups: people who never had a depression, people who had or have a depression but never were in treatment and, individuals who reported to be or have been in treatment for depression.

2. Methods

2.1. Study design and sample

Analyses were based on a representative telephone survey (computer assisted telephone interviewing, CATI), which was conducted in autumn 2011 in two large German cities (Hamburg and Munich). This survey was part of a large project on mental health in the metropolitan region of Hamburg, called "psychenet – Hamburg network mental health". A major component of this project is an awareness and education campaign on mental health including mental disorders. One purpose of the survey is to evaluate the effects of the information campaign with Munich as the control region. The present survey served as a baseline (before the start of the campaign); a follow-up is intended in 2014. The sample consisted of persons aged 18 years and older living in private households with conventional telephone connection in one of the two metropolises. The sample was randomly drawn from all registered private telephone numbers. Additionally, numbers were computer-generated to allow for extra-directory households as well. Repeat calls on different occasions were made until a number dropped out. 2014 men and women agreed to do the interview and participated in the study, which reflected a response rate of about 51%. Informed consent was given when the respondents agreed to complete the interview. The ethics commission of the medical association in Hamburg approved this study. A comparison with official statistics in the two cities showed that the distribution of gender, age, level of education, and family status were similar to those in the general population (Knesebeck, 2013b).

Vignettes with typical signs and symptoms suggestive of depression, schizophrenia and eating disorders were presented to the respondents at the beginning of the interview. To reduce the length of the questionnaire and to avoid excessive demands for the interviewee only two randomly permuted vignettes were included at a time. This leads to a sub-sample of about two thirds ($N=1293$) of the total sample that was presented a depression vignette. Gender of the 'patient' was systematically varied, i.e. in 50% of the cases the patient was female. The vignette was developed with the input of experienced clinicians and is congruent with ICD-10 and DSM-IV criteria for depression. In order to increase reliability and to 'neutralize' possible interviewer-associated effects, all vignettes were recorded with a trained speaker and these audio files were presented to the respondents.

2.2. Measures

After the interviewers presented the depression vignette (see Appendix), the respondents were asked about the patient's diagnosis. They were informed about the mental illness in question in case they did not identify the disorder correctly. Furthermore, the interviewee was asked to estimate the lifetime prevalence of depression in an open-ended question ('What do you think, how many persons out of 100 will have such an illness at some point in their lives?'). We compared the answers with epidemiological data on life time prevalence in Germany. Lifetime prevalence of 10–25% is considered correct for depression as prevalence estimates in the literature show this range (Bromet et al., 2011; Robert-Koch-Institute, 2010). Afterwards, the respondents were asked whether the depression is treatable (1='not at all' to 4='very well'). This was followed by the question how effective medication, psychotherapy, alternative therapy (e.g. acupuncture), participation in a self-help group and own activities like sport or relaxation are for the treatment of depression. The scale was ranging from 1 ('not at all effective') to 4 ('very effective') for each of the therapeutic measures. Furthermore, respondents' causal attributions for depression were assessed by a slightly modified list of causes described by Angermeyer and Matschinger (2003) as well as Schomerus et al. (2014). It contained ten items, which suggested potential causes of depression. The items were coded from 1 ('not true at all') to 4 ('completely true'). A factor analysis (principal component analysis with varimax rotation) yielded four independent factors. Items loading on the first factor were 'broken home', 'lack of parental affection', and 'sexual abuse in childhood'. This factor was named 'conditions of socialization' (Cronbach's Alpha 0.72). The second factor consisted of the items 'job stress', 'family strain', 'critical life event' and was termed 'psychosocial stress' (Cronbach's Alpha 0.70). The third factor named 'intrapsychic causes' (Cronbach's Alpha 0.50) comprised the items 'lack of willpower' and 'immoral lifestyle'. Finally, items loading on the fourth factor were 'brain disease' and 'heredity'. This factor was termed as 'biological causes' (Cronbach's Alpha 0.50). Together, the four factors accounted for a cumulative variance of 66%. The rotated factor scores were used for analysis.

Additionally, the respondents were asked whether they have ever been afflicted by depression themselves at some point in their life and if so, whether they are or were under treatment. For the analysis the respondents were divided into three groups: one group with no depression, a second group of individuals who stated to have suffered from depression but have not sought treatment and a third group who reported to be or have been in treatment for depression. Age, gender, and education were introduced as control variables. Education was measured by the highest school qualification achieved. Respondents were divided into three educational groups (lower secondary education, secondary education and upper secondary or higher education).

2.3. Statistical analysis

Descriptive analyses gave a first overview on the three groups and beliefs about depression under study. To test for between-groups difference Chi square-tests were performed. In order to explore associations between affliction, treatment and beliefs, binary logistic regression analyses were carried out. Odds ratios, 95% confidence intervals and significances are displayed. Regarding attitudes toward different treatment options, response categories were dichotomized, combining 'very effective' and 'rather effective' in one category and 'rather not effective' and