

## **Australian University Students' Perceptions of Mental Illness: A Qualitative Study**

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### **Abstract**

*Depression and anxiety are common experiences for young adults in Australia (Yap & Jorm, 2011; Jorm, 2012). Social factors resulting from stigmatising social discourses, including that promulgated through the media are major contributors to mental health issues in this age group (Wright, Jorm & Mackinnon, 2011; Yap & Jorm, 2011). However, there is limited qualitative research in this area. This qualitative study used interviews to investigate the social perceptions of depression and anxiety among young Australians. Participants (n=10) were university students aged between 19 and 24 years. The findings have demonstrated confusion around diagnostic labelling, concepts of mental health issues, and the power of the media as both productive and counter-productive in its portrayal of mental health and illness. On the basis of these findings we propose that positive and pragmatic psycho-education programs should be implemented at a younger age, in order to normalise experiences of depression and anxiety earlier in life. This could possibly counter the stigmatising discourses that young people experience. These findings can be used to inform health policy for the prevention of mental health issues and mental illness in Australia. In keeping with the Commonwealth of Australia (2013) recommendations, terms of 'mental health issues' and 'mental illness' are adopted throughout this work.*

### **Keywords**

mental health, Australian young adults, depression, anxiety, mental health issues, mental illness, social perception.

### **Background**

Mental health issues and emerging mental illness continue to present as significant areas of concern for young Australian adults, with onset often in mid-adolescence to early adulthood (Reavley, McCann, & Jorm, 2012; Yap, Reavley, & Jorm, 2012). This cohort has the highest rate of mental health issues for all age groups, with 26% of young people experiencing a diagnosable condition (ABS, 2009). Clinical depression and anxiety-related conditions are common for university students under academic stress, between the ages of 18 and 24 years (Adkins, Wang, Dupre, van den Oord & Elder, 2009; Yap & Jorm, 2011). Yet, stigma has been identified as a key factor preventing young people from seeking help in relation to their mental health (Jorm, 2012; Gulliver, Griffiths, & Christensen, 2010; Rickwood, Deane, & Wilson, 2007).

The literature on stigma has developed conceptually since Goffman's (1963) seminal work to include not only notions of difference, but also experiences of devalued identity through the processes of labelling, stereotyping, and discrimination (Yardley, 2008). Goffman's (1963) work conceptualised stigma to be social phenomenon in which a personal trait or attribute is considered an undesirable deviation from the norm. Therefore, the stigmatised individual is overtly distinguished from other members of their culture. Stigma has been viewed as detrimental for mental health, further compounding a person's distress and impacting negatively on help-seeking behaviours. This is related to the embarrassment or fear of judgment that can arise from the lived experience of mental health issues (Gulliver et. al, 2010). Further, recent qualitative findings reported that mental health issues and mental illness are particularly difficult to emphasise with because the experience is coupled with social stigma (Martinez-Hernaez, DiGiacomo, Carceller-Maicas, Correa-Urquiza, & Martorell-Poveda, 2014).

Stigma arises from multiple sources including family and friends, from interactions with health professionals and media (Gulliver et al., 2010). Fear of stigma from health professionals was acknowledged in previous studies with individuals fearing that they will be 'judged' or 'not taken seriously' (Rickwood et al., 2007). This may offer an explanation for the findings of a study which suggested that young people experiencing mental health issues / mental illness have a preference for self-reliance as part of their intervention outcomes (Gulliver et al., 2010), possibly as a result of their experiences of and knowledge of stigma. Such findings were further supported by literature suggesting that non-professional services and sources of support for mental health concerns have become increasingly popular amongst young people, especially with the rise of mobile technologies allowing health information to become more readily available (Proudfoot, Clarke, Birch, Whitton & Parker, 2013).

The growth of internet use may also have stigma-related implications for young people in their search for health services pertaining to mental health concerns (Burns, Durkin & Nicholas, 2009; Proudfoot et al., 2013). Recent studies presented mixed findings pertaining to 'self-guided' mental health interventions through various technological sources. Evidence supporting the use of self-directed mental health intervention is currently limited, despite the perceived notion that such interventions are increasingly relevant for young people (Lillevoll, Vangberg, Griffiths, Waterloo, & Eisemann, 2014).

The rise of 'app' technologies on mobile phone and tablets has triggered increased research into the importance and efficacy of publically accessible mental health care (Giota & Kleftharas, 2014). Potential risks include the lack of an evidence base in the design of many self-guided help programs, complications with the interplay of privacy issues, the nature of the clinical experience of mental health concerns (i.e., the participant's anxieties around public access of personal information and ethical considerations regarding non-professional health care access). For young people, such conflicts need to be closely examined with the increased use of e-health in the contemporary landscape (Jorm, Morgan, & Malhi, 2013).

Stigma reduction strategies in Australia have previously included mental health awareness campaigns and programs such as Mental Health First Aid, with an aim to improve understanding, or literacy of mental health within the broader community (Jorm, 2012; Jorm et al., 2006). Adequate mental health literacy could reduce stigma by increasing individuals' understanding of the reality of mental health concerns. There is some evidence to suggest that current mental health literacy efforts are helpful in positively changing health seeking *attitudes*. However, the same cannot be affirmed for a change of health seeking *behaviour* (Gulliver, Griffiths, Christensen & Brewer, 2012). Mental health literacy is particularly important for

adolescents who, as mentioned above, are more likely to turn to their peers and family for support prior to seeking professional help (Jorm et al., 2006). Mental health literacy for adolescents will not only help the individual, but also help those peers that turn to them to help, thereby encouraging peer support amongst adolescents. Unfortunately, this group is amongst the least likely to develop mental health literacy through programs such as Mental Health First Aid (Jorm et al., 2006; Kitchener & Jorm, 2006).

Despite the significant amount of work undertaken to improve mental health literacy to fundamentally reduce stigma, there remains a paucity of qualitative research which considers the social perceptions of mental health within the population of young Australian university students (Jorm, 2012; Jorm et al., 2006; Martinez-Henraez et al., 2014; Yap et al., 2012). Yet, they remain in a high risk age range for emergence of mental health issues and illness, whilst experiencing ongoing pressure due to study requirements and continual performance assessment. With this in mind, this study sought young people's (18-24 year olds) perceptions of common mental health issues, predominately depression and anxiety, alongside possible experiences of stigma. The research focused on the opinions of those both with and without a mental health diagnosis. The research questions were:

- Question 1: What are the perceptions of university students regarding anxiety and depression?
- Question 2: How does stigma of mental health issues and mental illness impact upon the help-seeking behaviours of 18-24 year olds?

## **Methodology**

Ethical approval was granted by the Human Research Ethics Committee at the University of Sydney. Semi-structured interviews were used to enable the collection of rich data that could be translated into meaningful themes using a thematic coding process structured around an iterative, reflexive method (Srivastava & Hopwood, 2009). This method of analysis utilises an iterative process where data collection and analysis happen together allowing the data collection to develop in relation to the findings that emerge from the analysis. Srivastava and Hopwood (2009) noted that reflexive iteration involves "visiting and revisiting the data and connecting them with emerging insights, progressively leading to refined focus and understandings" (p.77). Initial interviews with set questions were undertaken with participants (see Appendix 1). The initial interviews were thematically analysed according to the research questions. As core themes developed from this analysis we modified our original questions (while keeping the core questions the same) in order to test the developing themes and drew out data to further our understanding.

### *Interview schedule*

The interviews were 30-40 minutes in length, audio recorded and later transcribed verbatim.

The semi-structured interview schedule contained three parts: 1) the participant's personal account of depression and anxiety such as; "tell me about your experience of mental health issues or mental illness", 2) questions about the participants' understanding of both stigma and mental health services such as; "what does stigma in relation to mental health issues and mental illness mean to you?", and 3) video elicitation questions aiming to stimulate opinions about health campaigns and messages of mental health and illness in society such as; "to what extent are these video representations accurate?". In this context, video elicitation refers to the presentation of a video clip as a stimulus for discussion within the interview setting (Henry &

Fetters, 2012). These video clips were sourced from mental health campaigns in both Australia and internationally, plus excerpts from film and television. The videos were selected for a range of reasons: 1) a Beyond Blue video about the social interactions of a person with depression; 2) a Headspace video dealing with anxiety, chosen as it was youth-focused; 3) a stigma video from a 'See Me' Scotland campaign, which added an international context and focused on the role of the media in relation to mental ill-health; 4) the *Unwell Song* by Matchbox 20 and a clip from the movie *Silver Linings Playbook*, selected as recent examples of media that are popular with young people, portraying the lived experiences of mental health issues and mental illness.

### Participants

Notice-board advertisements were posted across campuses at a metropolitan Australian university. Potential participants responded by telephoning or emailing the researcher where more information was provided. Ten participants agreed to participate in the study; a sample of this size is typically sufficient to enable rich saturation of themes (Whitehead & Annells, 2010). Participants provided written informed consent and interviews were conducted on the university campus or private outdoor settings. Consent to digitally audio record and transcribe the interview was given prior to each interview. Each participant was allocated a pseudonym. The age range of the target sample was 18-24 years. The upper age range for the sample was determined because 24 is usually the upper limit for Australian youth mental health services and strategies (e.g. Headspace). Participant demographic data are described in Table 1. The mean age of participants was 21 years and 2 months with a range of 19-24 years; four out of ten participants had directly experienced a state of mental ill-health at least once. Nine of the ten participants were female.

Table 1 Participant demographic data

Participant ID/ Code	Sex	Age	Highest Level of Education	Born in Australia?	Personal experience of mental ill-health?
June	F	22 years	Studying undergraduate	Yes	No
Sarah	F	24 years	Master's degree	Yes	No
Shauna	F	19 years	Studying undergraduate	N/A	Yes – Bi-polar disorder
Rebekah	F	21 years	Studying undergraduate	No	No
Lesley	F	22 years	Studying undergraduate	Yes	Yes- Bi-polar disorder
Diana	F	22 years	Studying undergraduate	Yes	Yes-Depression and Obsessive Compulsive Disorder
Belinda	F	19 years	Studying undergraduate	No	No
Laura	F	22 years	Studying undergraduate	N/A	No
Mary	F	20 years	Studying undergraduate	Yes	Yes- Depression and Generalised Anxiety Disorder
Alix	M	21 years	Studying Master's degree	Yes	No

N/A = No Answer.

NB. Names used are pseudonyms to ensure confidentiality of the participant.

### *Data analysis*

Data were analysed using a basic thematic analysis where each line of speech was given a code; these were brought together and developed into themes (Fram, 2013). This involved the creation of open codes forming the preliminary analysis, descriptive coding describing the words of the individual, axial coding which formed the descriptions into key ideas and finally selective coding comprising the core themes most relevant in answering our research questions.

### *Trustworthiness*

Trustworthiness was ensured through a number of processes as suggested by Krefting (1991).

The lead author had been professionally trained in appropriate interviewing techniques. Theoretical triangulation was promoted as the research team came from different occupational and theoretical backgrounds. We also engaged in a memo-ing process in which the lead researcher reflected and re-worked the themes emerging from different levels of coding. Member-checking was conducted with two randomly selected participants (one participant with and one without lived experience of mental health issues / mental illness) with 100% agreement on final themes.

## **Findings**

As the data collected did not significantly differ between those who were diagnosed with mental health issues or illness, and those who were not, the data from both sets of participants are presented together. The analysis of the data yielded four themes: mental health and social interactions; diagnostic labelling; understanding of mental health services available for the young adult population, and media representation of mental health for young adults.

### *Mental health and social interactions*

The majority of participants listed an intrinsic or personal value in relation to the term 'mentally healthy'. Words such as 'energy' 'confidence' 'happiness' and 'balance' were used interchangeably across interviews (June, Shauna, Rebekah, & Belinda). The idea that mental health is directly linked with rationality was also a reoccurring theme: *'It's like a balance...like an ability to see things rationally...you see more... have a wider vision...and understand everybody's different.'* Rebekah expressed the general idea that engaging in objective thought processes allows one to work towards optimal mental health. Hence, for Rebekah, it was the ability to think logically through a situation that equated to a mentally healthy state of mind. Another respondent argued that it was being 'in-tune' with oneself and one's surroundings, in addition to having an understanding of 'resilience' (Sarah). Another stated that, *'It's being able to put things in perspective... not acting on your emotions straight away...being able to have that distance to... rationalise things.'* (Laura).

Most participants linked the impact of mental health concerns with social aspects of their lives, particularly how they are perceived within peer-group settings. The concept of 'concealing' a mental health challenge in social situations was acknowledged by several respondents, for example: *'I don't think [the mental health issue] is because of... their friends... usually the friends don't even know much about the mental illness'* (Belinda). Alix illustrated this idea, *'I've had friends who have suffered from mental illness, and you wouldn't be able to tell...I think [for] fear of... not being able to disclose it to everybody ... because [they're] unsure of*

*what is going to happen.* For these respondents, their concerns about mental health were linked with notions surrounding identity, belonging and *'fitting in'* (Belinda; Alix). Hence the choice not to disclose in a peer group setting derived from an individual's aim to protect themselves from the fear of ostracism, by *'changing the face'* of their illness around others. This may offer an explanation to Belinda's comment that it is *'hard to help'* a friend as individuals may be able to mask their experiences of mental health changes.

### *Diagnostic labelling*

Participants expressed a sense of confusion surrounding diagnostic labelling of mental health issues and mental illness and held mixed opinions on the purpose of clinical diagnoses. June stated that, *'It [diagnosis] does create stigma, but it also helps people to deal with it.'* For this participant the diagnostic label was viewed as a pathway to change, yet at the same time it was a contributing factor towards self-stigma. All ten participants commented on the magnitude of the stigma associated with mental health, stating that they had either witnessed or experienced social stigma at some point as a result of diagnostic labelling.

Clinical diagnoses were conceptualised as *'depersonalising'* (Rebekah) *'confusing'* (Shauna; Lesley) and *'not helpful'* (Shauna). For those participants diagnosed with a mood disorder, such as bipolar disorder, they had *'transitioned'* through different diagnoses, first using the broad diagnostic categories of depression and anxiety to describe their experience. At the time of their first episode, they did not know what it was to experience a mood disorder, they merely felt *'depressed'* or *'anxious'* and were labelled as such, yet later learned this was incorrect. Shauna stated, *'It's confusing... I've been probably told five different ones [diagnoses]... at some point... it doesn't really help anymore'*. Furthermore, Lesley stated *'I thought it was just anxiety and depression.'* For these participants, their understanding of their mental health changed through the application of a new diagnosis. They suggested that being diagnosed with a mood disorder, rather than the more common depression or anxiety which they understood, further complicated the perplexity they felt about mental health and illness.

The less common a diagnosis, the more stigmatised and confusing it was for both those who were given the diagnosis and those around them. Participants viewed mental health as being on a *'spectrum'* (Lesley, Diana, Alix) based on social discourses about the severity or threat of the particular diagnosis: *'[There's] definitely a significant difference in terms of the level of awareness'* (Belinda). Depression and anxiety were noted as being somewhat less stigmatised and therefore easier to discuss amongst peers: *'It was a lot easier to tell my friends that I had depression because it's a lot more common and talked about'* (Lesley). At the other end of the spectrum, psychotic and mood disorders as labelled by the Diagnostic and Statistical Manual of Mental Disorders - 5 (DSM-5) (American Psychiatric Association, 2013) were not relatable to everyday life situations and hence were more likely to be subjected to social stigma. Diana commented: *'schizophrenia [and] bi-polar are [at one end of the spectrum] ... and anxiety's at the other end of the spectrum... coz everyone talks about it.'* Therefore, the relative frequency of social discourses around anxiety-related experiences normalised this diagnostic category and reduced stigma. At the other end of the spectrum however, negative social discourses surrounding psychotic conditions meant that psychosis was heavily stigmatised. June stated that the language surrounding these conditions was *'derogatory'*. When asked about the types of words that society uses to describe mental ill-health, the words *'crazy'* and *'out of control'* were cited more than once (Sarah, Shauna & Lesley), by participants both with and without a lived experience of mental health issues / mental illness.

Participants were confused about the classification of diagnostic categories related to mental illness. Perceptions of depression varied amongst the participants, from those who aligned it with psychosis, to those who related it to simply *'feeling down'* (Diana). Lesley reflected on depression as merely being a state of the *'mind slowing down significantly.'* Most participants commented on depression as being a concern when it occurred frequently as opposed to transient feelings of sadness. Sarah described depression as an issue when it *'perpetuates and keeps happening.'* Similarly, Laura suggested that it was, *'consistently feeling that way for a long time...like social withdrawal.'* Length of time that individuals had felt depressed and particularly loss of interest in socialising, were both seen as adequate measures for determining the difference between *'feeling down'* and *'clinical depression'*.

Anxiety-related disorders, such as social anxiety disorder and obsessive compulsive disorder, were more relatable concepts amongst the respondents. However, participants found anxiety disorders harder to conceptualise and define than depression and psychotic conditions. Of interest was that anxiety was a more relatable concept even for those participants who had not experienced it in a clinical sense, despite the fact that half of the participants (both diagnosed and undiagnosed) were unclear about how to fully describe the experience. Since young people have generally experienced the sensation of being anxious, nervous and apprehensive in their everyday lives, anxiety was harder to define in terms of it being an illness. Comments such as, *'the person might just be anxious because of uni'* (Alix) and, *'people get classed under having it when they're just having a tough time'* (Sarah), suggest that regular feelings of worry were conflated with clinical anxiety: *'It could be the regular 'run of the mill' feeling'* (Alix). Most participants depicted anxiety in terms of its physical presentation. Shauna stated, *'I'm not that experienced with it... I'm just assuming it's when [they] get kind of nervous... panic attacks, that kind of thing.'* Hence, anxiety was not understood as a concrete disorder when compared to depression or psychotic illnesses.

#### *Understanding of mental health services available for the young adult population.*

Understanding of the availability and reality of mental health services for young people varied greatly amongst participants. A stronger knowledge of services available to young people was evident in the accounts of those who had experienced mental health issues / illness themselves. One area of shared understanding amongst all respondents related to online services, with all participants speaking about these services as an emerging and important area for help-seeking. The national mental health youth service 'Headspace' was cited as a place for seeking help by 3 out of ten participants. Those who had used the service held generally positive views about the organisation of the service, with the exception of Mary who stated that the structure could be more *'personal'* with *'more frequent appointments.'* Of participants with a diagnosis of mental health issues / mental illness, all 4 stated that talking based therapies were vital to their recovery. A number of participants were not confident about accessing counselling services available at their university. One participant was not aware that these services even existed: *'I didn't even know we had counselling services around the university.'* (Sarah). This is a significant knowledge deficit since university life and peer groups were listed as being the two biggest areas that depression and anxiety tended to impact (6 out of 10 participants).

When asked about how current services for young people could be further developed, all respondents considered that education about positive mental health and potential mental health changes was vital. Alix stated, *'There isn't enough emphasis placed on [mental health awareness] through education.'* Respondents felt that more emphasis should have been given to mental health in the high school curriculum. It was suggested that increased education about

mental health would reduce stigma, since mental health would be able to be discussed more amongst peers, thus becoming a normative part of everyday discourse (June, Rebekah, Lesley & Alix).

When questioned about mental health services, stigmatisation from professionals providing the services had contributed to negative service experiences. This form of stigma was articulated as age-related discrimination: *'There's kind of that aspect to it where they just kind of think 'aw you're a kid, you're young...they don't really take you seriously'* (Shauna). A similar story was recollected by Laura about her friend receiving hospital services for depression: *'Every time we took her to hospital... we just kind of got looked at... they assumed drugs were involved... it was just because of our age and how we looked.'* Significantly, fear of negative responses from health professionals was mentioned within three of the 44 interviews with participants with a diagnosis of mental health issues / mental illness.

### *Media and mental health for young adults*

Two conflicting perspectives were presented about stigma as related to mental health and the media. The first perspective was that the media can and does contribute to stigma, thereby having negative effects on young peoples' mental health and help seeking behaviours. The interesting second was that the media, when used appropriately, can be a powerful tool for anti-stigma campaigns, thereby improving help-seeking behaviours and normalising mental health concerns. Showing the videos to participants elicited diverse reactions about the effectiveness of mental health campaigns. Essentially, participants had not connected with all of the mental health promotional campaigns. June stated: *'It's good to have a variety of tacks... [mental health campaigns are] not going to work well for everybody.'* Responding to the international campaign on stigma shown to participants, Lesley said the following: *'The use of... chatting online I think... was more interesting and realistic.'* Four of the participants preferred this video over those from the Australian health campaigns which participants were asked to watch. When analysing the differences between this video and the Australian campaigns, it appeared that it was the content related to social media that resonated most with the participants. The topic of social media was seen by participants as being relevant to the social lives of young people. Belinda commented:

*In terms of the relationship with the mental ill-health type of stuff... I think I get a lot of that from social media... especially websites like Tumblr...that's the main one for expressing...like depression... problems with their mental illness.*

As this suggests, public social media sites, such as Facebook and Tumblr, were specifically mentioned as being spaces where conflicting images of mental health were presented. They could therefore present stigmatised views about mental health and illness which could be detrimental for young people. Conversely this is what is also helpful about these sites as they can be outlets for the expression of feelings and experiences and for seeking help and support from peers. In terms of addressing this issue through public health campaigns one participant stated *'I think the government really is trying [to resonate with young Australians about their mental health] ...there's an effort... [but]... I don't know how much it's working'* (Laura).

## **Discussion**

### *Considerations for health professionals*

Participants' responses to diagnostic labelling and the appearance of a spectrum of perceptions of mental health issues and illness, highlight confusion about diagnostic categorisation. Given

this, the attribution of a diagnostic label may further contribute to stigma as the label is often accompanied with cultural stereotyping. Current research supports this finding, while also suggesting that a fear of diagnosis is a contributing barrier for adequate access to mental health for young people (Martinez-Hernaez et al., 2014). A diagnostic label essentially pockets the individual into a social 'category' which in turn stereotypes the person within wider society, reducing them to a category and the associated stereotyped perceptions (Link & Phelan, 2001; Wright et al., 2011). As these stigmatising views are very prevalent in society, this can result in self-stigma and impact help-seeking behaviours (Jorm et al., 2006). Hence, our research suggests a move towards intervening on an individual's daily experiences associated with mental health changes rather than by a 'diagnosis to potentially alleviate social stigma around the label itself.

Participants had greater mental health literacy about more commonly experienced mental health concerns. Psychosis was viewed as less '*normal*' than feeling down or anxious and, was therefore less understood amongst participants. This misunderstanding means that individuals are more likely to draw on stigmatised social messages as opposed to their own personal understandings (Yap et al., 2012).

Several participants highlighted stigma in the context of professional services. Participants who reflected on their experience with utilising health services described a perceived judgment towards young people by health professionals because of their age. The experience of '*not being taken seriously*' was noted in the current study and also in previous literature (Rickwood et al., 2007). For participants in this study, this undermined their trust in health professionals, thereby undermining their perceived value of the services they were receiving.

Fear of judgment from health professionals limits the individual's chance of attaining an effective and collaborative pathway towards change (Gulliver et al., 2010). The need for effective client centred care for this age group therefore necessitates increased education of health professionals to reduce stigmatisation of young people with regards to mental health. That is, health services should ultimately be reflective of hope and engagement between young adults and their peers and relevant health professionals. This will enhance help-seeking and subsequently, a young person's experience of collaborative recovery.

#### *Future implications for young adult mental health literacy*

It is essential that public health education resonate with young adults though maintaining relevance and practicality. Government efforts to promote positive mental health and challenge stigmas associated with mental illness, were acknowledged by several participants. Yet this study found that not all the mental health campaigns resonated with participants. Further research in mental health promotion should seek to decipher those aspects of the current health campaigns that are working well in different contexts. The use of social media within the international mental health campaign video utilised with participants in this study, was viewed as most positive in terms of inspiring participants to gain access to mental health services. The media appears to play a dual role in both contributing to and reducing stigma. Given increasing use of social media amongst this age group, these contradictions are a critical point for further research (Martins, 2004). As stated by Burns et al. (2009), increasing use of the internet has had a tremendous impact upon the way in which young adults relate to one another. Hence, integrating positive images of mental wellbeing within social media sites is an important strategy for promoting positive mental health, increasing awareness and access to mental health services.

For our participants, exposure to stigma led to a confused perception of the lived experiences of mental health issues / mental illness. Negative, stigmatised views also resulted from adverse experiences with mental health services, or limited access to psycho-education on at a younger age. These experiences made individuals more susceptible to the influence of negative, extrinsic factors where they were less likely to develop a sense of resilience and rationality. In support of previous findings (Gulliver et al., 2010), participants of the current study highlighted the importance of resilience and self-reliance as key indicators of positive mental health, general wellbeing and recovery from mental health changes.

Yap and Jorm (2011) outlined that the first course of action, or first aid strategy, for a young adult caring for their own mental health is to confide in their peers. Yet our research showed that there are many barriers to this. For our participants, decisions not to disclose related to a fear of ostracism and concerns that their friends would not be able to relate to what they were feeling. Greater mental health literacy among this group combined with more effective public education strategies (Reavley et al., 2012) are required to address this situation. The need for early identification among peer groups is consistent with our findings (Curtis, 2010). Our findings suggested that young adults may be struggling with ways to achieve dynamic discussion around mental health with their friends, thereby missing out a key part of the prevention process.

Based on our findings, the authors argue that mental health literacy should be integrated at an earlier and more pragmatic level to help young adults achieve a sense of optimal mental health by their early 20s. This would facilitate a culture of hope, rather than fear. Our participants stated that early intervention for mental health issues may be improved through increased school education promoting mental health literacy. We suggest that positive, sustained psycho-education at a high school-age level may help to ingrain practical approaches towards tackling mental health at a younger age, facilitating greater understanding of depression and anxiety by the time the individual reaches the critical age of young adulthood.

Another finding of this study was participants' confusion surrounding perceptions of the lived experiences of mental health concerns and illness. We found that a positive experience of effective service delivery and/or psycho-education can help the person overcome any negativity regarding extrinsic factors. That is, services aimed at improving overall mental health and wellbeing should be priority, over the alternative of focusing solely on mental health issues and illness in isolation (Gulliver et al., 2010). This idea is supported by the literature (Gulliver et al., 2010; Yap et al., 2012) where a proposed sense of strength in character; i.e. the development in positive intrinsic values, may then lead to the individual's sense of mental health, or the perception that mental health is an achievable reality. That is, at an institutional level, schools and universities should be at the forefront of mental health advocacy. Ideas include peer support programs, integration of mental health awareness (where feasible) into academic curriculum and increased access to and knowledge of wellbeing and counselling support services.

## **Limitations**

There are several limitations to this study. Nine of the ten participants were female and therefore there may be a gendered bias, however this reflects the noted gendered disparity where females are more likely to seek help (Adkins et al., 2009). Future large scale research should employ a purposive sampling strategy to include more male participants. The small number of participants in the study means that the findings cannot be generalised. However,

small qualitative studies do inform the wider literature and are useful as pilot exercises for the identification of issues to explore in future studies. Since the current study concerned a topic sensitive in nature, we cannot ignore the possibility that there was a social desirability bias. This refers to the phenomena where the participant highlights what they think the researcher wishes to hear to avoid judgment (Henderson, Evans-Lacko, Flach & Thornicroft, 2012).

## Conclusion

Based on the findings of this study, the authors recommend earlier and pragmatic psychoeducation within schools and universities to help to normalise common mental health issues such as depression and anxiety and to advocate for education around mood and psychotic disorders. Further development of mental health literacy programs, such as Mental Health First Aid is essential for young people to promote help-seeking behaviours and reduce stigmas. Mental health promotion campaigns using social media can be beneficial. Finally, the authors suggest that this study be replicated with a larger sample to test our findings. This could increase the evidence base for the development of appropriate services better targeted to alleviate the detrimental impact of stigma around mental health for young Australian adults.

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## **Appendix 1**

### **Interview Script for Study**

#### Personal memoirs:

- General demographic questions: age, sex, location, SES, highest level of education, born in Australia and ethnicity.
- Tell me a little bit about yourself and your experience with mental illness.
- Upon diagnosis, what steps did you take in order to seek help?
- Do you have any personal concerns regarding access to mental health services? What are your concerns?
- What does the word 'stigma' mean to you? How does this concept relate to mental illness in your perspective?
- What does the term 'mental health' mean to you? What does it mean to be mentally healthy?
- Do you feel that being clinically diagnosed as 'mentally ill' stigmatises you amongst your peers? Why/ why not?
- Could you personally recognise the symptoms of either a depressive or anxiety related illness? Could you list some notable experiences that an individual may have?
- What would you advise your friend to do if they confided in you about mental illness?
- To what extent do you believe the media portrayals of mental illness influence you personally? Do you think these portrayals are accurate/ fair?

#### General questions pertaining to stigma and access to services:

- How do you feel society perceives mental illness? Does your view differ depending on the illness itself? i.e. schizophrenia vs depression.
- Are mental health services stigmatised amongst your age group?
- What do you feel are the key concerns for a person with mental illness in the age bracket between 18-25 years? (in terms of career, social networks and family life)
- How would you suggest that health services could be improved for the youth population?

#### Video elicitation component:

- Depression and Anxiety campaign → Beyond Blue.
- Sarah vs the dreadbutterflies → Headspace.
- See me Scotland campaign.
- ➔ Question: Since all of these videos are aimed at the youth population (raising awareness on mental illness), which do you feel is more positive in regards to a) attracting your attention b) inspiring you to help yourself/ another? To what extent are these videos attempting to alleviate stigma, if at all?
- Unwell song.
- Silver-Linings playbook.
- ➔ Question: Since both of these videos are portraying the lived experiences of mental illness in everyday life, to what extent do you feel the videos are accurate in their representation? Is the protagonist relatable to real life experience in your perspective?

#### General questions on this segment:

- Which media portrayal held the most 'truth' in regards to the experience of mental illness in your opinion?

- What aspects of the chosen video made it positive in terms of its portrayal?