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ORIGINAL RESEARCH

All of us? An exploration of the concept of mental health literacy based on young people's responses to fictional mental health vignettes

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Objectives. Mental health literacy is increasingly referenced as a goal of mental health policy. However, the current definition of this concept has a relatively narrow focus on mental disorders. The objectives of this study were to explore mental health literacy through the use of vignettes and to begin to articulate a broader definition.

Methods. Six groups of young people (n = 42) aged between 16 and 25 years old responded to open-ended questions about vignettes depicting fictional characters with diagnosable mental health problems. The responses were analysed using Foucault's governmentality theory.

Results. The responses to the vignettes highlighted a range of determinants of our mental health. The young people suggested informal mental health-promoting techniques and highlighted the importance of talking. Ambiguity was reported in relation to the types of knowledge that are important in responding to mental health need. Finally, the responses were reflective of young people who are empathetic and view mental health from the perspective of our shared humanity, rather than as a marginal issue.

Conclusions. As mental health literacy is increasingly becoming a goal of mental health policy, it is timely that a shared understanding of this important concept is articulated. The current definition of mental health literacy is narrow in its focus on the recognition of mental disorders. A more broad-based definition of mental health literacy should be adopted by policy makers, reflecting the full range of determinants of mental health and recognising the importance of mental wellbeing.

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Introduction

Youth mental health is increasingly being recognised as a major public health issue worldwide (e.g. Patel *et al*. 2007). It has been reported that around one in five young people in Ireland are experiencing a mental health problem at any given time (Sullivan *et al*. 2004; Martin *et al*. 2006). A further, more recent report estimates the prevalence of current depression as 30% among 12- to 19-year-olds (Dooley & Fitzgerald 2012). Lifetime prevalence of mental health problems among young adolescents (aged 11–13 years) in Ireland is reportedly as high as 36.8% (Coughlan *et al*. 2014). At the same time, many young people experiencing mental health problems do not access formal support services. In a systematic review of barriers to help-seeking, it was reported that between 66% and 82% of young people with serious depression or anxiety do not seek professional help (Gulliver *et al*. 2010).

One suggested strategy to improve levels of help-seeking for mental health problems is to increase population levels of mental health literacy (Gulliver *et al*. 2010; Jorm 2012). Mental health literacy has been defined by Jorm *et al*. (1997) as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention'. This definition has been widely accepted, as reflected in the growing body of peer-reviewed literature operationalising Jorm's definition by using fictional vignettes to determine ability to correctly identify certain mental disorders. The influence of Jorm and colleagues' approach to mental health literacy is evidenced, for example, by 112 citations of the 1997 *Medical Journal of Australia* paper introducing the term and 330 citations of a later paper in the *British Journal of Psychiatry* (Jorm 2000) in the database PsycINFO.

A common method in researching mental health literacy has been to test the ability of respondents to

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correctly identify common mental disorders, such as depression, depicted in fictional vignettes. A recent trend emerging in mental health literacy research has been to utilise the same method in order to drill deeper and focus on literacy around specific disorders such as schizophrenia (Furnham & Blythe 2012) and eating disorders (Mond 2014). This approach that measures levels of mental health literacy based on the ability to recognise mental disorders according to diagnostic criteria has inspired the assertion that 'the current definition of mental health literacy effectively translates to knowledge of the contents of the Diagnostic and Statistical Manual of Mental Disorders' (Kusan 2010: 13). Despite this narrow approach, mental health literacy has become a goal of national health policy in many countries, including Australia, Scotland and Ireland (The Scottish Government 2003; Australian Department of Health and Ageing 2009; The Department of Children and Youth Affairs Ireland 2014). While mental health literacy is increasingly included in national policy documents, the concept is not always well explained or defined. This is the case with *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014–2020* (Department of Children and Youth Affairs Ireland 2014), which makes reference to 'mental health literacy', 'mental literacy skills' and 'emotional literacy' but does not discuss or explain any of these concepts. With this in mind, it is timely to consider a broader interpretation of mental health literacy such as that expressed with particular reference to young people in the recent *International Declaration on Youth Mental Health,* which states as an objective under the heading 'Mental health literacy': 'raise awareness among young people, families and communities of the determinants of mental health and the mental health needs of young people aged 12–25 years' (Coughlan *et al*. 2013: 106).

This paper reports on vignette-based research with young people in Ireland, which explored mental health literacy. The research was undertaken, in part, to guide the provision of content for an online youth mental health resource (www.reachout.com) operated by the Inspire Ireland Foundation. The research was undertaken from a sociological perspective using *governmentality* theory (Foucault 2007), which is explained below.

Method and theoretical framework

This research was undertaken with diverse groups of young people aged between 16 and 25 years old in a range of settings to explore fictional mental health vignettes through a series of open-ended questions. The open-ended questions were administered at the beginning of focus group discussions on mental health. Four vignettes were generated for this research based on vignettes used by Jorm and colleagues (e.g. Jorm and Wright, 2008). Three of the vignettes included sufficient detail to meet a diagnosis in keeping with the Diagnostic and Statistical Manual (version IV). The fourth vignette, a 'non-case', depicted a young man who could be described as going through a difficult time due to personal and family circumstances. Responses to two of the four vignettes are reported in this paper (those depicting depression and generalised anxiety disorder).

Study sample

Fieldwork was conducted with six groups of Irish young people from a range of settings including colleges, schools and YouthReach centres[1] in both urban and rural areas.

A non-probability sample was considered appropriate for this research as the objective was to explore an emerging concept, that is, *mental health literacy*, rather than establish broad statistical trends. Purposive sampling allowed for the selection of young people in different contexts that represent the range of typical young people in Ireland across the age group 16 to 25 who are either in education, are working or are neither working nor in mainstream education. Ritchie *et al*. (2004) use the term 'symbolic representation' to describe the choosing of an individual or group selected in purposive sampling because that person or group is intended to represent and symbolise features of relevance to the investigation and 'picks up purposive representations of character' (Ritchie *et al*. 2004: 82–83).

Socio-demographic variables of interest in this general population research included

- Age – the full range in question is not homogenous developmentally or in terms of life circumstances and therefore groups were conducted separately for 16- to 19-year-olds and 20- to 25-year-olds.
- Gender – mental health problems and help-seeking behaviour vary by gender.
- Education/employment circumstances – which has an influence on, and is influenced by, more general life circumstances and access to different levels of support.
- Area of residence – broadly taking account of levels of social deprivation and the availability of support services, which varies between urban and rural areas.

Overall, the selection matrix generated based on the socio-demographic variables of interest identified 10 different groups. Those in full-time education were recruited through a secondary school and two

[1] YouthReach is an education and training programme for early school leavers aged between 15 and 20 years old.

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third-level colleges. Those not currently working or in mainstream school or college education were captured through the YouthReach service, which is an education and training service for early school leavers. Despite several attempts it was not possible to secure access to groups of young people in paid employment. Nor was it possible to access a group not currently working or in mainstream education who were aged 20 to 25 years old. This is a limitation of the present study.

Six groups were ultimately recruited through the following host organisations:

- A co-educational secondary school in Limerick city (coded and referred to in the results as CCB for an all-boys group and CCG for an all-girls group).
- Two universities through the respective Students Union Welfare Officers (University College Cork and the University of Limerick, coded as UCC, which was all female, and UL, which was all male).
- YouthReach, a service for early school leavers (one in rural county Cork and one in Cork city, coded as YRB, which was a rural male group and YRG, which was an urban female group).

A total of 42 young people participated in the focus groups and responded to the vignettes.

Procedure

Invitation to participate in the focus group during which the vignette-based questionnaire was administered was conducted through the respective host organisation. A detailed outline of the study was provided along with confirmation of ethical approval for the study (from the Social Research Ethics Committee, University College Cork) and an assurance that appropriate follow-up supports were available to all participants. The vignettes were distributed at the beginning of the focus groups and the respondents were given time to read and write responses, individually, to each of the three questions for each of the four vignettes.

The vignettes

Responses to the following two vignettes from this study are reported in this paper:

Liam's story: depression

Liam is an 18-year-old college student in the west of Ireland. He has always done well academically and at sport but over the past 2 months he has been finding it hard to concentrate on his course work and he keeps missing morning lectures because he is too tired to make it into college. He often wakes up early and that is when he feels at his worst. Even though he is tired all the time he cannot sleep at night and he is feeling miserable and hopeless. His girlfriend has told him that he has lost a lot of weight but he has little interest in food. He is spending less and less time with his friends, especially since he quit playing football.

Róisín's story: anxiety

Róisín is a 24-year-old university graduate, working for an aid agency in the not-for-profit sector, who lives with her boyfriend in a nice house in the suburbs. She gets on well at work but every now and again she feels unable to leave her desk to chat with colleagues or go for coffee breaks because she gets nervous and lightheaded. In a regular work team meeting recently she noticed that her hands had become really sweaty and she could feel her heart pounding. Outside of work, she has a good social life and gets on really well with her boyfriend, although she worries a lot about him because he plays football and, when he goes to play a match at the weekend, she cannot relax or eat anything until she knows he is home safe.

Three questions asked in relation to each vignette were:

1. In one sentence, what, if anything, do you think is wrong with_____?
2. What do you think are the most relevant parts of _____'s story in deciding whether there is anything wrong?
3. What supports (formal or informal), if any, should _____ use to help deal with his/her problems?

Theoretical framework

The data, that is, the responses to the open-ended questions pertaining to each vignette, were analysed using *governmentality* theory. Governmentality is an increasingly popular analytical tool in the social sciences and it can be used to open up understanding of the ways in which social institutions such as the education system, the health system or the penal system function. A governmental analysis can help to explain the philosophies guiding day to day functioning of those institutions. The concept was developed by Michel Foucault in the late 1970s to explain 'activity that undertakes to conduct individuals throughout their lives by placing them under the authority of a guide responsible for what they do and for what happens to them', or as he later put it, governmentality can be 'understood in the broad sense of techniques and procedures for directing human behaviour' (Foucault in Rose *et al*. 2006: 83). Governmentality allows us to analyse dominant *regimes of practices* in relation to various aspects of human life. Dean describes regimes

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of practices as 'historically constituted assemblages through which we do such things as cure, care, relieve poverty, punish, educate, train and counsel' (Dean, 2010: 40). A governmental analysis allows us to explore the logic underpinning practices so that we can ask questions such as 'how do we do mental health?' or 'how do we do economic policy?' Dean developed four dimensions underpinning any given regime of practices and those dimensions are used below to thematically analyse young people's responses to the mental health vignettes. The four dimensions are: *fields of visibility; techniques; knowledge;* and *identity formation*. Each of these four dimensions is explained briefly below.

Fields of visibility refers to what we visualise in association with a given regime of practices, that is, what is within the scope of dominant policy and practice. Dean offers the examples of clinical medical practice 'which presupposes a field of visibility of the body and its depths' and public health regimes, which 'locate the individual body within a visible field of social and political spaces' (2010: 41). Echoing Rose, the human brain has become increasingly important with reference to mental health to the point whereby brain malfunction is often the starting point in seeking to address individual mental health problems and the 'problem' of mental health. Fields of visibility in mental health practice are generally confined to a proportion of the population, often identified in public messaging as 'one in four' based on the number of people purported to experience a diagnosable mental health problem at some point in their life (e.g. as reported by campaigns such as *See Change* in Ireland).

Techniques, as a second dimension, refers to the methods, tools and strategies of a given practice. The categorical diagnosis of mental health difficulties utilising guidelines detailed in the Diagnostical and Statistical Manual (DSM), specifically since the third edition published in 1980, is a dominant technique of practice in mental health in contemporary western democracies. The importance of diagnosis as a technique in mental health practice is underlined by the intersection between mental health practice and other regimes of practices in public life, including, for example, the private health insurance industry, which relies on the diagnostic categories of the DSM or the World Health Organisation's International Classification of Diseases to validate claims. A further example relates to the provision of educational psychological supports within the school system, which also depends on diagnosis to determine the allocation of scarce resources. Techniques in mental health can also refer to the specific, commonly prescribed practices adopted at an individual level such as psychotherapy and pharmacology, the practice of which is indicative of valued knowledge paradigms in mental health.

The third dimension of a given regime of practices, then, is the forms of *knowledge* that are central and are valued in directing those practices. Valued knowledge and expertise usually informs key strategies and policies in relation to aspects of human life so that, for example, strategies are written from a particular epistemological perspective. Notwithstanding the heterogeneity of approaches in psychiatry (ranging from *critical* to *neurological*), at a general level, psychiatric expertise is the most highly valued domain of knowledge underpinning mental health practices. Fundamentally, psychiatry is a medical speciality focused on preventing and curing mental disorders and psychiatric knowledge informs the approach to diagnosis in mental health. There is also a new expertise emerging in mental health practice, generally described with reference to *experts by experience*. Experts by experience are usually people who have been diagnosed with a mental disorder and have used mental health services. The expertise in this regard is informed by a medical frame of reference albeit from a 'consumer' rather than a practitioner perspective.

The fourth and final dimension to outline in relation to regimes of practices is *identity formation*. Identity formation as it relates to regimes of practices focuses on the question as to the type of human being that is presupposed, imagined or desired in the context of those practices. So, for example, Rose (2007) refers to the increased tendency towards identification as *biological beings* and *neurochemical selves* with reference to the popular understanding of our mental health as determined (to varying degrees) by brain chemistry. Also addressing identity formation and mental health, Fullagar (2008) warns against the potential for the ever-growing number of mental health websites to become 'sites of somatic subjectivity' by popularising clinical depression.

Results

Vignette responses

Responses to the depression (Liam) and anxiety (Róisín) vignettes are reported below with reference to the key dimensions underpinning mental health practice from a governmental perspective as explained in the theoretical framework.

Fields of visibility

Many factors influence personal and collective mental health. The Liam vignette meets the diagnostic criteria for clinical depression, but rather than focus on the ability of respondents to correctly identify the diagnosis, the responses to his story shine a light on the everyday issues that can be associated with depression. The responses also reveal to us what it is that young

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people see or imagine when presented with a case of depression. Many of the young respondents, perhaps projecting personal experience, identified common life stressors that we all experience. One respondent suggested, for example, that 'someone close to him (Liam) has died' (CCB). Bereavement following the death of a loved one is a common human experience closely connected to our mental health. Bereavement is something that affects all of us and it is an environmental stressor of our mental health that can have both an immediate and lasting impact on our ability to feel well. A further respondent, evoking the spirit of existential *ennui*, suggested that 'he is tired of doing the same things again and again and wants to do something different' (CCB). It was also suggested that 'he could be getting bullied' (YRG). A more practical interpretation of Liam's mood was expressed by one secondary school student who responded 'I honestly don't know, I'd say it's something like he's not settling into college and finding it hard to cope with the change from secondary school into college'(CCG).

With reference to a story that is likely, in a clinical setting, to result in a diagnosis of clinical depression, the respondents envisaged common human experiences including bereavement, boredom, bullying and the challenge of adjusting to change. In response to the Róisín vignette, body image was one of the themes identified with one young man suggesting that 'she's fat, or thinks she is' (YRB). Given the recent economic recession in Ireland and the collective anxiety related to it, a further response to Róisín's story was telling. A secondary school student, presumably believing aid agency staff (Róisín's occupation) work voluntarily, summised that Róisín 'feels worthless and since she has no income she doesn't want her boyfriend to get injured and not be able to work' (CCB).

Techniques

Many respondents in the focus groups identified depression and anxiety in the vignettes, and would therefore be considered mental health literate if a conventional analysis was applied to the data. However, a technique beyond diagnosis that was applied by many in the sample was to imagine what it must feel like to be in Liam or Róisín's situation and apply empathy in trying to understand what might be going on in their lives. One girl, with reference to Liam, surmised that 'something deep is affecting him' (CCG) and, similarly, one young man stated 'something is bothering him, he's thinking of something that is worrying him' (YRB). Another respondent wondered if Liam was 'becoming overwhelmed with life' and suggested that Róisín 'seems to over-think and worry about situations' (UL). A number of respondents thought that Liam might be experiencing family problems or that he is 'under too much pressure from college' (CCB). Self-confidence was identified as the major issue of concern for Róisín as captured, for example, by this response stating that she is 'extremely self-conscious and not comfortable or confident with herself' (CCB).

If a technical response to diagnosis in mental health is often pharmacological or psychotherapeutic, the wide ranging responses to the depression and anxiety vignettes in this research were often of a practical and everyday nature. For Liam, for example, it was suggested that he 'try to get to bed early, do more exercise, eat healthy like no coffee past 7 o'clock' (YRB). For Róisín, it was suggested she use 'yoga/meditation for help in coping with the overwhelming situations' (UCC). The importance of talking as a technique in mental health was underlined by the responses suggesting that Liam 'needs to find courage to speak to someone' (UL) and that Róisín 'should tell someone (but it's) not always easy' (UL).

Knowledge

The dimensions of *techniques* and *knowledge*, while separable, are closely connected and can overlap in our analysis. For example, with reference to talking as a technique, it was not always clear from the responses whether the 'someone' Liam or Róisín should talk to should be a health professional, or perhaps a source of more personal, informal support. Whether it is recommended that someone speak with a health professional or with a friend is indicative of the value placed on professional mental health knowledge. One respondent highlighted that ambiguity between technique and knowledge by reinforcing the value of talking but indicating that it did not necessarily matter to whom: 'he (Liam) should just talk to someone, professional or not, and maybe they can help find out why he is feeling this way' (CCB). However, certain responses were in keeping with advice that can now be considered as standard such as, for Róisín, 'go to her GP immediately' (YRG). Other respondents were more uncertain. With reference to Róisín, one young man suggested she should 'maybe (visit) a doctor first in case it's her health, if not, (visit) a counsellor' (CCB). In Liam's case, one student believed that 'in case of a medical problem, he should see a GP. In case of any possible mental difficulties, he needs to seek out a support service or a trusted friend where he can discuss his issues (with someone) who can give him guidance on how to deal with them' (UL). Some respondents were more explicit. One secondary school student highlighted the perceived value of peer support, and by implication the knowledge of peers, suggesting 'group help can make Liam realise that other people are going through the same thing' (CCB).

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Identity formation

Given the focus on diagnosis and medical knowledge, the dominant regime of practices in mental health presupposes somatic beings increasingly tuning into the biological components of their identity. However, in response to the questions about support for Liam and Róisín, broader human subjectivities were articulated with reference to social context and social circumstances. The role of other people, for example, emerged as significant in response to Róisín's (anxiety) story providing a reminder that human beings are social beings. Many of the respondents viewed her relationship with her boyfriend as defining and of central importance in supporting her mental health. One student responded to the question as to what Róisín should do by stating: 'I don't know, she definitely shouldn't talk to her boyfriend about it though because he'd probably be freaked out and then run away'. Reflecting the importance of parental support, the same respondent concluded that Róisín 'should talk to her parents' (CCG). Another respondent noted that 'she always depends on others' (YRB).

While many respondents highlighted the importance and value of both talking and listening, one particular response added a gendered dimension reflecting the importance of cultural influences on our help-seeking behaviour. Speaking about Liam, it was suggested that 'talking is number one, but that's more difficult for a guy as they don't easily open up. If he tells somebody his problem it won't be half as bad as a problem shared is a problem halved' (CCG).

Discussion

The responses of young people to mental health vignettes are reported here to facilitate a discussion of how the concept of mental health literacy might be expanded to take account of broader fields of visibility, more techniques, different forms of knowledge and the perspective of empathetic young people defined by a sense of shared humanity rather than personal biological traits. The responses to the vignettes are reported as an interpretation of mental health scenarios that is counter to the approach promoted through the current definition of mental health literacy. As currently operationalised, mental health literacy is oriented towards educating the public in order to recognise mental disorders and know how to access professional support. This orientation towards mental disorders is consistent with Nikolas Rose's observation that a paradigm shift took place in mental health in the late twentieth century in mental health towards a biomedical explanatory model accelerated by technological advances in computerised brain imaging. Rose suggests that 'over the past half century, we human beings have become somatic individuals, people who increasingly come to understand ourselves, speak about ourselves and act upon ourselves – and others – as being shaped by our biology' (2007: 188). Evidence of the approach advocated within current mental health literacy research is articulated in an overview article for the journal *American Psychologist* on current trends and major findings in this area (Jorm 2012). Jorm reports that 'community surveys of mental health literacy in Australia, Canada, India, Japan, Sweden, the United Kingdom, and the United States show that many people are unable to correctly recognize mental disorders' (Jorm 2012: 232). Another consistent finding in mental health literacy research is the finding that the general public view informal support favourably compared with health professional support for mental health problems, which is also pointed out by Jorm with reference to five recent studies (Jorm 2012: 233). The analysis of such findings generally points to the need for greater education of the public in relation to the value of professional support rather than picking up on the broader perspectives communicated by lay respondents to mental health vignettes. Those broader perspectives are of particular interest in the present study. The responses reported here encourage mental health discourse with reference to all of us, and not just those of us directly affected by a mental health diagnosis personally or by the diagnosis of a family member or close friend. The narrow techniques, knowledge and identity formation in mental health practice encouraged by the current definition of mental health literacy is unnecessarily limiting and impedes a shared approach to supporting and promoting mental health and wellbeing across the whole population.

It is an interesting time to discuss approaches in mental health given the recent publication of the fifth edition of the DSM and some of the debate that has surrounded the expansion of diagnostic categories. It is also an interesting time in mental health because of apparently democratising concepts such as mental health literacy becoming increasingly popular. Current mental health policy in Ireland states that 'mental health and mental wellbeing are therefore part of everyday life, in that mental wellbeing is influenced, both positively and negatively, in every area of life; in families, schools, the workplace and in social interactions' (Department of Health and Children 2006: 16). An emerging trend in mental health policy is to recommend that the mental health literacy of the population is increased. A broader interpretation of mental health literacy than one which is measured by ability to recognise a diagnosis would more accurately reflect a critical understanding of mental health and its broad range of determinants, for better or worse.

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Conclusion

The responses of the young people to the mental health vignettes in this study are consistent with findings from previous, quantitative mental health literacy research in relation to the perceived value of informal support for mental health difficulties. The responses also reflect a broad view of mental health, which takes a range of determinants of mental health difficulty into account (such as bullying, economic circumstances and body image). The responses also reflect a coherence across the four dimensions underpinning our collective understanding of mental health: fields of visibility, techniques, knowledge, and subjective identity. The insights from the young people in relation to these four dimensions might usefully be applied to future mental health policy and practice in Ireland. For example, the training of undergraduates in health and medicine should facilitate learning in relation to common environmental stressors. In relation to diagnosis as a dominant technique in mental health and the tendency to ask 'what's wrong?', perhaps a reframing of our approach, which encourages the question 'what might be happening (or have happened) in the person's life?' would take into account the broader view reflected in the vignette responses in this study. In relation to valued knowledge in mental health, the findings reported here underline the need to more closely investigate informal help-seeking and help-giving so that such supports are better understood. In relation to practical implications around identity formation and our subjectivity in relation to mental health, a broader discourse, which takes into account the full range of determinants of mental health and the potential for mental health support from a wide range of formal and informal sources would encourage a change in thinking that recognises that mental health and mental health literacy is about all of us and our shared humanity.

A limitation of the present study is that certain groups could not be recruited, including groups of young people currently in employment who may have a different understanding of mental health. A further limitation in the study is that the questions asked in relation to the vignettes were potentially leading and future research should consider more open questions in relation to mental health vignettes.

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