Original Article

What Adolescent Girls Know about Mental Health: Findings from a Mental Health Literacy Survey from an Urban Slum Setting in India

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ABSTRACT

Background: Youth in vulnerable situations are known to have high rates of mental disorders but low help-seeking. Help-seeking is known to be influenced by mental health literacy (MHL), a key concept that is important for the recognition of mental disorders and planning intervention. **Aims:** To explore MHL and help-seeking patterns in a group of young women in an urban slum setting in India. **Materials and Methods:** A total of 337 young women between 16 and 19 years of age belonging to urban slum settings formed the study sample. Two vignettes on depression and self-harm were used to assess: (a) recognition of the disorder, (b) help-seeking, and (c) knowledge of treatments available. **Results:** Only 8% of women were able to label the condition as depression in the first vignette. Though suicidality was identified correctly by the majority of participants 73 (63%), they did not think it needed urgent intervention. Only a few considered mental health professionals as possible sources of help (19.3% for depression and 2.4% for self-harm). Majority of the young women felt friends and parents were sources of help, and that stigma and lack of awareness were the reasons for not considering professional help. **Conclusion:** MHL regarding depression and suicidality is low among young women from low-income areas. It is a critical and urgent need to encourage early and appropriate help-seeking for mental health problems in this vulnerable population.

Key words: *Adolescents, depression, help-seeking, mental health literacy, self-harm, women, youth*

INTRODUCTION

Mental health literacy (MHL) has been defined as the "knowledge and beliefs about mental disorders which helps in their recognition, management or prevention." It encompasses the knowledge about mental health which allows a person to take action to improve their own mental health or that of others.[1] MHL involves the recognition of mental disorders to facilitate prompt help-seeking; knowledge of professional help, treatments available, and effective

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self-help strategies; skills to give psychological first-aid to others; and knowledge of how mental disorders can be prevented.[2]

MHL is particularly important during adolescence and early adulthood which are considered as the peak period for the onset of mental disorders. Globally, the prevalence of mental illness in adolescents has been found to be high, ranging from 9.5% to 33%.[3-5] According to the National Comorbidity Survey Replication (NCS-R), half of all mental disorders start by 14 years and three-quarters by 24 years of age.[6] Studies from India have also shown high rates of mental health problems and suicidal behavior in the youth.[7,8]

Many young people do not seek help for mental health problems due to various personal and structural barriers such as stigma and concerns about confidentiality, lack of knowledge about the services, the notion that symptoms of psychological distress reflect only a temporary age crisis, and lack of appropriate responses from peers and adults.[2,9,10] Many of these barriers relate to limited MHL.

MHL of young people has been researched in several parts of the world.[2,11-15] However, there is limited data from low- and middle-income countries, including India. Such studies are needed to plan interventions to improve recognition, help-seeking, and prevention. A study on adults in rural India showed that mental illnesses were attributed to socio-economic factors.[16] It has been shown that poverty significantly impacts adolescent mental health.[17] Young women from deprived areas are particularly vulnerable because of a multitude of factors such as adversities associated with poverty, physical abuse, lesser access to education and job opportunities, sexual trafficking, and restriction of mobility.[18] Given the high rates of mental health disorders among young people and their unique vulnerabilities, there is a pressing need to study MHL in this age group.

The study was part of the Mental Health among Girls Growing Up – *MOGGU* (flower bud in Kannada) project. The project aimed to study mental health issues among young women between the ages of 16 and 19 years living in two urban slums of Bengaluru in India during 2011–2012. The current study aimed to investigate MHL in a sample of young women in urban low-income areas. We specifically sought to evaluate the different components of the concept of MHL relevant to two most common problems among youth, i.e., depression and self-harm. The three areas assessed were (a) recognition and labelling of the disorder, (b) ideas about help-seeking, and (c) knowledge of available treatments.

MATERIALS AND METHODS

The sample consisted of 337 young women between the ages of 16 and 19 years. To get representative samples of young women from lower socioeconomic strata, the participants were chosen from five different colleges which were in low-income areas of the city and enrolled young women from the neighbouring urban slums. Convenience sampling was used. Because there were no comparable Indian studies done on this topic, the sample size was calculated based on western studies.

Vignettes have been used in most studies as a reliable and easy way to assess MHL.[2,11,19] In this study, two vignettes depicting depression and self-harm in young women, with related questions, were pilot tested among ten young women for language, cultural and social relevance, and comprehensibility. These were then administered to 337 participants in their classrooms. On an average, 45 minutes were taken by the respondents to complete.

Vignette 1 – Depression
Ramya, a 16-year-old girl, has just completed her 10th standard and joined a Pre-University College. Her parents have noticed that she looks dull, sits alone most of the time, and has also been found weeping. She has been refusing to eat and answered in monosyllables if her parents ask her anything. She has started missing college a lot, saying that she is not feeling well. Her marks in the exams have also dropped significantly. One day she tried slashing her wrist with a blade, and her mother stopped her just in time.

Vignette 2 – Self-harm and suicidality
Thajunesa is a 19-year-old girl who lives with her parents and her three brothers. Her parents did not allow her to continue her studies after 10th grade. She was asked to do all the household chores. Her mother worked as a domestic help and took Thajunesa along to help her. She would often get scolded by her mother as well as her employers for not working efficiently. She had two friends she spoke to when she had time and with whom she shared her distress, however, her mother often did not allow her to go out or meet them. One day after a severe scolding for coming home late, Thajunesa felt that nobody cared for her or understood her. She texted her friend on the mobile phone saying that life was not worth living and that she was planning to end her life.

Questions assessing mental health literacy
(a) Recognition of the disorder, (b) ideas about help-seeking, and (c) knowledge of available treatments.

Open-ended questions were asked at the end of each vignette and included the following:
a. Identifying and recognising the disorder: "*What do you think is happening to Ramya/Thajunesa?,*" "*Does this problem have a name,*" "*Have you heard about anybody*

else who has experienced these kinds of difficulties?," "Have you heard of depression?," and "Have you known anyone who had harmed themselves?"

b. Emotional awareness and identification of emotions: *"What are the emotions the young woman in the vignette might be going through?"*

c. Help-seeking and dealing with the problem: *"Whom do you think the young woman should approach to seek help?" and "What would you have advised her to do, if she was your friend?"*

d. Knowledge of treatment: *"Do you think she should approach a health professional? If yes, who?" and "What kind of treatments do they offer?"*

e. Knowing someone who had such a problem: Questions were open-ended and aimed at understanding the participant's awareness of the disorders, awareness of treatment options available, and willingness to seek treatment for the same.

In addition to the questions with the vignettes, to specifically understand attitudes and barriers towards help-seeking from mental health professionals (MHPs), ten questions were asked at the end of the session, some of which were forced-choice or multiple choice questions (attached at the end of this article). The questions were related to awareness about treatment options available for mental disorders, views regarding benefits/disadvantages of taking treatment from an MHP, and their reasons for seeking/not seeking help from MHPs if they faced similar problems in the future.

Sociodemographic data included details of education, family income, family occupation, religion, marital status, years of marriage, and number of children. Written informed consent was obtained from the participants and guardians including assent wherever the respondent was less than 18 years of age.

The study was approved by the Institutional Ethics Committee of the National Institute of Mental Health and Neurosciences, Bengaluru.

Analysis
As the responses to the vignettes were descriptive, they were read and re-reviewed by three independent raters and coded thematically for quantitative analysis. Coded data were then entered and analyzed using Statistical Package for Social Sciences version 22. The responses for the vignettes on depression and suicidal ideation and the ten additional questions on help-seeking from MHPs were analyzed.

RESULTS

Sociodemographic details of respondents
The mean age of the respondents was 18.2 ± 0.9 years. All the participants were from a lower socioeconomic

background and lived in the urban slums. Two hundred and fifty-eight (76.6%) of the participants lived in a nuclear family setting. The average family size was 5.3 ± 2.8. Among parents, most mothers 178 (53.0%) were unemployed. The fathers of most of these girls were employed as casual laborers and skilled workers on a daily wage basis. Eleven (3.0%) of the participants were married and 6 (1.8%) had children.

Identifying and recognizing the disorder
Depression
When asked to name the problem in the depression vignette, 87 (48.6%) respondents used the term *distress* while 63 (29.0%) used the word *loneliness*. Only 6 (7.8%) used the term "depression" (*khinathe* in Kannada). Other significant responses included fear, lack of concentration, and being mentally disturbed.

Self-harm
"Distress" was used by 65 (29.0%) and "loneliness" by 68 (74.0%) girls as the primary emotion in the vignette on suicidal ideation. Seventy-three (63.0%) were able to identify feeling suicidal as one of their three responses. However, only 41 (14.6%) identified it as their first response. It was labelled as sadness by 35 (21.7%). Other responses were anger, fear, feeling stressed out, feeling hurt, helplessness, inability to adjust or express oneself, and being mentally disturbed.

Sources of help
Friends and peers were considered as the main possible source of help [109 (32.3%) for depression; 191 (56.7%) for suicidality], followed by parents, teachers, and doctors. Other sources of help reported were relatives, women's organizations, police and legal help, self-help, neighbors, and personality development classes. A much smaller number of respondents considered approaching MHPs: 65 (19.3%) for depression and 8 (2.4%) for self-harm [Table 1].

Identifying the seriousness of the problem
In the vignette on suicidality, the participants were asked *"what would you have advised the person to do in this situation, if she was your friend."* Not many were

Table 1: Sources of help if faced with a mental health problem (*n*=337)

Sources of help	Depression *n* (percentage)	Self-harm *n* (percentage)
Friends	109 (32.3)	191 (56.7)
Parents	67 (19.9)	49 (14.5)
Teachers	19 (5.6)	1 (0.3)
Doctors	41 (12.2)	3 (0.9)
MHPs	65 (19.3)	8 (2.4)
Others (neighbours, women's organisations, police, relatives)	36 (10.7)	85 (25.2)

MHP – Mental Health Practitioner

able to identify the severity of the situation. One hundred and sixty-eight (56.0%) responded that the friend in the vignette needed "*individual development.*" Seventy-nine (26.0%) felt that the friend should seek help from friends. A few others 7 (2.3%) felt that the friend should share her problems with others. Interestingly, only 9 (3.0%) participants reported that they would advise her to consult a doctor. The other responses were lodging a police complaint (for suicidality) and using meditation to help.

Knowing someone with the disorder and its relationship to labelling or help-seeking

For both the vignettes, the participants were able to identify others in their lives with similar problems. One hundred and fifty-one (48.0%) reported knowing someone with depression and 154 (50.0%) reported knowing someone who had tried to harm themselves. There was no difference in the labelling of depression by women who reported knowing or not knowing someone with depression (P = 0.925). More respondents who knew someone with depression said that they would seek help from an MHP [38 (27.0%) vs 27 (18.0%), P = 0.052]. There was no difference in the labelling of self-harm by women who reported knowing someone who had harmed themselves and not knowing someone who had done so [30 (22.0%) vs 41 (31.5%), P = 0.375]. There was also no significant difference in terms of help-seeking from an MHP for those who knew someone with self-harm and those who did not know anyone.

Advice on dealing with the problem

In both the vignettes, individual development emerged as the single most important component that the participants felt would help the girls deal with their problems. Responses such as "being brave," "thinking positive," "being confident and strong," "adjusting to the situation," and "increasing social behaviors" were clubbed under the broad rubric of individual development. A substantial majority of respondents [222 (73.5%) in the depression vignette and 168 (55.8%) in the suicidal ideation vignette] felt that individual development will help deal with the problem. Seeking help was considered essential by 79 (26.2%) respondents in the suicidal ideation vignette. Only 26 (8.6%) participants for the depression vignette identified consulting doctors as a method of dealing with the problem.

Response to forced choice questions on mental health literacy

Reaching a mental health professional

Eighty (46%) participants reported that they knew how to reach a MHP. Of those who said they knew how to reach a professional, 66 (19.6%) said they knew agencies that could help with suicide prevention. In response to a forced-choice question as to whether she should approach

a MHP, 51% of participants in the depression vignette and 28% of respondents from the suicidality vignette answered in the affirmative. Of these, the majority answered that she should consult a Psychiatrist [Table 2].

Awareness of benefits of help-seeking from mental health professionals

One hundred and five (33.0%) of the participants said they knew someone who had sought professional help for similar difficulties and only half of these reported that the treatment benefitted in any way.

Talking and counselling were mentioned by majority 239 (75.6%) as a form of treatment and only a few 12 (3.8%) mentioned medication. While 14 (4.4%) mentioned hypnotherapy, 51 (16.1%) said they did not know the nature of treatment(s) that MHPs offered.

Seeking help for self if faced with a mental health problem

Almost all the girls said that they would not consider seeking help from MHPs for various reasons. Stigma (21.2%) was cited as a major reason by a majority of the respondents, followed by lack of information, fear, financial constraints, lack of belief in MHPs, misconceptions, and lack of proximity to a mental health clinic [Table 3].

Table 2: Do you think she should approach a health professional? If yes, whom? (*n*=337)

Disorders	Depression	Suicidal ideation
Yes *n* (percentage)	172 (51)	95 (28.2)
Personnel *n* (percentage)		
Psychiatrist	71 (21.1)	41 (12.2)
Mental health professionals	36 (10.7)	13 (3.8)
Doctors	18 (5.3)	6 (1.8)
Counselors	1 (0.3)	2 (0.6)
Women's organisations	0 (0)	1 (0.3)
Don't know	1 (0.3)	1 (0.3)
Did not answer	45 (13.3)	31 (9.2)

Table 3: Reason for not consulting a mental health professional for self if faced with a similar problem (*n*=337)

Reason	Frequency *n* (percentage)
No belief in MHPs	18 (5.3)
Lack of information/awareness	60 (17.8)
Stigma	71 (21.1)
Family will not approve	9 (2.7)
Undermining the seriousness of the problem	6 (1.8)
Financial problems	54 (16)
Fear	45 (13.3)
Not wanting to be on medications	3 (0.9)
Misconceptions	9 (2.7)
Accessibility of mental health services	3 (0.9)
Don't know	59 (17.5)

MHP – Mental Health Practitioner

DISCUSSION

This study aimed to assess MHL in a population of young women aged 16–19 years living in a low-income area. Epidemiological studies have shown that almost half of mental health problems start by 14 years of age.[6] In India, the prevalence of mental health disorders among adolescents and children has been found to be 1.81–35.6%.[20-23] World over, despite the high prevalence of mental health problems, it has been found that young people are reluctant to seek help.[9] It is well known that recognition and identification of mental health problems are associated with help-seeking.[24] Previous studies have identified that low health literacy constitutes a major barrier to taking treatment.[25,26] This study conducted among young women from low-income areas also found low levels of MHL, indicating the need to enhance the same among youth, particularly in low-income settings.

This study has yielded three important insights to MHL in this group: (1) being unable to identify and label the problem as a psychological or psychiatric condition, (2) sources of help for mental health problems being mainly friends and parents, and (3) inadequate knowledge about mental health services and treatments.

Labelling the mental health problem correctly
Overall, the results reveal a poor level of awareness regarding mental health problems and available help. In studies done worldwide, only half of the surveyed sample of adolescents were able to correctly label the problem in the case vignette as depression.[2,12,13,19,27] However, in our study, the ability to label depression correctly was extremely low (7.8%), though they could give the underlying emotion labels such as distress. The use of labels such as feeling "hurt," "lonely," and "lack of self-confidence" in the depression vignettes probably indicates that the responses were not recognized as pathological. Wright *et al.*[14] noted, among 2,802 Australian young people, that being able to identify disorders by name increased help-seeking tendency, while using labels such as "stress," "paranoid," and "shy" limited the help-seeking ability. Labelling has implications for seeking treatment, and the use of inaccurate labels has been found to reflect less intention to seek help.[14] Interestingly, in our study, knowing someone with depression or self-harm did not increase the respondents' chances of labelling the disorder correctly. However, the fairly higher tendency to label self-harm correctly (63.0%) could have been due to the dramatic and obvious nature of the symptom involved.

Sources of help
Very few considered MHPs as possible sources of help for the problems faced by girls in the vignettes (19.3% for depression and 2.4% for self-harm)—stigma, poor access to mental health services, and lack of awareness about the nature of treatments offered being the most common reasons. Although knowing someone with depression slightly increased the chances of participants' seeking help from an MHP, knowing someone with self-harm did not make a difference.

Most of the participants felt that MHPs treat these conditions by talking and counselling (75.6%), whereas only 3.8% acknowledged that MHPs use medications. This is also reflected in a few studies from the developed world, in which though 40–57% of the sampled youth felt that antidepressants are helpful, preferring counselling to medications seems to be universal.[12] In a telephonic survey done by Yap *et al.*,[11] it is interesting to note that while most of the respondents recognized the requirement for professional help for posttraumatic stress disorder, social phobia, psychosis, and suicidal thoughts, they considered self-help strategies for depression.

In our study, friends, parents, and teachers were identified by most people as sources of help. Across studies, it has been found that young people prefer turning to friends or family members when faced with problems.[28] Marcell and Halpern–Felsher indicated in their work with adolescents that help for risk behaviors (smoking/drug use) or mental health issues (depression) is primarily sought from friends or other significant adults in their life and that health care professionals are approached only for physical-health-related issues.[29] It appears that young women seem to consider doctors and mental health professionals as less possible sources of help than parents or friends and are more likely to turn to a peer or parents in case of a crisis.

In both the vignettes, a significant majority of respondents stressed on "individual development" as a method of coping. Individual development included responses that advised for the inculcation of certain qualities such as confidence, courage, and increasing prosocial behaviors. Majority of young people who meet the diagnostic criteria for a mental disorder do not seek professional help.[30,31] In such a scenario, self-help strategies assume importance and have been shown to be of benefit in milder forms of depression and anxiety.[32,33] Planning interventions targeting the use of self-help strategies for milder forms of psychological distress and depression, and guidance on when and how to seek help from professionals, using innovative and youth-friendly methods, are important. A few studies have also looked at the impact of specific targeted interventions to increase MHL, such as school mental health programmes, entertainment and education through comics, etc.[34,35]

In India, gender disadvantage coupled with poverty constitutes a major risk factor for mental disorders in women.[36] Women in adolescence and young adulthood are especially vulnerable. Gender discrimination, living in an unsafe neighbourhood, and associated physical or verbal abuse were associated with a higher likelihood of having a mental disorder.[21] According to a nationally representative mortality survey done in India, 56% of suicide deaths in women occurred between 15 and 29 years of age.[37] Girls included in our study constituted a group that is very vulnerable and at risk for developing mental disorders because of factors such as low literacy among parents, gender disadvantage, physical abuse, and lower access to education and employment. In spite of and perhaps because of this, they seem to have very limited knowledge of mental health problems and help-seeking. Thus, interventions aiming at increasing MHL, especially in vulnerable populations such as young women, are direly needed. The interventions could take the form of simple story books, self-help books, skits, street plays, or films which might appeal to this younger population with low literacy levels.

This study has several strengths. There are very few reports on MHL in India, especially among vulnerable populations such as young women and related to depression and self-harm, which are the most common problems in this age group. Instead of using a questionnaire method, which might result in forced choice responses, most of our data was gathered by open-ended questions which decreased bias in responding. However, the major limitation is related to generalizability of our findings and the lack of a comparison group. A study conducted among a group of young women from low-income urban slum areas in one city may not be entirely representative of other low-resource settings such as rural areas or other disadvantaged groups of young women. Earlier studies have noted that, because of their higher intuitive abilities and better recognition of others' emotional states, girls would be more likely to label and identify mental health problems correctly.[12] It is possible that including young men from the same group would be able to highlight important differences. Women from low-income groups are raised in a different sociocultural milieu and have less access to the internet and easy information than women in middle-high income groups, and because of this chasm, findings are likely to reflect low MHL. Literacy regarding psychosis and substance use was not assessed. Further, assessing MHL through vignettes and scenarios about common mental health problems does not amount to actual know-how regarding real-life problems.

Implications and contribution

In conclusion, MHL is quite low among young women aged 16–19 years belonging to low-income areas in Bengaluru. Interventions that increase awareness about mental health need to be planned for this vulnerable group to ensure timely help-seeking and prevent morbidity due to untreated disease and mortality due to suicide. Randomized and controlled studies focussing on the efficacy of such interventions in this age group are also needed.

Conflicts of interest

There are no conflicts of interest.

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