Mental Health Literacy: A Generational Gap in the Public’s Knowledge and Perceptions of Mental Illness

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Abstract

Mental health literacy refers to an individual’s knowledge and beliefs about mental illness. The purpose of this study was to compare the mental health literacy of two generations: Young adults (ages 18-24, n = 36) and older adults (ages 65+, n = 26). Participants were administered three vignettes of an individual with three different DSM-IV disorders: Major depressive disorder, obsessive-compulsive disorder (OCD), and paranoid schizophrenia. Four components of mental health literacy were assessed: Knowledge, treatment preferences, stigma, and desired social distance. Results indicated that young adults demonstrated higher levels of mental health literacy than older adults. Specifically, young adults evidenced less stigma and less desired social distance from an individual with mental illness compared to older adults in the schizophrenia and OCD vignettes. Significant differences emerged in knowledge and treatment preferences in the OCD vignette only, with young adults more likely to accurately identify the psychiatric diagnosis, χ²(12, n = 47) = 25.07 p = .014, and more likely to indicate that no treatment was needed, χ²(1, n = 62) = .025, p = .025. Results suggest that young adults have greater mental health literacy relative to older adults. These findings may reflect differences in educational background as well as previous exposure to mental illness and media and suggest that older adults may benefit from increased efforts aimed at enhancing knowledge and decreasing stigma toward individuals with mental illness.
Defining mental health literacy

The term mental health literacy was first introduced in 1997 and defined as ‘knowledge and beliefs about mental disorders which aid their recognition, management, and prevention” (Jorm, Barney, Christensen, Highet, Kelly & Kitchener, 2006, p. 3). Since the term was first introduced, Australia has become a leading front runner in researching the public’s level of mental health literacy. A large body of Australian research has found that mental disorders are not well recognized by the public (Kermode, Bowen, Arole, Pathare, Jorm, 2009). Research by Farrer and colleagues (2008) found that perceptions of treatment, stigma, and diagnosis are all, to some extent, unrecognized by the general public. Although many individuals have a strong level of knowledge in standard medical conditions, the same has not been shown to be true for mental disorders (Farrer, et.al., 2008).

Mental health literacy is particularly important, as it may aid in preventing serious adverse consequences. For example:

*A woman begins to notice that her daughter is no longer getting good grades in school, seems to not care about her future, and looks at everything in a negative way. She has lost most of her friends and tends to spend a majority of her time in her room by herself.* To the untrained eye, a parent may suspect that his/her child is just going through a “phase”, or simply has a personal weakness of some sort. However, a person with highly developed mental health literacy may be able to recognize that his/her daughter is displaying signs of depression and seek appropriate treatment, in turn possibly preventing incidence of suicide or other negative consequences.

Factors Influencing Mental Health Literacy
One factor that has been found to affect mental health literacy is the media (Buila, 2009). Much of the knowledge that the public has on health-related issues stems from sources such as television and the Internet. It is not until recently that the media has begun to focus on mental health. As mental health professionals learn more about disorders and treatment options, a greater number of commercials, videos, and movies have begun to address mental health issues. A variety of popular movies, such as “A Beautiful Mind” or “One Flew Over the Cuckoo’s Nest,” have focused on serious mental illness and have likely influenced the publics’ knowledge and awareness of certain types of mental disorders. Other forms of exposure to mental disorders come from television and commercials. Pharmaceutical companies have begun to release commercials and general television advertisements for psychotropic medications promoting forms of help in dealing with the symptoms of depression, anxiety, and other psychiatric disorders, in turn potentially influencing the publics’ awareness of these disorders. As a result of the increase in exposure to mental health issues via media, researchers are beginning to examine some concerns over the information that is being released. One concern they have is that the media can release inaccurate information (Farrer et al., 2008). When it comes to film and television, perceptions on mental health are largely influenced by what can cause the most drama and catch the audience’s attention. In many ways, accuracy of information is not the main priority. Although Australia was the first to investigate this topic, other nations have begun to do the same.

Education is another factor that has likely contributed to the publics’ mental health literacy. Individuals’ knowledge about mental illness is likely to be influenced by their degree of exposure to these issues in health, psychology, and other related courses. Many schools are beginning to include programs that address binge drinking, eating disorders, and self-esteem.
Earlier generations did not receive as much formal education in these areas as today’s students. Mental health disorders that are commonly prevalent in teens today are increasingly beginning to be included in class discussion. This is very different from the health classes of the baby boomer generation and prior due to the fact that teen suicide and eating disorders were not as common as they are today (Burns & Rapee, 2006).

The final, and perhaps most obvious, influence on mental health knowledge is personal experience. Individuals who know someone who is struggling (or struggles themselves) with a mental disorder are more likely to be knowledgeable in the area of mental health than those who do not (McGorry, 2005). McGorry’s research states that everyone knows someone (either directly or indirectly) who suffers with a mental illness and encourages the public to acquire greater knowledge about mental disorders.

There are four main components that comprise overall level of literacy: Knowledge, treatment, stigma, and desired social distance, each of which will further be discussed below.

*The role of knowledge in mental health literacy*

Mental health knowledge is one component of mental health literacy and refers to an individual’s ability to recognize existence of a particular psychiatric disorder when provided with symptoms and information about the disorder (Burns & Rapee, 2006). Although knowledge by the public is slowly increasing, Farrer et al (2008) reported that there are significant gaps in the amount of knowledge that the public has on mental health. Farrer et.al. (2008) asked participants to rate the most likely causes of psychiatric disorder in a vignette of an individual suffering from depression or schizophrenia. A majority of the participants attributed symptoms of depression to day-to day problems and/or a recent trauma. Responses for the schizophrenia vignette, however, varied by age group. Individuals ages 18-24 and 70+ believed that the schizophrenia symptoms
were due to day-today problems, whereas participants between the ages of 25-69 attributed symptoms to childhood problems. Overall, a majority of the individuals in this study tended to support the idea that people with mental disorders developed their symptoms as a result of environmental factors, such as daily problems or negative experiences in their childhood. It is noteworthy that very few supported biological explanations, which is one of the contributors to the development of schizophrenia (DSM-IV, 2000).

The role of treatment in mental health literacy

The second component of mental health literacy is treatment preference. Research indicates large gaps in the opinions of professionals and that of the public with respect to treatment of mental disorders (Burns & Rapee, 2006). With the options for treatment changing at an alarming rate, it is important for the public to know that they have more options than simply talking with a friend or pastor as was once believed (Cotton, Wright, Harris, Jorm, & McGorry, 2006). It appears, however, that preferences toward help from friends or members of the church may be shifting. Research by Burns and Rapee (2006) focused on treatment preferences by the general public and found that “the public gave more favorable ratings to non-medical interventions such as vitamins, minerals, and special diets. In fact, the public frequently views medication, hospitalization, and psychiatric treatment as harmful.” This research suggests that medical advancements in the field of psychology are moving faster than the general public is able to keep up with. Because of the public’s lack of understanding on various forms of treatments, they are opting for the less evasive, more simply method to treatment, even if it is not the best choice. In order to ensure that the public has a good understanding of mental health and the most advanced treatments for mental health illnesses, education will need to be stressed in this area.
A more recent study examining age differences in mental health literacy with regards to mental health found that “seeing a doctor or GP (general practitioner) was rated by all age groups as the best kind of help” (Farrer, et.al., 2008). Though this finding indicates increased likelihood of visiting a medical professional, it may also suggest a subtle stigma around visiting a mental health professional. In the study conducted by Farrer et al (2008) that examined treatment preference for mental health, friends and family were also rated extremely high as a top choice for help in both age groups, especially among younger participants, whereas psychiatrists were rated extremely low by both age groups being examined. This further suggests the presence of stigma related to visiting a psychiatrist or other mental health professional. Swami et al (2009) reported that “it is believed that up to 70% of individuals with mental health disorders do not seek help” (p. 181). This finding may be attributed to the presence of stigma by the overall public. Swami et al (2009) also support the idea that help-seeking for mental health disorders will improve with reductions in stigma, increased confidence in psychiatric treatments, and better overall mental health literacy.

The role of stigma in mental health literacy

Stigma represents a third component in addressing mental health literacy. Stigma refers to the public’s perception of individuals with mental disorders. Data suggests that individuals may view mental disorders as a sign of personal weakness or a flaw in an individual’s character (Goldman, H., 2010, p.1289). Research suggests, however, that stigma may be more pronounced among older adults. Farrer and colleagues (2008) reported that “stigma among older people may be greater, and inhibit openness to new information about the recognition and etiology of mental disorders.” One study suggests that stigma is less prominent among younger adults (Burns & Rapee, 2006; Norman et al (2008), suggesting that young adults may be more accepting of those
suffering from a mental health disorder (Pescosolido, Martin, Long, Medina, Phelan, & Link, 2010).

One of the largest problems in relation to stigma has to do with the fear of being labeled. Buila (2009) states that “stigma about mental illness continues despite a broadening of public conceptualization of mental illness and a greater acceptance of less severe forms of mental illness” (p. 363). Unfortunately, many individuals tend to view people with a mental disorder as being dangerous, unpredictable, and odd. In a recent article by Guimon (2010, p. 20), he stated that:

“the negative attitudes towards mental illness can be based not only on ignorance and intolerance but also on such real factors as dangerousness, unpredictability, disability, and the burden the psychiatric patient represents for the community, particularly for members of the family and professionals who experience the stress that results for caring for them.”

Although this statement mentions several reasons behind stigma and how it is attached to individuals struggling with a mental health problem, the first reason that is mentioned for stigma is ignorance by the public. By increasing mental health literacy, it is hoped that others will understand that mental disorders are not something that one can control and, that they generally do not cause someone to be dangerous.

The role of social distance in mental health literacy

The fourth aspect of mental health literacy is desired social distance. In general terms, social distance refers to the level of distance that individuals desire between themselves and another (Teachman, Wilson, & Komarovskaya, 2006). With respect to mental health literacy, social distance refers to the likelihood of an individual accepting someone with a mental illness
as a friend, neighbor, loved one, etc. The less social distance desired by the individual, the
greater their level of mental health literacy.

Research suggests that “the more familiar an individual is with mental illness the less
likely they are to express negative reactions toward that individual or desire extensive distance
from them” (Marie & Miles, 2008, p. 126-127). Marie and Miles (2008) also supported the idea
that increased contact between the mentally ill and laypersons decreases their level of stigma.
Overall, the public’s desire for social distance can lead to several negative outcomes for the
person suffering with the disorder. It may place many individuals who have received psychiatric
treatment at a disadvantage “in such areas as employment, income, housing, personal
relationships, and health care” (Norman, Sorrentino, Windell, & Manchanda, 2008). Not only
does this cause problems in their day-to-day lives, but is can also negatively impact their self-
esteeom and psychological well-being.

Research conducted by Kermode, Bowen, Arole, Pathare, and Jorm (2009) assessed the
public’s desired social distance by asking them questions about a depression and schizophrenia
vignette. Some of these questions included: “Would you be a neighbor to the person in this
vignette? Would you allow this person to marry into your family? Would you develop a
friendship with this person?” Results indicated that people were least likely to allow the person
portrayed in each of the vignettes to be extremely close to them (such as marrying into their
family) but felt more comfortable with relationships involving farther social distance, such as
occasionally socializing with that person or having them as a neighbor. Results also suggested
the presence of age-related differences, with younger adults demonstrating less desired social
distance than older adults.

A Generational Shift
Several studies have directly compared mental health literacy of younger and older adults. When comparing young adults (ages 18-24) to older adults (ages 70+), past research has concluded that although both groups have limited knowledge, older adults performed more poorly in recognizing depression and schizophrenia in case vignettes (Farrer, et al., 2008; Kermode et al, 2009). Another study found that older adults, in general, tended to view the individuals in the vignettes as having a character weakness or suffering day-to-day problems, whereas, younger adults tended to believe the problems were due to a recent trauma or childhood problems (Guimon, 2010).

There are a variety of reasons as to why younger adults may have enhanced mental health literacy compared to older adults. First, younger adults are experiencing mental illness at increasing rates. One study reported that up to 12% of children (under the age of 18) are struggling with a mental disorder (Spitzer, A. & Cameron, C., 1995). With such high numbers of children struggling with a mental health disorder, it is likely that many of these children tend to have some extent of knowledge on this subject matter. Additionally, the use of social media may affect mental health literacy across generations. For example, messages on mental health from the media may be much more accessible to younger generations than for older adults who do not commonly use the Internet or other common media outlets. Lastly, differences in formal education about psychological issues may also underlie age-related differences in mental health literacy. For example, school programs addressing mental health were not generally taught to the older generation when they were in school. (Farrer, et al, 2008).

The Current Study

The current study aimed to compare mental health literacy between two generations: Young adults (ages 18-24) and older adults (ages 65+). Participants were provided with three
vignettes portraying a male with different psychiatric conditions. To replicate past research, two of the vignettes depict a man with depression or schizophrenia. To investigate mental health literacy of a disorder that has not been previously investigated, a third vignette portrayed an individual with Obsessive-Compulsive Disorder (OCD). Participants read all three vignettes and were then asked to answer a variety of questions pertaining to four components of mental health literacy: Knowledge, treatment, stigma, and social distance. Consistent with past research, it was hypothesized that younger adults would have more knowledge on mental health, demonstrate less stigma, recommend treatment from a professional rather than family member, and desire less social distance than older adults.

METHODS

Participants

A total of 62 (36 young adults, 26 older adults) participants were recruited for this study. Ages of the young adult group ranged from 18 to 24 ($M = 18.72, SD = 1.52$) with 22.6% being male and 35.5% female. Ages of the older adult age group consisted of individuals aged 65 and older ($M = 73.26, SD = 6.77$), with 24.2% male and 17.7% female. No significant differences were found with respect to educational background between the two age groups, all $p$’s > .05. Given that older adults were recruited from 2 different types of settings (VFW and church), t-tests were conducted to examine possible demographic differences between the two recruitment settings. Results indicated a greater presence of males in the older age group recruited from the VFW compared to the church, $t(19) = 8.437, p = .010$. No other significant differences emerged between the 2 recruitment settings. Additional participant characteristics are displayed in table 1.

Measures
To assess mental health literacy, three vignettes describing a fictional male suffering from depression, obsessive compulsive disorder (OCD), or paranoid schizophrenia were administered to each participant (Appendix B). Two of these vignettes (depression and schizophrenia) were obtained from a previous study conducted by Farrer et al. (2008). The OCD vignette was created by the researcher using diagnostic criteria from the DSM-IV. Following each vignette, participants were asked a variety of questions pertaining to each of the four domains of mental health literacy (knowledge, treatment, stigma, and social distance, Appendix C). Questions addressing knowledge asked participants to read a vignette and indicate whether or not they believe that the individual in the vignette has a mental illness. If they respond with a “yes,” they were then asked to state (in free response format) what disorder was represented in the vignette. To assess treatment, participants were asked to indicate whether or not the individual in the vignette needed treatment, and if so, to respond (in free response format) to the question “If so, what kind of treatment do they need?” To assess stigma, participants were asked to respond to statements such as, “People like John are dangerous” and “It is best to avoid people who act like John” using a 5-point Likert scale ranging from “strongly agree” to “strongly disagree.” To assess social distance, participants were asked to respond to statements such as “I would be a neighbor to John” or “I would allow John to marry into my family” using a 5-point Likert scale ranging from “strongly agree” to “strongly disagree.”

Procedure

Upon obtaining institutional informed consent, data collection was initiated. Locations for data collection varied by the two age groups. Young adults were recruited from two separate undergraduate psychology courses (Psychology of Personal Adjustment and Psychology of Adolescence) at North Central College. Older adults were recruited from three separate
locations: the Veterans of Foreign Wars (VFW), a non-denominational church in the Chicago suburbs, and a small Lutheran church in a rural Illinois town. In all settings, participants were recruited voluntarily after the researcher sought approval from the individual in charge at each site. The researcher introduced the project to the participants and allowed them to decide whether or not they would like to participate. Questionnaires were distributed to all participants, and participants had an unlimited amount of time to complete them. Following data collection, participants were debriefed and provided with an informational sheet explaining the nature of the study.

RESULTS

Depression Vignette

Eighty-three percent of all participants accurately identified the individual in the depression vignette as experiencing major depression. Specifically, 31.1% of older adults and 51.1% of younger adults correctly identified the individual in the vignette as having depression; this finding reflected a trend toward significance but was not statistically significant, $x^2(7, n = 45) = 8.739, p = .061$. Some interesting responses that were frequently mentioned included: adjustment disorder, insomnia, and anxiety disorder. For a more complete listing of responses by the participants, refer to table 2. The two groups did not differ with respect to any of the remaining three components of mental health literacy (treatment preferences, stigma, or desired social distance) in the depression vignette, all $p$’s > .05.

In addition to using chi-square tests to examine differences in individual items assessing stigma and social distance, t-tests were used to examine differences in composite stigma and social distance scores. Composite stigma and social distance scores were computed by adding the
scores for all questions assessing stigma and all questions assessing social distance in the questionnaires in order to obtain a composite score. There were no significant overall differences in the stigma composite score between young adults (M = 26.91, SD = 6.5) and older adults (M = 28.42, SD = 6.82), t(60) = .147, \( p = .703 \), or in the social distance composite score between young adults (M = 28.30, SD = 4.53) and older adults (M = 27.92, SD = 4.82), t(60) = .162, \( p = .689 \).

**Schizophrenia Vignette**

No significant group differences were found with respect to knowledge, treatment, or social distance in the schizophrenia vignette, all \( p \)’s > .05. When examining treatment preferences in the schizophrenia vignette, the most commonly suggested treatment among young adults was “medication and therapy” and the most commonly suggested treatment among older adults was “counseling” (Table 3). One significant difference was found in an item assessing stigma. Specifically, young adults were more likely to disagree with the statement “John is illustrating a sign of personal weakness,” \( \chi^2(4, n = 62) = 9.91, p = .042 \), with 27.4% of young adults and 11.3% of older adults disagreeing with this statement. Composite scores taken to assess social distance and stigma were also computed for the schizophrenia vignette and revealed no significant group differences, both \( p \)’s > .05.

**OCD Vignette**

Results indicated that young adults were significantly more likely than older adults to accurately identify obsessive-compulsive disorder in the OCD vignette, \( \chi^2(12, n = 47) = 25.07 \) \( p = .014 \). There was also a significant difference between groups with respect to treatment preference, with young adults more likely to say that no treatment was needed for the OCD vignette (75%) compared to older adults (96.3%), \( \chi^2(1, n = 62) = 4.994, p = .025 \). Group
differences also emerged with respect to stigma, with older adults more likely to view the individual in the OCD vignette as dangerous compared to young adults, $x^2(3, n = 62) = 14.16, p = .003$. Specifically, 50% of young adults, compared to 11.5% of older adults, indicated that the individual in the OCD vignette was dangerous. Older adults were also less likely to disagree with the statement “It is best to avoid people who act like John,” $x^2(3, n = 62) = 17.23, p = .001$. With respect to social distance, older adults were significantly less likely to allow the individual in the OCD vignette to marry into their family compared to young adults, $x^2(3, n = 62) = 15.35, p = .002$. In addition, composite scores examining stigma and social distance with respect to OCD were computed and no significant differences were found, all $p$’s > .05.

DISCUSSION

This study found that young adults demonstrated greater mental health literacy overall relative to older adults. However, differences in mental health literacy were only evidenced in the schizophrenia and OCD vignette, and not the depression vignette. In the schizophrenia vignette, the only difference that emerged was with respect to stigma, with older adults more likely to attribute the symptoms to a personal weakness. In the OCD vignette, several differences were found between the two groups. The first difference was in respect to treatment preferences. A majority of young adults felt that no treatment was needed. Significant differences also emerged with respect to stigma, with older adults more likely to believe that it is best to avoid the individual presented in the OCD vignette and less likely to want the individual in the OCD vignette to marry into their family, suggesting more desired social distance between themselves and the vignette.
There may be several reasons why significant differences were primarily found in the OCD vignette. One explanation for this might stem from the media. The media may have a strong influence on the results of this study for several reasons. Television shows such as TLC’s “Obsessed” is a popular television show geared for adolescents depicting the symptoms and struggles that individuals with OCD face on a regular basis. Another popular show that is more relatable to young teens is MTV’s “True Life” that has depicted adolescents coping with mental illnesses, including OCD, on several occasions. The purpose of this show may not only be to shed light on a mental illness but to also increase understanding and acceptance by the public. It is possible that such television may enhance mental health literacy for those who watch them. Not only are viewers better able to understand the illness, but they may also become less stigmatizing than they were before they had a knowledge of the disorder. Although these programs are also accessible to older adults, the channels (especially MTV) are geared toward adolescents, suggesting more exposure to young adults.

There are several reasons that might explain why there were no significant differences in mental health literacy between the two groups in the depression vignette. It appeared that both groups had relatively good knowledge about depression. One explanation may stem from the fact that the young adults were recruited from two psychology courses. Therefore, these participants may have had previous exposure to common psychological disorders. Likewise, the majority of older adults in this study had obtained at least two years of college (M = 14.32, SD = 2.51). Therefore, it is possible that both groups received formal education training about depression, as it is among the most common types of mental disorders (DSM-IV, 2005). In addition, many participants from both age groups expressed to the researcher after the study that they knew someone who was struggling with depression. Therefore, their proximity to
individuals with depression may have led them to have a greater level of knowledge on the subject matter.

In the schizophrenia vignette, the only significant differences that emerged between the two groups were related to stigma and opinions about treatment. This suggests that although both groups were equally able to accurately identify symptoms of schizophrenia, they held differing beliefs about the appropriate treatment as well as holding stigma related to this disorder. Many of the older adults believed that the case vignette was “illustrating a sign of personal weakness,” which directly contradicts what the scientific community has revealed about the etiology of schizophrenia and reflects a lack of knowledge about the fundamental cause of the disorder. This would further explain why they are more likely to stigmatize individuals with schizophrenia than young adults. It is possible that this belief contributed to older adults’ greater tendency for stigmatization of this disorder. Overall, older adults’ level of knowledge in regards to this particular mental illness was not as developed as young adults.

Responses about treatment preferences yielded some of the most interesting results in the study. Responses to open-ended questions varied among the participants within each age group. Several interesting responses to the schizophrenia vignette were stated such as “lack of learning/facing responsibility” and “dementia.” It is possible that these responses, stated by participants in the older age group, may reflect the effects of personal experience and belief systems in mental health literacy. Though speculative, it is possible that the individual who responded with “dementia” may have experienced someone who has struggled with dementia such as a partner or family member or has struggled with it themselves. Therefore, they may be more likely to see the systems of dementia in the schizophrenia vignette than many of the other participants. One of the young adults believed the individual in the depression vignette was
struggling with Adjustment Disorder. Because some young adult participants were recruited from a Psychology of Personal Adjustment course, where they had discussed the topic of Adjustment Disorders, they may have recognized the symptoms of Adjustment Disorder in the vignette more so that an older adult would have. This suggests that an individual’s environment and experience play a large role in their level of knowledge on mental health. Though there were no differences between the two groups with respect to educational background, participant’s education surrounding psychiatric illness was not specifically assessed in this study.

The results of this study hold important implications for mental health education. Efforts to ensure public mental health education are also needed. It is important for policies to be in place in order to guarantee all schools health programs are teaching kids early on about mental health disorders. The same is true for older adults. However, the media may play a more important role for this population. The media can take a direct role in educating the public, decreasing stigma, and improving social distance.

Study Limitations

This study is not without limitations. First, the study utilized a small sample size (N = 62) which may influence the generalizability of the study. Future research should aim to replicate these results with a larger sample. Another limitation was the participants themselves. Many of the older adults in the study required more explanation and assistance. In several instances, the researchers had to intervene in order to make sure the participant understood the directions and questions given. In addition, older adult participants were more likely to talk to one another about the questions although they were instructed not to. In addition, the older adult population was hard to reach without having access to locations with older adults initially. In many ways, having to obtain older adult participants from three separate locations could have resulted in
more variability amongst the participant characteristics. Therefore, flaws were likely to emerge.
The lack of participants as well could have had a direct influence on the validity and
generalizability of the study. Another aspect to consider is whether the older adults speculated
with one another in regards to the questions that were given to them instead of simply providing
their best educated guess. The researcher observed that the older adults seemed to demonstrate
concern with respect to whether they indicated the “right answer.” This may reflect differences
in the groups’ past participation in research studies. It is likely that the young adults have more
experience participating in research studies, given that they are often required to do as in their
Psychology 100 course. Therefore, the young adults may have been more socialized to data
collection and the awareness that there is not necessarily a “right or wrong” answer in research.
Although this was only speculation on behalf of the researcher, it may explain why they were
more likely to discuss the questions with one another. In many ways, it seemed to be their
method for “copying” to obtain the right answer. On the other hand, the young adults were in a
classroom setting with the presence of their instructor and did not require further explanation.
Therefore, the atmosphere of the room was very quiet and the young adults did not discuss any
part of the questionnaire with one another, potential creating an environment with less
distractions and options to compare responses. Overall, the environment and level of interaction
amongst the participants varied drastically between the two groups although the researchers
attempted to keep them the same.

*Directions for Future Research*

Future research comparing generational differences in mental health literacy may want to
continue to present new disorders instead of focusing primarily on depression and schizophrenia.
After examining research in this area, it seems as though this is the first study to include an OCD
vignette when examining mental health literacy. The results for the OCD vignette in the current study yielded some of the largest differences in responses between the two groups being examined. Therefore, it would be interesting to examine OCD on a larger scale with more participants. In addition, future research could extend to the investigation of the education system in relation to mental health literacy as well as taking participants socio-economic status into account. These two variables may be relevant in addressing mental health literacy because of their strong connection to the availability of resources and media access, which may in turn affect mental health literacy. For example, children of higher socioeconomic status may be more likely to have a television in their home as well as a computer. Therefore, they may be more likely to observe television advertisements for depression medication or television programs that educate about a particular illness. In addition, students that are middle class or higher may be more likely to have a health course that touches on mental health whereas children in poor public school systems may have cut their health courses or not dedicate as much time to aspects of mental health. Because the investigation of the public’s knowledge on mental health is still somewhat new, there are endless possibilities for future research within this focus area.

Many might argue that the media plays a large role in educating the public on mental health issues. It has been found that children and adolescents spend an average of 2.5 to 3 hours a day watching television (Gory, Marshall, & Biddle, 2004). With such a large percentage of time that teens spend watching television, they may be more heavily influenced by media compared to older adults. The present study did not assess media exposure, though this is a variable of interest that should be addressed in future studies. Overall, the research presented in this study suggests that differences between young and older adults are not as different as many might believe. When it comes to depression and schizophrenia, young and older adults do not tend to vary
significantly with many aspects related to mental health literacy suggesting that the public’s level of mental health literacy may be greater than what was originally believed. Additional research should aim to replicate this finding in future studies.
Table 1
Participant Demographics: Age and Years of Schooling (N = 62)

<table>
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<tr>
<th>Variables</th>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>12.77</td>
<td>1.88</td>
<td>12-16</td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td>14.32</td>
<td>2.51</td>
<td>11-18</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single*</td>
<td></td>
<td></td>
<td></td>
<td>92.3</td>
</tr>
<tr>
<td>65+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td>4.8</td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
<td></td>
<td>30.6</td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
<td></td>
<td></td>
<td>4.8</td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
<td></td>
<td></td>
<td>1.6</td>
</tr>
</tbody>
</table>

*All young adults in the study were single; however, one participant did not report their marital status.
Table 2

Participants’ responses to open-ended question addressing the diagnosis of the depression vignette

<table>
<thead>
<tr>
<th>Type of Help Preferred</th>
<th>Young Adults</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>n = 36</td>
<td>n = 26</td>
</tr>
<tr>
<td>Depression</td>
<td>51.1</td>
<td>31.1</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>2.2</td>
<td>0</td>
</tr>
<tr>
<td>Stress</td>
<td>0</td>
<td>2.2</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>0</td>
<td>2.2</td>
</tr>
<tr>
<td>Poor Education System</td>
<td>0</td>
<td>2.2</td>
</tr>
<tr>
<td>Depression or anxiety</td>
<td>2.2</td>
<td>0</td>
</tr>
<tr>
<td>Insomnia or Depression</td>
<td>4.4</td>
<td>0</td>
</tr>
<tr>
<td>No Illness</td>
<td>0</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Note: 60% of young adults responded and 40% of older adults responded. The 17 remaining participants left the question blank.
Table 3
Participants’ responses to open-ended question addressing the diagnosis of the schizophrenia vignette

<table>
<thead>
<tr>
<th>Type of Help Preferred (Reflected by %)</th>
<th>Young Adults</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>n = 36</td>
<td>n = 26</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>33.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Depression or Physical Illness</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Insecurity</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Bipolar</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Dementia</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Mentally Disturbed</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Paranoia</td>
<td>7.4</td>
<td>1.9</td>
</tr>
<tr>
<td>Lack of learning/facing responsibility</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>2.8</td>
<td>0</td>
</tr>
<tr>
<td>Crazy</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Meltdown/Breaking Point</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Anxiety and Paranoia</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Paranoia and Schizophrenia</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Forgot the name</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Insomnia</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Not sure/I don’t know</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>5.6</td>
<td>14.8</td>
</tr>
</tbody>
</table>

Note: 61.1% of young adults responded and 38.9% of older adults responded. The remaining participants left the question blank.
Table 4

Participants’ responses to open-ended question addressing the diagnosis of the OCD vignette

<table>
<thead>
<tr>
<th>Type of Help Preferred</th>
<th>Young Adults</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>$n = 36$</td>
<td>$n = 26$</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder/ OCD</td>
<td>51.1</td>
<td>23.4</td>
</tr>
<tr>
<td>Depression</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Fear</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Insecurity</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Compulsive</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Needs to Clean</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.1</td>
<td>0</td>
</tr>
<tr>
<td>An alarming fear of germs</td>
<td>2.1</td>
<td>0</td>
</tr>
<tr>
<td>Neurotic</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Phobia</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Not sure/I don’t know</td>
<td>0</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Note: 55.3% of young adults responded and 44.7% of older adults responded. The remaining participants left the question blank.
References


Appendix A:

The Four Components of Mental Health Literacy

- **KNOWLEDGE**: Ability to recognize the disorder presented as a case vignette. Three potential answers: depression, obsessive-compulsive disorder, and schizophrenia.

- **TREATMENT**: Open-ended response to determine the participants preferred treatment for the individual presented in the vignette.

- **STIGMA**: Perceptions that the participants had in regards to the individual presented in the vignette. Example: Level of dangerousness, whether or not they have a character weakness.

- **SOCIAL DISTANCE**: Distance desired between the participant and the individual presented in the vignette. Example: I would be a friend to this person. I would allow this person to marry into my family.
Appendix B: Vignettes presented to participants

Case #1: (Depression)
John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all of the time, he has trouble sleeping nearly every night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John’s lowered productivity.

Case #2: (Schizophrenia)
John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last 6 months, he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear John walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage John to do more things, he whispers that he won’t leave home because he is being spied upon by the neighbor. They realize that John is not taking drugs because John never sees anyone or goes anywhere.

Case #3: (Obsessive-Compulsive Disorder)
John has lately been struggling with staying on task and arriving to work on time. In the mornings, he tends to focus too much on one particular thing such as germs. He finds that he is obsessed over his fear of germs and will compulsively wash his hands for about 15 minutes at a time, 15 to 20 times a day. He finds that he is preoccupied with the idea of having dirty hands and spends a great deal of time worrying about it.
Appendix C: Questionnaire

Instructions: Please read the following 3 case examples and answer the questions that follow them. When you are finished, you may turn your questionnaire over. If you have any questions, please raise your hand for assistance.

Case #1:

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all of the time, he has trouble sleeping nearly every night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John’s lowered productivity.

1. Do you think that John has a mental illness? (Please circle one)

   YES               NO

2. If yes, then what would you identify John’s mental illness as?
3. Do you think that John needs treatment? (Please circle one)

   YES       NO

4. If you responded yes, what kind of treatment does John need?

For the following questions, Please circle the answer that you agree with the most. Each of the responses range from strongly disagree to strongly agree.

5. John is illustrating a sign of personal weakness.

   Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree

6. This problem is not a real medical illness.

   Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree

7. People like John are dangerous.

   Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree

8. It is best to avoid people who act like John.
9. Would you be a neighbor to John?

10. Would you develop a friendship with John?

11. Would you allow John to marry into your family?

Case #2:

Linda is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last 6 months, she has stopped seeing her friends and has begun locking herself in her bedroom and refusing to eat with the family or to have a bath. Her parents also hear Linda walking about her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone else is there. When they try to encourage Linda to do more things, she
whispers that she won’t leave home because she is being spied upon by the neighbor. They realize that Linda is not taking drugs because Linda never sees anyone or goes anywhere.

1. Do you think that John has a mental illness? (Please circle one)

   YES               NO

2. If yes, then what would you identify John’s mental illness as?

3. Do you think that John needs treatment? (Please circle one)

   YES          NO

4. If you responded yes, what kind of treatment does John need?

For the following questions, Please circle the answer that you agree with the most. Each of the responses range from strongly disagree to strongly agree.

5. Linda is illustrating a sign of personal weakness.
6. This problem is not a real medical illness.

7. People like Linda are dangerous.

8. It is best to avoid people who act like Linda.

9. Would you be a neighbor to Linda?

10. Would you develop a friendship with Linda?
11. Would you allow Linda to marry into your family?

Strongly Disagree        Disagree        Neutral        Agree        Strongly Agree

Case #3

Adam has lately been struggling with staying on task and arriving to work on time. In the mornings, he tends to focus too much on one particular thing such as making sure that the coffee pot is shut off. In order to be certain, Adam repeatedly hits the “off” button on the coffee pot between 25-50 times to make sure it is off. He also finds that he is obsessed over his fear of germs and will compulsively wash his hands for about 15 minutes at a time. He finds that the little things that he obsesses over have consumed his life. It can take him nearly a full hour just to complete small tasks such as eating breakfast. The only way for him to relieve the stress that he feels from these obsessions is to act on them.

1. Do you think that John has a mental illness? (Please circle one)

   YES               NO

2. If yes, then what would you identify John’s mental illness as?
3. Do you think that John needs treatment? (Please circle one)

YES          NO

4. If you responded yes, what kind of treatment does John need?

For the following questions, Please circle the answer that you agree with the most. Each of the responses range from strongly disagree to strongly agree.

5. Adam is illustrating a sign of personal weakness.

Strongly Disagree        Disagree        Neutral        Agree        Strongly Agree

6. This problem is not a real medical illness.

Strongly Disagree        Disagree        Neutral        Agree        Strongly Agree

7. People like Adam are dangerous.

Strongly Disagree        Disagree        Neutral        Agree        Strongly Agree
8. It is best to avoid people who act like Adam.

Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree

9. Would you be a neighbor to Adam?

Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree

10. Would you develop a friendship with Adam?

Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree

11. Would you allow Adam to marry into your family?

Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree