MENTAL HEALTH LITERACY: A CASE VIGNETTES STUDY FROM LAHORE, PAKISTAN

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ABSTRACT

OBJECTIVE
To examine mental health literacy of six psychiatric disorders in a convenient sample in Lahore.

STUDY DESIGN
Exploratory study

PLACE AND DURATION OF STUDY
The study was done in the medical outpatient department of a public sector hospital in Lahore. The data collection was done between April 2015 to December 2015.

SUBJECTS AND METHODS
We selected a convenient sample of 72 people from an outpatient department of a hospital in Lahore.

RESULTS
People have better knowledge about depression than other conditions.

CONCLUSION
This is a small study and results should be interpreted cautiously. It is feasible to conduct case vignettes studies for multiple disorders and they provide rich data and opportunity for comparison of knowledge for different disorders.

KEY WORDS
Mental disorders, Mental health literacy, Awareness of Psychiatric disorders.

INTRODUCTION

Researchers have been interested in general public's views about mental illness for decades[1]. With regard to this topic two slightly overlapping but distinct research traditions have emerged over time; attitudes to mental illness and mental health literacy. The attitudes to mental illness literature is concerned more with how general public views patients with mental illness. Studies in this domain help to understand stigma related with mental illness[2,3]. On the other hand mental health literacy (MHL) tradition of research was preceded by and is an extension of physical health literacy literature. Jorm defined mental health literacy (MHL) as the " knowledge and beliefs about mental disorders which aid recognition, management or prevention"[4].

Mental health literacy is concerned with people's recognition of specific disorders, their knowledge of the causes and risk factors, and their knowledge of the help available. When people are making a decision about seeking help for a health problem, their knowledge and understanding of the problem determines the course they will take. Mental health literacy aids in early recognition of mental disorders and encourages appropriate help-seeking behaviour. Populations may have diverse and competing views about causes and treatments of illnesses. People's cultural background may be an important contributor to their understanding and beliefs about psychiatric disorders[5]. Therefore study of mental health literacy in any culture is a stepping stone towards planning public health education about mental illnesses to improve access to treatment.

The most common methodology adopted to study health literacy is based on case vignettes studies. The participant in the research is given a description of a case and then asked questions about the described case to check their knowledge and beliefs about it[6].

Historically most of the mental health literacy studies were conducted in the western world or with ethnic groups originating from non-western countries living in the western countries[7]. This however has changed over last decade or so. In a systematic review of literature from non-western cultural groups Adrian Furnham and Aseel Hamid identified 28 studies. Some of the themes identified across these studies were; younger people were better in identifying psychiatric disorders, females were better in recognizing the disorders and recognizing the need for help and mental health literacy was better in developed countries. People had better knowledge of depression than schizophrenia. Urban populations showed greater recognition of both depression and schizophrenia than rural populations and recommended a mental health professional for treatment[6].

To determine mental health literacy in local settings, this study with a convenient sample was designed where we provide case vignettes for depression, schizophrenia, mania, psychosis, conversion disorder and PTSD followed by a questionnaire to assess literacy of laymen in Lahore. One of our objectives was to compare mental health literacy with regard to different

diagnoses and for that reason we chose six different vignettes. Depression and Schizophrenia have been most commonly studied before. In addition to these conditions we included mania, PTSD, OCD and conversion disorder. PTSD and conversion have special relevance in Pakistan; PTSD because of high level of trauma exposure and conversion disorder because its prevalence is higher than western world.

SUBJECTS AND METHODS

Participants

A convenient sample of 72 people from a medical outpatient department of a public hospital in Lahore was selected. Sample was selected from the people who accompanied a relative to an outpatient appointment. We focused on the medical outpatient walk-in service. We specifically excluded people seeking help for psychiatric disorder.

Instruments

In addition to demographic information we gave a questionnaire which explored different aspects of participants knowledge about the illness described in the vignette. The questions inquired about
- Whether the vignette describes an illness or not
- What is the nature of the illness
- What is the name of the illness
- How much the participant know about this illness
- What are the causes of this illness
- Who can suffer from this illness
- What is the treatment
- Who can treat
- What is the outcome

Procedure

Study was approved by the Pakistan Association of Cognitive Therapy Ethics Board and it conforms to the provisions of the Declaration of Helsinki (as revised in Edinburgh 2000). Written informed consent was taken from the participants. We gave them vignettes for six psychiatric conditions and a questionnaire after each vignette. We used SPSS to analyze the data.

RESULTS

Participants ranged in age from 17 to 75 years (M = 32.25, SD = 12.36). Monthly income ranged from minimum 5000.00 to Maximum 70000.00 (M = 20695, SD 12927). Other demographic details are provided in the table 1.

Table 1
Differences between Widowed and Still-Married on Psychological Well-being, Satisfaction with Life and Depression (N=200.)

Gender	
Male	38 (52.8%)
Female	34 (47.2%)
Marital Status	
Single	44 (61.1%),
Married	28 (38.9%)
Family History of Mental Illness	
Present	14(19.4%)
Absent	57(79.2%)
Missing	1(1.4%)
Participants Experienced Mental Illness	
Present	47 (65.3%)
Absent	24 (33.3%)
Missing	1(1.4%)

Table 2
Details of participants' responses about illness, its name, type and subjective knowledge.

		Depression N (%)	Mania	Psychosis	OCD	Conversion Disorder	PTSD
Illness	Yes	70 (97.2%)	36 (50%)	70 (97.2)	58 (80.6)	50 (69.4)	50 (69.4)
	No	2 (2.8%)	14 (19.4)	1 (1.4)	2 (2.8%)	5 (6.9)	17 (23.6)
	DK		22 (30.6)	1 (1.4)	12 (16.7)	17 (23.6)	5 (6.9)
Type of Illness Mental		68 (94.4%)	32 (44.4)	68 (94.4)	51 (70.8)	13 (18.1)	51 (70.8)
	Spiritual				1 (1.4)	1 (1.4)	
	Physical					21 (29.2)	
	Mental and Physical				2(2.8)	13 (18.1)	
	Other	2 (2.8%)				1 (1.4)	2(2.8)
	DK	2 (2.8%)	40 (55.6)	4 (5.6)	18 (25)	23 (31.9)	19 (26.4)
Name	Right	61 (84.7%)	12 (16.7)	26 (36.1)	37 (51.4)	44 (61.1)	34 (47.2)
	Wrong	10 (13.9%)	4 (5.6)				
	DK	1 (1.4)	56 (77.8)	46 (63.9)	34 (47.2)	27 (37.5)	35 (48.6)
	Other				1 (1.4)	1 (1.4)	3 (4.2)
Subjective knowledge	A little	19 (26.4%)	13 (18.1)	14 (19.4)	16 (22.2)	18 (25)	14 (19.4)
	Somewhat	2 (2.8%)		4 (5.6)	2 (2.8%)		1 (1.4)
	A lot	43 (59.7%)	8(11.1)	24 (33.3)	22(30.6)	22 (30.6)	26 (36.1)
	Other	1 (1.4%)	4 (5.6)	1 (1.4)	1 (1.4)	1 (1.4)	1 (1.4)
	DK	7 (9.7%)	47(65.3)	29 (40.3)	31 (43.1)	31 (43.1)	30 (41.7)

Table 3
Details of responses about causes and sufferers of illnesses.

		Depression N (%)	Mania	Psychosis	OCD	Conversion Disorder	PTSD
Causes	Psychological	25(34.7%)	15(20.8)	(26) 36.1	34(47.2)	13(18.1)	10(13.9)
	Social	28(38.9%)	7(9.7)	5 (6.9)	2(2.8%)	1(1.4)	8(11.1)
	Psychological and Social	16(22.2%)	6 (8.3)	8(11.1)	2(2.8%)	1(1.4)	1(1.4)
	Biological		1(1.4)			19(26.4)	
	Social and Biological	1(1.4%)		3(4.2)			
	Psychologicaland biological			2(2.8%)		5(6.9)	
	Spiritual			4(5.6)			1(1.4)
	DK	2(2.8%)	36 (50.0)	20(27.8)	23(31.9)	25(34.7)	15(20.8)
	Trauma		1(1.4)	1(1.4)	3(4.2)		33(45.8)
	Trauma and Psychological						1(1.4)
	Trauma and Social						2(2.8)
	Other		6(8.3)	2(2.8%)	7(9.7)	8(11.1)	1(1.4)
	Multiple			1(1.4)	1(1.4)		
Who can suffer	Anyone	37 (51.4%)	18(25.0)	25(34.7)	28(38.9)	25(34.7)	20(27.8)
	Women	6(8.3%)		1(1.4)	6(8.3)	3(4.2)	
	Socio-economic problems	5 (6.9%)		1(1.4)	1(1.4)		
	Trauma	1(1.4%)	1(1.4)		1(1.4)		14(19.4)
	Other	2 (2.8%)	16 (22.2)	3(4.2)	3(4.2)	4 (5.6)	3(4.2)
	Anyone And Women	1(1.4%)					
	DK	12(16.7%0)	35(48.6)	29 (40.3)	26(36.1)	32 (44.4)	17(23.6)

DK = do not know.

Table 4
Details of responses about treatment, its course and other help available.

		Depression N (%)	Mania	Psychosis	OCD	Conversion Disorder	PTSD
Treatment	Medication	48 (66.7%)	20 (27.8)	21 (29.2)	20 (27.8)	34 (47.2)	30 (41.7)
	Therapy	3 (4.2%)		2(2.8)	5(6.9)	3(4.2)	4(5.6)
	Spiritual Treatment			1(1.4)	1(1.4)	2(2.8)	
	Other	7 (9.7%)	8(11.1)	3(4.2)	5(6.9)	3(4.2)	4(5.6)
	Medication and Therapy	7 (9.7%)	4 (5.6)	4(5.6)	7(9.7)	2(2.8)	4(5.6)
	Medication and Spiritual Treatment	1 (1.4)	1(1.4)	2 (2.8)			
	DK	6 (8.3)	39 (54.2)	39 (54.2)	34 (47.2)	28(38.9)	30(41.7)
Who can help	Doctor	43 (59.3)	21(29.2)	25 (34.7)	25 (34.7)	38(52.8)	36(50)
	Psychiatrist	17 (23.6)	7 (9.7)	4 (5.6)	6 (8.3)	2 (2.8)	6(8.3)
	Psychiatrist and Family and Friends					1(1.4)	
	Psychologist		1(1.4)		2 (2.8)		
	Family and Friends	3 (4.2)		2 (2.8)			1(1.4)
	Other	2(2.8)	3 (4.2)		1(1.4%)	1(1.4%)	1(1.4)
	Doctor and Psychiatrist	1(1.4)		2 (2.8)	1(1.4%)		
	Doctor and Psychologist	1(1.4)	1(1.4%)		1(1.4%)	1(1.4%)	1(1.4)
	Doctor and Family and Friends	1(1.4%)	2 (2.8)		2 (2.8)		1(1.4)
	Psychiatrist and Psychologist	3(4.2%)	3 (4.2)	3 (4.2)	2 (2.8)	2 (2.8)	2(2.8)
	Psychologist and Faith Healer				1(1.4%)		
	Traditional Healer			2 (2.8)		2 (2.8)	
	Doctor And Traditional Healer			1(1.4%)		1(1.4%)	
	Faith Healer				1(1.4%)	2 (2.8)	
	DK	1 (1.4%)	34(47.2)	33(45.8)	30(41.7)	22(30.6)	24(33.3)
Course	Treatable	67 (93.1%)	37 (51.4)	29(40.3)	33 (45.8)	44(61.1)	45(62.5)
	Not Treatable			7(9.7)	7(9.7)	5(6.9)	
	Self-remitting	1(1.4%)					
	DK	4 (5.6%)	34(47.2)	36(50)	32(44.4)	23(31.9)	26(36.1)
	Other		1(1.4)				1(1.4)

Majority of participants considered depression and psychosis mental illnesses. For other disorders 25 to 55% of participants were not sure. Eighteen percent people labelled conversion as physical illness. People were able to correctly name depression much more frequently than any other disorder. People mostly believed that depression was caused by psychological and social factors and about 50% believed that PTSD was caused by trauma. There was more uncertainty in people's mind about other disorders. Apart from conversion disorder not many people mentioned physical factors as causative. Spiritual causes did not figure high. For treatment medication was quite high in the priority for depression. For other disorders "Do not know" was reported frequently.

Doctors and psychiatrists were considered appropriate to provide treatment by many but a substantial number did not know who will be appropriate source of treatment. Depression was considered treatable by more than 90% but for other conditions this percentage was 50%.

DISCUSSION

In this study we find that majority of people can recognize depression and their views about its causation and treatments are not much different from the western countries. The information about other disorders is not as good. To our surprise very few people suggested spiritual causes for these disorders. A substantial proportion could identify trauma as possible cause for PTSD.

These findings are not different from studies in the developing world. The rate of recognition for schizophrenia has been between 27 and 50%[8,9]. In our study 36% were able to correctly identify psychosis. For depression studies have reported a higher recognition rate of 60-70%[10,11]. In our sample 84.7% were able to identify depression.

For depression more than 95% of the participants believed that it was caused by psychological, social or a combination of the two factors. This is an endorsement of the psychosocial model of depression. One difference from the studies conducted in the western countries is that biological factors are not seen as important as social and psychological factors[13].

There was a difference in perception about appropriate treatment between different disorders. Depression was seen as treatable by medicine but for other disorders people were unsure and 'do not know' was a common answer. This trend may reflect people's experience. Depression is relatively common condition and it is likely that participants would know somebody who has suffered from Depression and has been treated for it. A small proportion of people mentioned therapy (meaning psychological interventions) as treatment. Therapy is not widely available and it is likely that people are not familiar with it as an option for treatment.

Case vignettes are a widely used method to assess public health literacy about psychiatric disorders[5,6]. Most of the studies have examined one or two conditions at one time. We decided to study multiple conditions simultaneously to see the difference in participants' knowledge about different conditions. This proved to be a useful strategy. Selection of a convenient sample mainly from urban centre may have influenced our results. This includes people who have sought treatment from a health facility where western medicine is practiced. They are likely to hold views consistent with the west. Similar studies from a population who are not seeking help may give different results. The size of the sample is small compared with some other studies. We need a study with a bigger and more heterogeneous representative sample to have a definite understanding of people's views about mental illness.

ACKNOWLEDGMENTS

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Journal of Pakistan Psychiatric Society

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