Mental health awareness among adult attendees of Armed Forces Hospital Southern Region family and community center

Abdulmajeed Saad Almusma¹, Abdulrahman Yahya Sharifi², Jaber Abdullah Alshahrani²

¹Department of Family Medicine, Armed Forces Hospital Southern Region, Abha, ²Department of Family Medicine, Armed Forces Hospital Southern Region, Saudi Arabia Aseer Region Khaim Mushayt, Saudi Arabia

Abstract

Aim of Study: To assess mental health literacy among Saudi adults attending the Ahad Rufaidah extension of Armed Forces Hospitals, Southern Region, 2017. Methodology: Following a cross-sectional descriptive study design, 400 adult Saudi attendants of the Armed Forces Hospitals, Southern Region – Ahad Rufaidah extension were included in this study. An anonymous interview validated questionnaire was utilized for data collection. It included variables related to participants’ personal characteristics, knowledge assessment, and attitude regarding mental illness. Results: More than half of participants (55.3%) had poor knowledge regarding mental health, while 44.8% had satisfactory knowledge. Only 3.6% of participants had a positive attitude toward mentally ill persons, 43% were indifferent toward them, while 53.4% had a negative attitude toward them. Participants’ attitudes toward mental health differed significantly according to their knowledge grades (P < 0.001), with the majority of those with positive attitudes having satisfactory knowledge (93.3%) and most of those who had negative attitudes had poor knowledge (66.8%). Participants’ knowledge grades differed significantly according to their gender, with more satisfactory knowledge grades among males than females (50.8% and 22.4% respectively, P < 0.001) and educational level, with more satisfactory knowledge grades among more educated participants (P = 0.002). Participants’ attitudes toward mentally ill persons differed significantly according to their gender (P = 0.013) and their educational level, with the highest percentage of positive attitude among university-educated participants (35.3%, P < 0.001). Conclusions: There is widespread mental health illiteracy among attendants in the Ahad Rufaidah extension of Armed Forces Hospitals, Southern Region. Their attitude toward mentally ill persons is rarely positive but largely negative or indifferent.

Keywords: Attitude, knowledge, mental health literacy

Introduction

According to the World Health Organization, mental health is defined as a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to her or his community.³

Almost 25% of the population worldwide suffers from mental illness, which is high prevalence need to be scoped. Mental health problems are one of the main causes of the overall disease burden worldwide.³

Mental health and behavioral problems (e.g., depression, anxiety, and drug use) are reported to be the primary drivers of disability

How to cite this article: Almusma AS, Sharifi AY, Alshahrani JA. Mental health awareness among adult attendees of Armed Forces Hospital Southern Region family and community center. J Family Med Prim Care 2020;9:5678-83.
worldwide, causing over 40 million years of disability in 20 to 29 year olds.[3]

A significant relationship between the levels of post-stroke depression and functional disability.[4] Maintaining good physical and mental health is important in the community to improve and facilitate the cycle of life in the way of getting more excellent relationship as well as increasing the number of producing people which result in a healthy society physically, mentally, and economically.

The awareness is increasing worldwide toward mental health. Lack of awareness may increase morbidity and mortality among affected persons. The role of the community in the prevention and care of the mentally ill is very important and unfortunately, still, there is no mental health program in many developing countries.[3]

“Mental health literacy” refers to an individuals’ knowledge and beliefs about mental disorders that aid their recognition, management, and prevention. Community attitude and beliefs play role in determining help-seeking, as well as ignorance and stigma, to prevent the affected people from seeking appropriate medical help. Mental health programs can be integrated into primary healthcare for treatment and rehabilitation of the mentally ill, but this cannot be achieved without an understanding of community attitude toward mental illness.[6]

This research explores adults’ mental health literacy, i.e., their attitude and beliefs toward causes, manifestations, treatment options, and barriers affecting people’s awareness in primary health care (PHC) for attaining better outcomes and making good life choices.

**Methodology**

The cross-sectional descriptive study was conducted on Armed Forces Hospitals, Southern Region [AFHSR] in Khamis Mushayt City, Aseer Region (under the auspices of the Medical Service Department of Ministry of Defense, KSA). This study was done at Ahad Rufaidah extension, which is Joint Commission International (JCI)-accredited, that provides the services of family medicine. The research was approved from the IRB center of Armed forces hospital on 8 November 2017.

The study population comprised all Saudi adults (aged above 18 years old) who are Less than 18 years old, non-Saudi, medical staff, or those with past or present history of mental disorder were excluded.

**Data collection tool**

An anonymous interview validated questionnaire was utilized for data collection. A modified version was developed by the World Psychiatric Association Program to reduce stigma and discrimination.[1]

**Scoring and grading of knowledge responses**

Correct responses were assigned a score of (1), while other responses were assigned a score of (0). Therefore, total scores for knowledge questions ranged from 0 to 18. Those who obtained total knowledge scores <50% (i.e., 0–8) were considered to have “poor” knowledge grade, while those who obtained ≥50% (i.e., 9 or more) were considered to have “satisfactory” knowledge grade.

**Scoring and grading of attitude responses**

Responding by “agree” to a positive attitude statement or responding by “disagree” to a negative attitude statement was assigned a score of (+1). Responding by “neutral” was assigned a score of (0). Responding by “disagree” to a positive attitude statement or responding by “agree” to a negative attitude statement was assigned a score of (-1). Therefore, participants’ total attitude scores ranged from -10 to +10. Those who obtained total attitude scores (>0) were considered to have “positive” attitude, while those who obtained (≤0) were considered to have “negative” attitude, and those who obtained an attitude score of (0) were considered to have an “indifferent” attitude.

**Ethical considerations**

- Armed forced Hospital had approval the conduction of the manuscript on November 8, 2017
- Informed consent was taken to fill the questionnaire after explaining that data will be kept confidential and will be used for research purposes only.

**Data management**

The Statistical Package for Social Sciences (SPSS version 22.0) was used for data entry and analysis. Descriptive statistics were computed in the form of frequency and percentage. Regarding analytic statistics, the Chi-square test was utilized to test the association and/or difference between categorical variables.

**Results**

Table 1 shows that 66.3% of participants were 30–50 years old, while 17% were <30 years old and 16.8% were >50 years old. Most participants were males (78.8%), married (91.8%), university-educated (67.3%), and living in Ahad Rufaidah City (82.3%).

Table 2 shows that, regarding manifestations of mental illness, 55.8% responded correctly regarding “eccentric behavior”, while 50.2% responded correctly regarding “nudity.” The least correctly responded manifestations were “self-neglected” (33.3%), “loss of interest in daily activities” (40.3%), and “insomnia” (42.5%).

Table 3 shows that, regarding the causes of mental illness, 49.3% responded correctly regarding “possession by evil spirits”, while 46.8% responded correctly regarding “drug or alcohol abuse.” The least correctly identified causes of mental illness were “poverty and family problems” (4.8%), “brain disease” (18.5%), and “genetic inheritance” (28.7%).
Table 4 shows that 53.5% of participants agreed that mentally ill persons are dangerous because of their violent behavior, while 45.8% of participants agreed that they are unwilling to share a room with any mentally ill person. On the other hand, 49.8% of participants disagreed that they can maintain friendships with mentally ill persons and 43% disagreed that mentally ill persons can be treated outside hospitals.

Figure 1 shows that 55.3% of participants had poor knowledge regarding mental health, while 44.8% had satisfactory knowledge.

Table 5 shows that participants’ attitudes toward mental health differed significantly according to their knowledge grades ($P < 0.001$), with the majority of those with positive attitudes having satisfactory knowledge (93.5%) and most of those who had negative attitudes had poor knowledge (66.8%).

Table 6 shows that participants’ knowledge grades differed significantly according to their gender, with more satisfactory knowledge grades among males than females (50.8% and 22.4%, respectively, $P < 0.001$). Moreover, participants’ knowledge grades differed significantly according to their educational level, with more satisfactory knowledge grades among more educated participants ($P = 0.002$). However, participants’ knowledge grades did not differ significantly according to their age group, marital status, or residence.

Table 7 shows that participants’ attitudes toward mentally ill persons differed significantly according to their gender ($P = 0.013$). Moreover, participants’ attitudes differed significantly according to their educational level, with the highest percentage of positive attitude among university-educated participants (35.3%, $P < 0.001$). However, participants’ attitudes did not differ significantly according to their age group, marital status, or residence.

**Discussion**

The term “Mental health literacy” was first used to describe knowledge and beliefs about mental disorders which aid their recognition, management, or prevention. It stresses the importance of being aware of mental health problems for the sake of prevention and early management by people close to them. It has been demonstrated that many people do not seek help or postpone help-seeking due to various personal and structural barriers such as fear of stigma and discrimination.
Almusma, et al.: Mental health awareness among adult attendees

The findings of this study showed that more than half of participants had poor knowledge regarding manifestations and causes of mental illness. The main knowledge gaps and misbeliefs among participants regarding manifestations of mental illness were being “self-neglected,” “loss of interest in daily activities,” and “insomnia.” On the other hand, the main knowledge gaps and misbeliefs expressed by participants’ responses regarding the causes of mental illness were “evil spirit” or “divine punishment,” “poverty and family problems,” “brain disease,” and “genetic inheritance.”

These findings are in accordance with those of several other studies. Sadik et al.[11] in Iraq, reported that 30% of the respondents were with a poor perception of mental illness. The study by Ganesh found a substantial proportion of the southern Indian community had poor knowledge regarding mental illness, especially regarding the causes of mental illness, and believed that mental illness could result from the punishment of God.[12]

It is to be noted that the misbeliefs of participants in the present study were almost equally expressed by all groups. However, more satisfactory knowledge grades were observed among males than females and also among more educated participants. However, participants’ knowledge grades did not differ significantly according to their age group, marital status, or residence.

Table 4: Participants’ attitude toward mental health persons

| Statements related to mentally ill person | Agree | Indifferent | Disagree |
|------------------------------------------|-------|-------------|----------|
| Can be treated outside hospital          | 101   | 127         | 172      |
| Tend to be mentally retarded             | 133   | 143         | 124      |
| Causes public nuisance                   | 133   | 126         | 141      |
| Can work normally                        | 136   | 141         | 123      |
| Dangerous because of violent behavior    | 214   | 83          | 103      |
| Afraid to have a conversation with him/her | 118  | 158         | 124      |
| Upset or disturbed about working on the same job with him/her | 109 | 170 | 121 |
| Can maintain friendship with him/her     | 121   | 80          | 199      |
| Unwilling to share a room with him/her   | 183   | 212         | 5        |
| Ashamed if someone knew that someone in my family is mentally ill | 60 | 214 | 126 |

Table 5: Participants’ knowledge grades according to their attitude

| Attitude | Poor | Satisfactory | P  |
|----------|------|--------------|----|
|          | No.  | %            | No. | % |
| Negative | 118  | 66.8         | 60  | 33.7 |
| Indifferent | 95   | 96.0         | 4   | 4.0 |
| Positive | 8    | 6.5          | 115 | 93.5 |

Table 6: Participants’ knowledge grades according to their personal characteristics

| Personal characteristics | Poor | Satisfactory | P  |
|-------------------------|------|--------------|----|
| Age groups              |      |              |    |
| <30 years               | 39   | 57.4         | 29  | 42.6 |
| 30-50 years             | 149  | 56.2         | 116 | 43.8 |
| >50 years               | 33   | 49.3         | 34  | 50.7 |
| Gender                  |      |              |    |
| Male                    | 155  | 49.2         | 160 | 50.8 |
| Female                  | 66   | 77.6         | 19  | 22.4 |
| Marital status          |      |              |    |
| Married                 | 199  | 54.2         | 168 | 45.8 |
| Single                  | 22   | 66.7         | 11  | 33.3 |
| Educational level       |      |              |    |
| Elementary              | 14   | 93.3         | 1   | 6.7 |
| Secondary               | 71   | 61.2         | 45  | 38.8 |
| University              | 136  | 50.6         | 133 | 49.4 |
| Residence               |      |              |    |
| Ahad Rufaidah           | 178  | 56.0         | 140 | 44.0 |
| Others                  | 43   | 52.4         | 39  | 47.6 |

These findings are in accordance with those of several other studies. Sadik et al.[11] in Iraq, reported that 30% of the respondents were with a poor perception of mental illness. The study by Ganesh found a substantial proportion of the southern Indian community had poor knowledge regarding mental illness, especially regarding the causes of mental illness, and believed that mental illness could result from the punishment of God.[12]
Table 7: Participants’ attitude grades according to their personal characteristics

| Personal characteristics | Negative | Indifferent | Positive | P |
|--------------------------|----------|-------------|----------|---|
|                          | No. %    | No. %       | No. %    |   |
| Age groups               |          |             |          |   |
| <30 years                | 38 55.9  | 14 20.6     | 16 23.5  |   |
| 30-50 years              | 118 44.5 | 66 24.9     | 81 30.6  | 0.115 |
| >50 years                | 22 32.8  | 19 28.4     | 26 38.8  |   |
| Gender                   |          |             |          |   |
| Male                     | 143 45.4 | 68 21.6     | 104 33.0 |   |
| Female                   | 35 41.2  | 31 36.5     | 19 22.4  | 0.013 |
| Marital status           |          |             |          |   |
| Married                  | 158 43.1 | 93 25.3     | 116 31.6 |   |
| Single                   | 20 60.6  | 6 18.2      | 7 21.2   | 0.150 |
| Educational level        |          |             |          |   |
| Elementary               | 9 60.0   | 3 20.0      | 3 20.0   |   |
| Secondary                | 75 64.7  | 16 13.8     | 25 21.6  | <0.001 |
| University               | 94 34.9  | 80 29.7     | 95 35.3  |   |
| Residence                |          |             |          |   |
| Ahad Rufaidah            | 142 44.7 | 83 26.1     | 93 29.1  |   |
| Others                   | 36 43.9  | 16 19.5     | 30 36.3  | 0.318 |

These findings are in agreement with those of several other studies. In southern India, Ganesh found that male subjects had better knowledge of all aspects of mental illness and Iraq reported no significant association with age regarding the community’s view of mental illness. This could be due to the tool used or sample characteristics as a rural and urban community are involved in both studies.

Educational level was found to be one of the sociodemographic characteristics significantly affecting the perception of mental illness in this study. Respondents who have no formal education are by 90% more likely to have poor perception when compared with degree holders and above. This finding is in agreement with the study done in Agaro town.

Adewuya and Makanjoula, in Nigeria also found out that perception of mental illness correlates with educational level. Less-educated respondents were more likely to attribute mental illnesses to supernatural retribution. This could be due to a poor understanding of scientific explanation regarding the causation of mental illness. Moreover, Issa et al. noted that higher education leads to greater openness about mental illness.

Benti et al. stated that education and social media are the major factors that move the perception of the community to the scientific perspectives. Similarly, Ganesh highlighted the important role of the mass media in informing and influencing community attitudes about mental health. They noted that any attempt to raise public awareness regarding mental illness and fight stigma should involve the media, in a carefully planned and studied manner.

Findings of the present study revealed a widespread negative, or indifferent attitude among participants toward mentally ill persons. Most respondents thought that mentally ill people cannot perform regular jobs, have no friends, dangerous, owing to their violent behavior. Almost half of the participants are unwilling to share a room with any mentally ill person, cannot maintain friendships with mentally ill persons, and did not agree that mentally ill persons can be treated outside hospitals and that will reflect on the family medicine physicians when they deal with mentally ill persons or their families.

These findings are following those of Wahl et al., who stated that the public usually holds negative attitudes about persons with mental illnesses, among them that such individuals are dangerous, unpredictable, unattractive, and unworthy and are unlikely to be productive members of their communities. Ganesh, in Southern India, found that more than half of the subjects revealed that they had fear of the mentally ill and only a few want to maintain a friendship with them.

These negative perceptions have been remarkably constant despite advances in scientific understanding of mental illnesses and extensive efforts to improve public understanding. This condition is perceived as frightening, shameful, and incurable, while the patients are characterized as dangerous, unpredictable, untrustworthy, unstable, lazy, weak, worthless, and/or helpless in the community.

Watson and Corrigan noted that people may be reluctant to seek treatment for or disclose mental health problems for fear of social rejection and discrimination, leading to treatment discontinuation.

Thiru and Yad stated that stigmatizing attitudes toward people with mental illness is common among all classes of people. They explained these attitudes by that expressed negative opinions toward consumers of mental health services are since most people are not literate regarding the biological and environmental factors that cause mental illnesses.

Conclusions

Based on the findings of this study, it can be concluded that there is widespread mental health illiteracy among the Saudi adult attendants in the Ahad Rufaidah extension of Armed Forces Hospitals, Southern Region. Regarding manifestations of mental illness, the least correctly responded were “self-neglected,” “loss of interest in daily activities,” and “insomnia.” The least correctly identified causes of mental illness were “poverty and family problems,” “brain disease,” and “genetic inheritance.” Their attitude toward mentally ill persons is rarely positive but largely negative or indifferent. Poor knowledge regarding mental health is strongly associated with negative attitudes. Knowledge and attitude are strongly associated with some personal characteristics, e.g., gender and educational level.

Financial support and sponsorship

Nil.
Conflicts of interest

There are no conflicts of interest.

References

1. http://www.who.int/features/factfiles/mental_health/en/. Last visit at Saturday 31 DEC 2016 8:44 pm.
2. Degenhardt L, Whiteford HA, Ferrari AJ, Baxter AJ, Charlson FJ, Hall WD, et al. Global burden of disease attributable to illicit drug use and dependence: Findings from the Global burden of disease study 2010. Lancet 2013;382:1564-74.
3. Lozano R, Naghavi M, Foreman K, Lim S, Shibuya K, Aboyans V, et al. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: A systematic analysis for the Global burden of disease study 2010. Lancet 2013;380:2095-128.
4. Bakian AV, Huber RS, Scholl L, Renshaw PF, Kondo D. Dietary creatine intake and depression risk among US adults. Translational psychiatry 2020;10:1-1.
5. World Health Organization. Mental health care in developing countries: a critical appraisal of research findings, report of a WHO study group [meeting held in Geneva from 15 to 21 September 1981]. World Health Organization; 1984.
6. Thai QCN, Nguyen TH. Mental health literacy: Knowledge of depression among undergraduate students in Hanoi, Vietnam. Int J Ment Health Syst 2018;12:1.
7. Benti M, Ebrahim J, Awoke T, Yohannis Z, Bedaso A. Community perception towards mental illness among residents of Gimbi town, Western Ethiopia. Psychiatry journal. 2016 Jan;2016.
8. Jorm AF. Mental health literacy: Public knowledge and beliefs about mental disorders. Br J Psychiatry 2006;177:5.
9. Klineberg E, Gunnell D, Biddle L, Donovan J. Symptom recognition and help seeking for depression in young adults: A vignette study. Soc Psychiatry Psychiatr Epidemiol 2010;2010:11.
10. Loureiro LM, Jorm AF, Mendes AC, Santos JC, Ferreira RO, Pedreiro A. Mental health literacy about depression: A survey of Portuguese youth. BMC Psychiatry 2013;13:9.
11. Sadik S, Bradley M, Al-Hasoon S, Jenkins R. Public perception of mental health in Iraq. Int J Ment Health Syst 2010;4:26.
12. Ganesh K. Knowledge and attitude of mental illness among general public of Southern India. National journal of community medicine 2011;2:173-8.
13. Deribew YST. How are mental health problems perceived by a community in Agaro town? Ethiop J Health Sci 2005;9:153-9.
14. Adevuya AO, Makanjuola ROA. Lay beliefs regarding causes of mental illness in Nigeria: Pattern and correlates. Soc Psychiatry Psychiatr Epidemiol 2008;43:336-41.
15. Issa BA, Parakoyi DB, Yussuf AD, Musa IO. Caregivers'knowledge of etiology of mental illness in a tertiary health institution in Nigeria.
16. Wahl O, Susin J, Lax A, Kaplan L, Zatina D. Knowledge and attitudes about mental illness: A survey of middle school students. Psychiatr Serv 2012;63:649-54.
17. Pescosolido BA, Martin JK, Long J, et al. A disease like any other? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. Am J Psychiatry 2010;167:1321-30.
18. Dobransky KM. Reassessing mental illness stigma in mental health care: Competing stigmas and risk containment. Soc Sci Med 2020;249:112861. doi: 10.1016/j.socscimed.2020.112861. Online ahead of print.
19. Charles H, Manoranjitham SD, Jacob KS. Stigma and explanatory models among people with schizophrenia and their relatives in Vellore, South India. Int J Soc Psychiatry 2007;53:325-32.
20. Watson AC, Corrigan PW, Ottati V. Police officer attitudes and decisions regarding people with mental illness. Psychiatr Serv 2004;55:49-53.
21. Thiru GS, Yad MJ. Are mental health professionals immune to stigmatizing beliefs? Psychiatr Serv 2005;56:610.