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Young Adult's Mental Health Literacy in Relation to Depression and Their Attitudes Towards Complementary Medicine Practice

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Abstract

Depression and mental health-related issues are increasingly prevalent in young adolescents and adults and so is the use of Complementary Therapies (CTs) to treat depression. Systematic reviews have found that, of all CTs, acupuncture, exercise, and the herbal remedy St John's Wort have the greatest amount of evidence for efficacy in treating depression. We aimed to assess Mental Health Literacy (MHL) levels in the treatment of depression and Complementary Therapy's (CT) usage in adolescents and adults. Surveys were distributed to a pre-existing cohort of community women; and a group of young athletes and university students (n = 156, aged ≥16 years). Participant's level of MHL and the CT's usage for their personal health was assessed. MHL regarding the identification of depressive symptoms was low, particularly in males aged under 35 years. The majority (59%) of participants utilized CTs 12 months prior to survey completion. Evidence-based professional services were perceived more helpful than self-help methods in treating depressive symptoms. Our findings support previous research indicating high levels of use of CTs. Whilst there was a favorable regard for professional services, greater education regarding the identification of depressive symptoms in young men is needed to improve the MHL in this population.

Keywords
Complementary therapies; eating disorder; treatment; depression

1. Introduction

Mental Health (MH) disorders such as depression are the most common health-related issues in young adults [1], but MH Literacy (MHL) or understanding of depression (its recognition and treatment) particularly in men can be poor [2]. It may lead to a delay in help seeking and can contribute to high rates of people with poor MH going untreated each year [3-5] and other adverse outcomes [6]. However, MHL can improve over time [7, 8].

In addition to recommend treatments for depression (e.g., antidepressants and cognitive behavioral and other therapies) [9] Complementary Therapies (CTs) including acupuncture and herbal remedies (e.g., St John's Wort) have been used. These are reported to be associated with positive outcomes and may be more frequently used than other evidence-based treatments for depression [8, 10, 11]. A more recent systematic review of 49 registered clinical trials have suggested St. John's wort comparative effectiveness towards standard antidepressants for the treatment of depressive symptoms with less adverse events [11].

In patients with mild to moderate major depression, moderate quality evidence suggested the efficacy of St. John's wort towards placebo and its comparative effectiveness towards standard antidepressants for the treatment for depression severity and response rates, while St. John's wort caused significant less adverse events. In patients with recurrent major depression, moderate quality evidence showed that mindfulness-based cognitive therapy was superior to standard antidepressant drug treatment for the prevention of depression relapse. Other CAM evidence was considered as having low or very low quality.

In this study we used the National Integrative and Complementary Medicine (NICM) definitions which were derived from the Cochrane Collaboration [11]:

"*Broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. Complementary medicine includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within complementary medicine and between the complementary medicine domain and that of the dominant system are not always sharp or fixed.*"

To treat depression, it is essential to understand what knowledge the population holds about the ailment, including recognition of the symptoms and where, or if they would seek help and treatment. Further research into preventative measures, self-help and complementary health treatment options are necessary. Notably, there are gaps in knowledge about MHL regarding CTs for depression in younger adults, in particular men. Therefore, we aimed to further explore depression related MHL in a convenience community sample, and to investigate the effects of current MH status and other sociodemographic features on MHL.

2. Materials and Methods

2.1 Study Design

Western Sydney University's Human Research Ethics Committee approved this observational analytical study (H11080, April 2015). Participants were recruited from a research database stablished 15 years ago [12] (The Women's Eating and Health Literacy (WEHL)) and by advertising in public spaces of the University and sporting groups in 2015. Participants of the WEHL study (aged over 18 years) were invited to enroll in the current project in 2015. The cohort of this study consisted of the community women and university students of all gender identities who responded to our advertisements. Surveys were distributed to those who were interested to participate. Surveys were completed online or by post and all the participants provided informed consent.

2.2 Depression: MHL Survey

Based on Jorm et al. [8] the following open-ended questions were asked about what participants believe is wrong with "John" who has depression (Appendix A): 1. What condition the participants believed the symptoms in the vignette presented?, 2. How could John best be helped by the treatment?, and 3. What group of people were essential to John's recovery? Participants then rated the helpfulness/harmfulness/no effects, outcomes, and CT effects for his problem.

2.3 Assessment Instruments

Depression and anxiety symptoms were assessed via Kessler-10 (K10) questionnaire with moderate reliability [13]. An average score to indicate positive mental health ranges from 10-15 [14]. Participant's physical and mental health [15] was measured via SF12 questionnaire which has a sound reliability and validity [16]. The scoring is from 0-100 (lowest to highest health level) with the mean and standard deviation score of 50±10 [15]. The reminder of our instruments were questionaries that collect information about the participants' personal views and experiences in using complementary therapies. The survey is not constructed with multiple responses. It measures the same construct and thus can't be subjected to psychometric testing such as internal consistency. This survey was adapted from a widely used survey instrument used to assess mental health literacy in Australian population by Jorm et al, [8, 17] who have demonstrated face validity over the course of numerous publications in mental health literacy and also in our previous publications in mental health survey [8, 12, 17-19].

2.4 Statistical Analysis

All analyses used IBM Statistical Package (SPSS 23) and the data was inspected for normality. Chi-square and T tests were employed, $p < 0.05$. Open-ended responses were collated and presented by frequency of response. Regard for treatments were assigned six different categories: very positive, positive, neutral, negative, and very negative. As missing data was low (<10%) no imputation was made.

3. Results

The response rates of the mailed surveys (n = 96) and emailed surveys (n = 125) to the previously established research database were 45.83% (n = 44) and 42.4% (n = 53), respectively. The total response rate was 43%. We received 59 surveys by advertising in the university and sport clubs; however, the response rate for this group is unknown, because we couldn't identify the exact number of people who have viewed the recruitment posters. Approximately, 76.3% (n = 156) of the returned surveys (n = 119) were fully completed. For the purposes of this study, we only included those participants who have responded to any question on CTs (n = 118) including the questions in Table 4.

As shown in Table 1 (participant features) the 118 survey respondents had moderate levels of psychological distress, and impaired quality of life. As shown in Table 2, the majority (70.3%) reported using at least one form of CTs 12-months prior to study participation. The most widely utilized CTs were vitamins. Favorable attitudes towards CTs and experiences of using them are reported in Table 2.

Table 1 Participant's demographic and health-related features (N = 118).

Variables	N (%)
Gender	
Female	99 (83.9)
Age (years)	
≤18	19 (16.1)
18-24	25 (21.2)
25-34	34 (28.8)
35-44	22 (18.6)
≥45	18 (15.3)
Marital status	
Single	41 (34.7)
Married	53 (44.9)
Living as married	14 (11.9)
Separated/divorced	9 (7.6)
Widowed	1 (0.8)
Occupation	
Employed fulltime	54 (45.8)
Part time	24 (20.3)
Home maker^	13 (11.0)
Student	9 (7.6)
Not employed	14 (11.7)
Mean (SD), Median, n	
Psychological distress (Kessler 10)	19.3 (7.5), 17.0, 115

Physical health-related quality of life (SF-12)	42.7 (7.4), 43.1, 96
Mental health-related quality of life (SF-12)	42.0 (6.1), 43.2, 96

Home maker: ^a person who is not employed or student, nor looking for a job, and who is attending house duties in their home; SD: Standard Deviation; Kessler 10 [14] components of SF12 including physical wellbeing and mental wellbeing [15].

Table 2 Personal use of complimentary therapies12-months prior to participation in the study (N = 118).

Variables	N (%)
Used CTs	
Yes	83 (70.3)
No	35 (29.7)
Most used CTs	
Vitamins	54 (45.8)
Relaxation	36 (30.5)
Minerals	29 (24.6)
Yoga	28 (23.7)
Personal experience with CTs	
Experienced good results	7 (5.9)
Improved general wellbeing	21 (17.7)
Other (relaxation, helps with depression, inexpensive options, increase in energy levels, improved sleep)	9 (7.8)
Depressive symptoms recognition	
Body image/Self Esteem issues	63 (53.4)
Depression	38 (32.2)
Other (post-natal depression, anorexia, bulimia, anxiety, mental health disorder, low mood)	16 (13.4)

For the purposes of this study, we only included participants who responded to any question on CTs including the questions in Table 4; CTs: Complimentary Therapies.

Most participants considered John was suffering from 'body image related lack of self-confidence'. Recognition of depressive symptoms was higher with age (≤34 vs. ≥35, $p < 0.001$); higher in females than males (37.7% vs. 5.3%, $p = 0.006$); was associated with the level of education ($p = 0.047$), but not related to mental health status of the participants (e.g., depression) (Table 3).

Table 3 Associations between depressive symptom recognition, demographic features, and mental health status (N = 118).

	Depression* (n, %)	Other disorders (n, %)	Chi-square	P	df
Age (years)			13.7	0.001	1
▪ ≤34	16, 21.0	60, 78.9			

▪ 35 & over	22, 55.0	18, 45.0			
Gender			7.7	0.006	1
▪ Male	1, 5.3	18, 94.7			
▪ Female	37, 37.7	61, 62.3			
Education			3.93	0.047	1
▪ Year 10, 12 and trade	4, 16.0	21, 84.0			
▪ University graduates	34, 36.96	58, 63.04			
	n, Mean (SD)	n, Mean (SD)	*t*	P	Cohen's d
Kessler 10	36, 17.7 (7.1)	78, 20.0 (7.7)	-1.54	0.126	7.51
SF 12					
▪ Physical health related QoL	23, 43.12 (3.7)	72, 42.7 (8.3)	0.258	0.797	7.46
▪ Mental health related QoL	23, 43.1 (5.9)	72, 41.6 (6.1)	1.04	0.300	6.06

*Number and percentage of the participants categorized by demographic features or mental health status (e.g., male participants who recognized the depressive symptoms etc.); SD: Standard Deviation; Kessler 10 [14]; Components of SF12 including physical wellbeing and mental wellbeing [15]; QoL: Quality of Life.

When a list of potential conditions that John may have suffered from was provided, 32.2% of the participants were able to correctly identify John's display of depressive symptoms. Table 4 presents beliefs about the helpfulness of treatments and the majority selected seeking social support in conjunction with counselling, visiting a psychiatrist and anti-depressant use. The most helpful CTs were physical activity, relaxation, regular meditation, and yoga. Just over 19% of the participants believed that John would recover based on the provided treatment but, indicated that relapse was likely (39%). Exercise was perceived as the most beneficial therapy for John's symptoms (96.6%) followed by acupuncture (42.4%) and St John's Wort (43.2%) (see Table 5).

Table 4 Beliefs about the most helpful person, treatment, and therapy for John.

	N = 118	%
Most helpful person		
Psychiatrist	31	26.3
Counsellor	26	22.0
GP or family doctor	25	21.2
Close friend	16	13.6
Psychologist	13	11.0
Other (family, phone counsellor, complementary medicine provider, doctor other than psychologist & social worker)	7	5.9
Most helpful treatment		
Antidepressants	90	76.3

Nutritional supplements	21	17.8
Others (sleeping pills, pain relievers)	5	4.2
Most helpful therapy		
Physical activity	114	96.6
Relaxation	110	93.2
Meditation	99	83.9
Yoga	98	83.1
Creative therapy	86	72.9
Tai Chi	77	65.3
Vitamins/minerals	76	64.4
Regular massages	72	61.0
Most unrecognized treatment		
Chelation	97	82.2
Alexander technique	86	72.9
biofeedback	80	67.8
St John's Wort	51	43.2
acupuncture	38	32.2
Most harmful therapy		
Homeopathy	14	11.9
Magnet Therapy	8	6.8
Hypnotherapy	7	5.9
Herbal Chinese medicine	5	4.9
Most unharmful therapy		
Acupuncture	40	33.9
Regular massages	28	23.7
Shiatsu	21	17.8
Pet therapy	14	11.9
Creative therapy	9	7.6
Yoga	8	6.8

Table 5 Beliefs about the likely outcome usefulness of exercise, acupuncture, and St John's Wort in treating John's condition.

	N = 118	%
Results if John was treated		
Full recovery, no further problems	23	19.5
Full recovery, problems will reoccur	46	39.0
Partial recovery	23	19.5
Partial recovery, problems will reoccur	26	22.0
Results if John was not treated		
Full recovery, problems will reoccur	3	2.5
Partial recovery	4	3.4
Partial recovery, problems will reoccur	15	12.7
No improvement	22	18.6

Get worse	74	62.7
Exercise usefulness		
Yes	114	96.6
No	3	2.5
Acupuncture usefulness		
Yes	50	42.4
No	67	56.8
St John's Wort usefulness		
Yes	51	43.2
No	65	55.1

4. Limitations

Limitations of this study include the use of self-reported surveys which may be prone to reporting and recall biases. The cohort of this study consisted of a combination of general population sample [20, 21] that was representative of young woman living in the Australian Capital Territory, and a convenience sample of higher education university and college students. The population was broadly representative of young woman with at least a high school education in Australia [12, 22], and the campuses surveyed were from diverse socio-economic background. Although there is a very high proportion (56%) of the Australian population who engage in higher education [23] this sample was not representative of the wider Australian population and the results may not be generalizable to men, more senior and asymptomatic people. The findings can be used to inform future studies to examine in greater depth issues concerning MH, for example differences in gender, age, and education. Such groups may be imported to target in interventions aimed to improve MHL in the future.

5. Discussion

In this study of moderately symptomatic participants there was a low level of MHL when participants were asked to identify the condition John was suffering. This finding is consistent with Burns and Cotton [3, 24]. However, when the participants were presented with a list of possible conditions, recognition of depressive symptoms was higher. We observed increases in symptom recognition when advised the possible diagnosis. This demonstrates a moderate understanding of the symptoms. Older and more educated females had a better recognition of the depressive symptoms.

Overall, the participants had a good knowledge of how to treat and manage depressive symptoms, electing a range of clinical practitioners along with a strong personal support network comprising of family and friends. Participants were aware of the importance of treatment for full or partial recovery, for symptom management and recognition. Attitudes towards antidepressants were also more favorable that previously reported [25].

This may be due to differences in sample demographics, our sample being a relatively young, predominately female, and symptomatic community sample. In this study males aged ≤34 had the lowest recognition of depressive symptoms which is consistent with Cotton et al. [3]. However, the current evidence is insufficient to support or contest the efficacy of antidepressant medication for

mild depression mainly due to increased adverse effects and added or combination of antidepressants to manage the adverse effects [26].

Over half of the surveyed participants had used CT therapies in the 12 months prior to the study. Use included vitamins/minerals, relaxation techniques, yoga, and massage which is consistent with previous studies [26]. Participants believed that using CTs positively improved their symptoms by reducing the stress levels, increasing relaxation, relieving chronic pains, and other health conditions. Exercise, relaxation, meditation, and yoga were perceived the most helpful forms of CTs. The high regard for exercise is supported by evidence based studies for the treatment of depression [27]. However, less extensive evidence supports positive effects of relaxation, meditation [28], and acupuncture in treating depression [29].

The top three types of therapies regarded as harmful by our cohort were homeopathy, magnet therapy and hypnotherapy are in accord with the limited and mixed evidence reported for these approaches [30-32]. In contrast, acupuncture and St John Wort were rated more highly and had a greater evidence base [33-35]. Similarly, the use of self-help strategies offer many benefits to the user [36].

6. Conclusion

Identification of depression was found to be low suggesting a need for greater education to enhance the ability of young adults to recognize the symptoms of a mental health issue. The use of CTs is growing, yet people may be unaware of their potential benefits. On the other hand, the results indicate people would access an appropriate professional clinician for help over a self-help or complementary practitioner.

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Author Contributions

PH & NF conceived of the presented idea and developed the theory. NF & LD performed the computations and verified the analytical methods. NF, PH and CS supervised the findings of this work. All authors discussed the results and contributed to the final manuscript.

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Competing Interests

PH receives sessional fees and lecture fees from the Australian Medical Council, Therapeutic Guidelines publication, and New South Wales Institute of Psychiatry and royalties from Hogrefe and Huber, McGraw Hill Education, and Blackwell Scientific Publications. She has received research grants from the NHMRC and ARC. She is the Chair of the National Eating Disorders Collaboration Steering Committee in Australia (2019-) and was Member of the ICD-11 Working Group for Eating Disorders (2012-2019) and was Chair Clinical Practice Guidelines Project Working Group (eating disorders) of RANZCP (2012-2015). She is a Consultant for Takeda (formerly Shire) Pharmaceuticals (July 2017-2020). All views in this paper are her own. CS declares as a medical research institute, NICM Health Research Institute receives research grants and donations from foundations, universities, government agencies and industry. Sponsors and donors provide untied and tied funding for work to advance the vision and mission of the Institute. NF, and LD have no conflict of interests.

Additional Material

The following additional material is uploaded at the page of this paper.

1. Appendix 1

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