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Short communication

Associations between ability to recognise a mental health disorder and lived experience of mental illness in an Australian sample.

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ABSTRACT

Community awareness of mental illness is crucial for helping people access mental health support. The association between ability to recognise mental health disorders and lived experience is not well examined in Australian populations. Australian adults (n = 1265) provided responses to a vignette depicting a person with depression and self-reported a previous diagnosis of depression and/or anxiety. People who had lived experience with depression and/or anxiety had significantly higher levels of this aspect of mental health literacy than people without lived experience. Public mental health literacy promotion efforts should consider incorporating insights from people with lived experience of mental illness.

1. Introduction

Depression is a leading cause of disability, resulting in significant personal and economic cost (WHO, 2017). Despite the availability of effective treatments for depression (Morgan et al., 2013), most people with depression do not seek treatment (Kohn et al., 2004). There are many reasons for this treatment gap including self-stigma and anticipated negative attitudes about mental illness from others (Angermeyer et al., 2017).

Increasing mental health literacy is one way to encourage people with depression to seek treatment (Hansson et al., 2016). If people know others or have had experience with people with mental illness, they garner insight which translates in to higher mental literacy (Lauber et al., 2003; Svensson and Hansson, 2016). It seems sensible then to assume that people who have lived experience of mental illness would have higher levels of mental health literacy than people without lived experience. However, this important question has received minimal empirical attention with mixed findings (Dahlberg et al., 2008; Goldney et al., 2001; Reavley et al., 2014; Yu et al., 2015).

Therefore, the aim of the present study was to examine the association between the ability to recognise depression using a well-established vignette, and having previously been diagnosed with depression and/or anxiety. The findings of this study will build on our current understanding of mental health literacy, specifically the recognition of depression.

2. Methods

2.1. Procedures

The methods for the National Social Survey (NSS) have been previously described (Byrne et al., 2018). Briefly, the NSS was administered through a 20-station computer aided telephone interviewing system. The sample is taken from a telephone databased and targeted one eligible person over 18 years of age from each household. In addition to demographic characteristics, the NSS includes questions from researchers related to a specific topic. To examine mental health literacy, survey interviewers presented a well-established depression vignette (Morgan et al., 2013; Reavley and Jorm, 2011; Reavley and Jorm, 2012). Briefly, the vignette describes 'John', a 30-year old male who feels unusually sad, is persistently tired yet has sleeping difficulties. He has experienced a loss in appetite and bodyweight, has difficulty in decision-making, and is overwhelmed with usual daily tasks. The interviewer read the vignette, then asked the following open-ended question; 'What do you think, if anything, is wrong with John?' Participants' responses were entered into the CATI system verbatim by the interviewer. Lived experience of depression and/or anxiety was identified using a dichotomous ('Yes'/'No') response to the question; 'Have you ever been told by a doctor that you have Depression and/or Anxiety?'.

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Table 1
Respondent characteristics.

Characteristic	With lived experience		Without lived experience	
	N	%	*N*	%
Gender				
Male	81	37.5	517	49.3
Female	135	62.5	532	40.7
Marital status				
Married/de facto	114	52.8	703	67.0
Separated/divorced	32	14.9	70	6.7
Widowed	20	9.3	86	8.2
Single	48	22.2	185	17.6
Age				
18–34 years	39	18.1	194	18.5
35–44 years	31	14.4	122	11.6
45–54 years	37	17.1	141	13.4
55 years and over	109	50.5	584	55.7
Highest level of education				
Primary schooling or below	3	1.4	22	2.1
Secondary/high School	74	34.3	320	30.5
Technical studies or further education	37	17.1	206	19.6
University or higher education	102	47.2	496	47.3
Employment status				
Employed full-time	56	25.9	379	36.1
Employed part-time/casual	38	17.6	217	20.7
Unemployed	18	8.3	37	3.5
Retired/pensioner	92	42.6	364	34.7
Student	4	1.9	25	2.4
Home duties	6	2.8	19	1.8

2.2. Statistical analysis

Respondent characteristics, including mental health literacy are presented using frequencies and proportions. Text-based responses for the open-ended question were searched for the term 'depression' using wildcards (e.g., "*depres*"). A logistic regression model was calculated to test the association of mental health literacy with self-reported lived experience of depression and/or anxiety, controlling for gender, marital status, age, education, and employment status. Text-based responses for the open-ended question were examined using Microsoft Excel. Other analyses were conducted using SPSS Version 23 (IBM Corp, Armonk, NY). Statistical significance was accepted where $p < 0.05$.

3. Results

A total of 1265 responses were received representing a response rate of 24%. Mean interview duration was 38 minutes. Two hundred and sixteen respondents (17.1%) reported lived experience of depression and/or anxiety. Participant characteristics are shown in Table 1.

Overall, 787 respondents (62.2%) used the term, 'depression' or a derivative such as 'depressive illness' or 'depressed', in response to the open-ended question. Of those with lived experience of depression and/or anxiety, $n = 159$ (73.6%) correctly identified the condition described in the vignette. Of those without lived experience of depression and/or anxiety $n = 628$ (59.9%) correctly identified the condition described in the vignette. The logistic regression model revealed that there was a significant association between mental health literacy and lived experience of depression and/or anxiety (odds ratio = 1.89, b = 0.64, SE = 0.17, $p < 0.01$), even after accounting for gender (odds ratio = 1.78, b = 0.58, SE = 0.12, $p < 0.01$), marital status (odds ratio = 1.08, b = 0.07, SE = 0.04, $p = 0.04$), age (odds ratio = 1.00, b = −0.00, SE = 0.00, $p = 0.27$), education (odds ratio = 1.00, b = 0.00, SE = 0.01, $p < 0.53$), and employment status (odds ratio = 0.75, b = −0.29, SE = 0.14, $p = 0.04$).

4. Discussion

Our findings that people with lived experience of depression and/or anxiety have better mental health literacy supports earlier Australian and Chinese studies reporting a significant association between mental health literacy and having experienced or worked with people with a mental illness (Reavley et al., 2014; Yu et al., 2015), but contrasts that of Dahlberg et al. (2008) and Goldney et al. (2001). Whereas Dahlberg et al. (2008) and Goldney et al. (2001) screened for mental illness using clinical assessment tools, our findings demonstrate this effect generalized to those with self-reported lived experience as well. These methodological differences may explain the differences between their findings and those of the present study. Dahlberg et al. (2008) attribute the lack of association between mental health literacy and lived experience to cognitive impairment due to depression. However, recent evidence suggests those with lived experience have deep insights into depression especially regarding hope, recovery, service use, and the impact of the wider environment (Chambers et al., 2015). Leveraging off those with lived experience to aid community education programs may help reduce stigma and further improve mental health literacy for Australians.

The present study is not without limitation. Lived experience was assessed by self-report using a single question, and did not differentiate between previous or ongoing experience with depression and/or anxiety. Future studies could target persons with known history of mental illness to investigate if illness duration, symptom severity, or treatment experiences influence associations between mental health literacy and lived experience. The overrepresentation of persons over 55 years of age and the known differences in mental health literacy of older Australians (Reavley et al., 2014) may also partly explain the differences in findings between the present study and previous work. Finally, the vignette only considers one aspect of mental health literacy; that is the ability to recognise a condition. Other aspects of mental health literacy such as risk or causative factors, and how and where to seek professional help remain important considerations.

5. Conclusions

The present study demonstrates a high degree of mental health literacy and a significant association between mental health literacy and lived experience of depression and/or anxiety in an Australian adult sample.

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Declaration of interest

The authors have no conflicts of interest to declare.

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Supplementary materials

Supplementary material associated with this article can be found, in

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