Stigma versus Mental Health Literacy: Saudi Public knowledge and Attitudes Towards Mental Disorders

Dr. Amal Ibrahim Khalil
Assistant professor of Psychiatric and mental health Nursing
Menoufyia University, Egypt
Currently working at/ King Saud Bin Abed Al-Aziz University for Health Sciences
College of Nursing, Jeddah

Abstract

Background: A sound mental health is the key component of health and the absence of mental health could create a great deal of burden to the functioning of a nation. As well the attitudes of the public towards mental health issues are important factors in fighting the stigma with mental disorders

Aim: To investigate the Saudi people level of mental health literacy and attitudes regarding mental disorders and those affected people.

Participants and Methods: A descriptive cross sectional survey was used and a convenient sample of 255 subjects from general Saudi population attending to general public collections area, such as, shopping malls, universities, and restaurants in Jeddah city.

The tool consisted of sociodemographic data sheet and self-administered checklist developed by Kumar et al., 2012 for assessing the attitude and awareness level of public towards mental disorders.

Results: A total of 255 people were interviewed. Most of the respondents 66.3% were females and the majority of the studied population have little awareness and had negative attitude toward the nature of mental illness as well 72.2% indicted that Evil Spirit causing mental illness. Negative attitude responses were ranging from 47 -57% regarding stigmatization, after effect and treatment.

Conclusion and recommendations: the findings concluded that there was a decreased level of mental health literacy among studied population as well as negative attitudes and stigmatization of mental illness. Therefore, more work needs to be done to educate the public about the psychobiological underpinnings of psychiatric disorders and the value of effective treatments.

Keywords: Stigma, Knowledge, Attitudes, Mental health literacy, Saudi Population

Background

For all individuals, mental, physical and social health are vital elements of life that are closely interwoven and deeply interdependent. As an understanding of this relationship increases, it becomes even more apparent that mental health is crucial to the overall well-being of individuals, societies, and countries. Today, mental health problem is recognized as a public health problem in developed as well as developing

countries.

The term mental health literacy has been characterized as comprising several components which include (i) the ability to recognize specific disorders or different types of psychological distress; (ii) knowledge and beliefs about risk factors and causes; (iii) knowledge and beliefs about self-help interventions; (iv) knowledge and beliefs about professional help available; (v) attitudes which facilitate recognition and appropriate help-seeking; and (vi) knowledge of how to seek mental health information. (Jorm et al.1997). A positive public attitude towards the mentally ill is a necessary prerequisite for the proper community care and treatment of such patients. Public attitudes towards the mentally ill may be influenced by such factors as race, culture, religion, level of education and more and more factors. On the other hand, mental health literacy has been comparatively neglected. For major physical diseases, it is widely accepted that members of the public will benefit by knowing what actions they can take for prevention, early intervention, and treatment. However, this type of public knowledge about mental disorders (mental health literacy) has received much less attention. Surveys in several countries have put forth evidence for deficiencies in the public's knowledge of how to detect or prevent mental disorders. A sound mental health is the key component of health. Absence of mental health could create a great deal of burden to the functioning of a nation (Kumar A.2005).

The attitudes of the public towards mental health issues are important factors in the stigma experienced by people with mental illness (Kumar, 2005).

Stigma toward mental illnesses is a great concern in the field of mental health. Stigma toward mental illnesses often isolates people with mental illness from close relationships (Jenkins & Carpenter-Song, 2008) and prevents them from following treatment plans and participating in psychoeducation (Fung et al., (2007), (Tsang, et al., (2007); (Fung, Tsang, & Corrigan, (2008). Stigma associated with mental illnesses acts as one of the biggest hurdles in providing treatment to mentally ill people. Because of the stigma, the mentally ill people are perceived as "different" and are seen with negative attributes and are more likely to be rejected regardless of their behavior (Arkar, 1994). Additionally, Stigma is considered as stereotypes, negative attitudes, and negative behaviors (Corrigan & Watson, 2002). These elements are regarded differently in various cultures and countries. Griffiths and others (2006) reported that stereotypes, attitudes, and levels of diffusion of knowledge were different in two general populations between Japan and Australia. These authors concluded that healthcare systems, general education about mental illness, and cultural differences would affect these findings. Haraguchi, et al. (2009) reported that Chinese people were more likely to have negative attitudes toward those with schizophrenia compared to those of Japanese people. The study, however, included subjects from varied backgrounds within the culture. Japanese subjects were primarily rehabilitation workers at a general hospital and students in a healthcare and wellness school, while Chinese subjects were mainly rehabilitation workers at a psychiatric hospital and students majoring in medicine and psychotherapy. The report articulated a significant difference in knowledge about psychiatric symptoms and medication between the two groups, but the limitation regarding the varied backgrounds was acknowledged.

In summary, cultures as well as healthcare systems and education can impact stereotypes and perpetuate negative attitudes toward people with mental illness. An overview of the literature in relation to mental

illness in Saudi Arabia indicates the lack of an accurate estimate for the prevalence of such problems among the Saudi population. However, a few studies have been conducted in relation to specific mental disorders or particular populations and age groups (Al Mutari,2015). For example, a study conducted by Al-Sughayr and Ferwana, (2012) measured the prevalence of mental illness among high school students selected from four sites (N=354) and indicated that the rate of mental illness among the study population was 48%. It was found to be more prevalent among females (51%) than males (41%). This study was limited, however, by a relatively small sample size and the used measures. Regardless of individual initiatives to document mental illness in Saudi Arabia, the field of study is still under development. Generally speaking, mental illness is becoming a global concern, and the number of sufferers is reaching crisis level. For this reason, this problem requires proper intervention and management (AlMutri ,2015).

More recent studies, using samples from diverse populations have suggested that the burden of psychiatric morbidity existing in Africa is very similar to that prevailing in Western countries (Deribew, &Tamirat 2005). Gail and his colleagues reported that 18.5% of outpatients in a teaching hospital in Addis Ababa suffered primarily from psychiatric disorders compared with 9.5% that are diagnosed as suffering from infectious diseases.

Help seeking behavior regarding mental health problems may be affected by different factors such as tolerance and support in the family, lack of money, knowledge and attitude. Only a few studies exist in the world dealing with people's knowledge and attitude towards major mental health problems (Deribew, &Tamirat 2005).

One study conducted in Butajira regarding the attitude and practice of people towards mental disorder using key informant questionnaires developed by the WHO showed that, 41% of the informants preferred modern medicine for neuropsychiatry disorders. None of informants thought that help could be obtained from modern medicine for possession. Epilepsy ranked first followed by schizophrenia in their frequencies of occurrence as perceived by the informants. Schizophrenia was thought to be the most serious mental disorder followed by epilepsy and mental retardation (Kumar etal.2012).

Stigma is considered an amalgamation of three related problems: a lack of knowledge, (ignorance), negative attitudes (prejudice) and exclusion or avoidance behaviors (discrimination) (Scheff.1966). The reluctance to seek professional psychiatric help means that late presentations are common. The extent to which patients benefit from improved mental health services is influenced not only by the quality and availability of services but also by their knowledge and belief systems (Kleinman, 1991).

Nevertheless, there is evidence that a range of interventions can improve mental health literacy, including community campaigns, interventions in educational settings, mental health first aid training, and information websites. There is also evidence for historical improvements in mental health literacy in some countries. Increasing the community's mental health literacy needs to be a focus for national policy and population monitoring so that the whole community is empowered to take action for better mental health.

Furthermore, there have been many local, regional, national and international efforts in recent years to promote positive attitudes towards mental health issues. These efforts have been developed in the context of anti-stigma campaigns, health promotion strategies and mental health awareness campaigns (McCarthy, 2003).

Significance of the study:

Studies in Saudi Arabia have revealed low detection rates for mental disorders despite the higher prevalence rate, most were not diagnosed (Al-Khatami & Ogbeide 2002). A sound mental health is the key component of health and absence of mental health could create a great deal of burden to the functioning of a nation (Kumar, 2005). In addition, the attitudes of the public towards mental health issues are important factors in fighting the stigma experienced by people with mental disorders as because of this stigma, the mentally ill people are viewed as "different" and are seen with negative attributes and are more likely to be rejected regardless of their behaviors. Moreover, individuals who harbor stigma toward those with mental illnesses are less likely to choose these individuals as employees and less likely to communicate with them (Corrigan & Watson, 2002). When those with mental illness perceive negative attitudes from society, they are afraid of being treated negatively in a demeaning manner by others (Link &Phelen, 2001; Jenkins & Capenter-Song, 2008). Therefore, decreasing stigma toward mental illness is a critical task in the field of mental health. Also, in Saudi Arabia, there are no current findings available that demonstrate public knowledge and attitude towards mental disorders. Therefore, it is important to explore the public perception and attitudes regarding mental disorders and affected people.

Aim of the study

The main aim of this study was to investigate the Saudi people level of mental health literacy and attitudes towards mental disorders and those affected people. More specifically the study will answer the following research questions:

- What are the Saudi people' level of awareness regarding mental disorders?
- What are the attitudes of Saudi citizens towards mental disorders?
- What are the relationship between participant's sociodemographic characteristics, their level of awareness and attitudes with mental health literacy?

Subjects and Methods

Research design

A descriptive cross sectional survey was used to achieve the objectives of this study and to answer the study questions.

The participants

The sample was based on convenient sampling technique consisting of 255 subjects from general Saudi population came to general public collections area, such as, shopping malls, universities, and restaurants in Jeddah city.

Tool of the study:

The study tool consists of two main parts:

- Part I. Sociodemographic data sheet contained information about age, sex, educational status, residence, marital status, presence of mental illness history and from where did they listen about mental illness?
- Part II. The self-administered checklist developed by Kumar et al., 2012 consists of a 50-item questionnaire was used to achieve the objectives of the study. The response format for each statement was rated by two points i.e. yes/no. It consists of the following items in each area: (A) Nature (seven items). The items number 2, 3, 4, and 6 should be answered by "NO", (B) Cause (six items). Only the item no 2 should be answered by "No", (C) Treatment (12 items). The reverse answer was given for item number 3,4,5,6,7,9, (D) After effects (six items) only number 1 and 4 were reversed in answer, (E) Stigma (ten items). Here all items except number 10 should be reversed in answer to reflect the positive attitude and fewer stigma and (F) Community mental health ideology (nine items) only item number 1,5, and 7 should be answered in reverse as well.

Validity and reliability of the study tool:

To ensure the content validity of the adopted checklist, we used back translation process as it has been adopted by the world of medical research. A back translation is when a translated document is translated (back) into the original language. The idea was to verify whether the translation covers all aspects of the original English version of the scale or not. Then to ensure the face validity and reliability the final translated Arabic version of the questionnaire was evaluated by a panel of experts who were selected, on the basis of their qualifications and experience in nursing research and education. The tools were piloted and tested by 10 individuals from the public to identify ambiguities in questions, time required for completing the questionnaire, and any difficulties that might be encountered by the participants in reading or understanding the questionnaire. The results of the pilot study showed that the questionnaire was clear, easy to read, and required around 15 minutes to be completed.

Ethical Considerations

An official permission from the corresponding author Dr. Pradeep Kumar to use the scale was received via Email. In addition, the participants were informed about the nature and the purpose of the study. All participants were informed that their participation is voluntary and they can withdraw from the study at any time. A written consent was obtained from all participants. Confidentiality and anonymity of the collected data was assured.

Data management and analysis plan:

- The data was analyzed by using SPSS version 18. The collected data were coded; validated, cleaned and missing data was controlled before analysis. Appropriate statistical tests such as, descriptive statistics, and Pearson Product Moment Correlation were used to determine the relationships that exist between selected demographic variables (age, gender, education, marital status, and occupation) and perceived wrong ideas and attitudes toward mental disorders.

Results:

Table 1 provides a summary of the characteristics of the sample. Majority of respondents were female 66.3% compared to 33.7% male. Participants were predominantly young adults, the age ranged between16-70 years, mean age was 29.7 (SD± 11.53), 54% percent of the studied sample were single compared to 42 % were married and 1.2% ,2.0% were divorced and widowed respectively. As regard to the level of education of the respondents, the majority 65.6% were in university education compared to 20.8%, 10.2%, and 2.7 were in secondary, middle, and elementary level of education respectively. Concerning the occupation, the majority of the studied group 88.6% are working in non-professional (i.e. non-medical, allied health or nursing) career, nearly half 48.2% living in apartment. The majority 86.3% have no history of mental illness in their families. 84% of the studied sample reported that they have no relative relationship and 93.3% had listen before about mental illnesses as the as more than half 55.7% of the participants had listened from more than one resources, such as T.V, internet, books and social gathering.

Variables	Frequency	%
Gender		
Male	86	33.7
Female	169	66.3
Marital status		
Married	109	42.7
Single	138	54.1
Divorced	3	1.2
others	5	2.0
Level of education		
Elementary	7	2.7
Middle	26	10.2
Secondary	53	20.8
University	168	65.6
Occupation		
Professional	9	3.5
Non professional	226	88.6
others	20	7.8
Living home		
Villa	107	42.0
Traditional house	19	7.5
Flat	123	48.2
others	6	2.4
Presence of mental illness		
Yes	35	13.7
No	220	86.3
Presence of relative relationship		
Yes	40	15.7
No	215	84.3
Listening about mental illness		
Yes	238	93.3
No	17	6.7
Where did you listen?		
T.V.& Radio	41	16.1
Intranet	11	4.3
Theory studying	2	0.8
Clinical practices	1	0.4
Theory and clinical studying	7	2.7
Books	8	3.1
Social seats	26	10.2
More than one source	142	55.7

Table 1: Descriptive characteristics of the participants of the study (No. =255)

Table 2 provides summary for the level of awareness and attitude of the Saudis people regarding mental illness.

Nature as regards to the nature of mental illness the results indicated that the majority (94.9%) and (79.6%) of the studied group were aware by N5& N7 that signified that suicide and suspicion are symptoms of mental illnesses. On the other hand, for the items that should be answered by 'No' (N2, N3and N6) the results indicated that majority (54.9%), (74.5%) and (48.6) respectively have little awareness and negative attitude toward the nature of mental illness, compared with (18.0%) (N4) who didn't agree that harming others can be said as mental illness.

Cause: Interestingly, it was noted that general population were little more aware and had positive attitude towards the cause of mental illness except in items numbers C1 and C2. As in the items C1, only (37.3 %) signified that the 'unsatisfactory marital life' is a cause of mental illness, versus to (72.2%) indicated that "Evil spirit caused mental illness".

After effect: Some significantly varying changes were found between the 6 items for after effects of mental illnesses. As the majority (91.2%), (88.2%) and (79.6 %) of the respondents were more aware and had positive attitude towards mental illness on AF2, AF6, and AF3 respectively. While in AF4 only 32% agree that "After recovery from mental illness patients cannot do technical works" compared to 47.8 % in AF5 which signified that mental patient who had been already treated in mental hospital were more dangerous in comparison to civilians.

Community Mental Health: The majority (94.1%), (94.1%), (92.5%), (80.8%) and (71.4%) of participants were more aware and had positive attitude to community mental health ideology on the response in item number CM2, CM3, CM8, CM4 and CM6 respectively. On the other hand the results revealed that respondents' had (31.8%),(57.3%) ,(68.2),and (49.0%) negative attitude in items CM9,CM7,CM5and CM1 respectively .These items signified respectively 'mentally ill person should not be admitted in mental hospital until he/she does not do harm to anyone,' 'to keep mental patient in residential area may be a good mode of treatment but it may endanger the local people residing in that area,' 'mental patient should be treated within the society,' 'if the person suffers from mental problem appears in the locality then he should only be admitted in a mental hospital.'

Stigma: As all items related to stigma (S1 – S9) should be answer by 'No' to reflect positive attitude and higher level of knowledge and awareness. The pattern of responses was interesting here as when it came to questions about etiquette, higher percentage 89.9% showed positive outlook as in item number ten which was 'we should not laugh at mentally ill people'. However, when it came to keeping patient with mental illness under control, it is better to keep them inside locked room" 80.8% of respondents answered in affirmative followed by 74.9% and 68.2% (S6 and S8 respectively) these items respectively signified that patients with mental illness are unwanted load on society and it is dangerous to live in the neighborhood with mental illness. On the other items, negative attitude responses were ranging from 47 -57%. Thus it shows that stigma still is a problem with the general population.

Treatment: The results in category are very surprising as it reflects the positive attitude and outlook towards the treatment of mentally ill people in every item except in items T3, T4, T5, and T9. Those signified respectively that marriage, Electroconvulsive therapy, treatment from faith healers and medicines

should be used separately to treat patients with mental illnesses, should be answered in reverse (NO response) to reflect the higher knowledge and awareness

Despite the overall positive attitude, the results revealed that more than three quarters 78.4% of the sample had negative attitude towards persons with mental illness and they agree that mentally ill people can be treated by keeping them away from others or by keeping them chained (T6).

Table 2: Total number of "YES "response of the study sample in different categories of the scale items N= 255.

Category of scale	YES	%
NATURE:		
People with mental illness can be better identified?	27	10.6%
*People taking excessive substances can be labeled as psychiatric patients?	140	54.9%
*Epileptic patients can be grouped under psychiatric patients?	190	74.5%
*Harming others can be said as mental illness?	46	18.0%
Suicide can be said as a symptom of mental illness?	242	94.9%
*"Talking to oneself" is a symptom of mental illness?	124	48.6%
"Suspecting people" is one of the symptoms of mental illness?	196	76.9%
CAUSES:		
Unsatisfied marital life is one of the causes of mental illness?	95	37.3%
*Evil spirits causes mental illness?	184	72.2%
Too much hard work causes mental illness?	132	51.8%
Failure in life can be considered as one of the causes?	153	60.0%
One of the causes of mental illness is tension and pressure?	162	63.5%
Disharmony in the family can cause mental illness?	195	76.5%
AFTER EFFECT		
*Many women who have taken indoor treatment in mental hospital behave as a child?	114	44.7%
Patients with mental illness can live as normal people after treatment?		
Patients who have taken treatment from psychiatric hospitals are less dangerous than	233	91.4%
who have not taken?	203	79.6%
After recovery from mental illness patients cannot do technical works?		
Patients taken indoor treatment in a psychiatric hospital are more dangerous than	82	32.2%
normal people?	122	47.8%
Mental illness affects social relations?		
	225	88.2%
COMMUNITY MENTAL HEALTH IDEOLOGY:		
*Patient with severe mental illness should be kept in the category of disabled?	125	49.0%
It is our duty to take better care of people with mental illness?		

Family can play important role in the treatment of patient with mental illness?	240	94.1%
Patient with mental illness should get special benefits from government?	240	94.1%
*Patient with mental illness should not be admitted in psychiatric hospital until he harms himself or others?	206	80.8%
There is no danger in establishing psychiatric facilities in residential areas?	174	68.2%
*It is good to establish psychiatric facilities in residential areas but it poses danger to the normal population of that area?	182	71.4%
People with mental illness should be treated in the society?	146	57.3%
People with psychological problems when seen should be admitted in a psychiatric hospital?	236	92.5%
	81	31.8%
STIGMA:		
*After treatment patient with mental illness should not be allowed to work in government offices?	142	55.7%
*People once affected with mental illness keeps on doing thing against social norms?	121	47.5%
*It is unwise to marry a person with mental illness?		
*To keep patient with mental illness under control it is better to keep them inside locked room?	143	56.1%
*Patients with mental illness should not be given any responsibilities?	206	80.8%
*Patients with mental illness are unwanted load on society?		
*Psychiatric hospital should be away from cities so that normal people does not get any problems?	121	47.5%
*It is dangerous to live in the neighborhood of person with mental illness?	191	74.9%
*It is wise to take divorce once a spouse is affected with mental illness?	158	62.0%
Even though people with mental illness may behave inappropriately but it is no good to laugh at them?	174	68.2%
	142	55.7%
	229	89.8%
TREATMENT:		
Solving problems is considered important in the treatment of patient with mental illness?	225	88.2%
Psychosocial treatment along with pharmacological treatment is important for people with mental illness?	219	85.9%
*Marriage usually cures mental illness?	152	59.6%
*Electroconvulsive therapy is the only treatment for mental illness?	218	85.5%
*Treatment from faith healers is the only way to treat mental illness?	188	73.7%
*Persons with mental illness are treated by keeping them away from others or by keeping them chained?	200	78.4%
*The best way to treat mental illness is by teaching to control emotions?	50	19.6%
Family support plays significant role in the treatment of mental illness?	232	91.0%

*The only treatment of mental illness is medicines?	181	71.0%
Persons with mental illness when motivated to work as per their abilities treat their illness?	221	86.7%
Religious activities help in the treatment of mental illness?	227	89.0%
Good company helps in the treatment of mental illness?	237	92.9%

(Items with an asterisk represents negative attitude when answered "YES')

Table 3 represents the total mean and SD of scale subcategories as the table shows that the highest total score of positive attitude and level of knowledge was given for treatment 7.46±1.303 of mentally ill patients followed by 6.27±1.328 in community mental ideology. On the other hand, the total score of Nature is 4.44±1.129 compared with 4.54±2.168 of the stigma towards mental illness. More ever, very little difference 3.61±1.393 and 3.95±1.056 between total mean responses was received regarding the knowledge of identifying causes and the after effects of mental illness.

Table 3: Mean and standard divisions of scale categories distribution among study sample (N =255)

Scale categories	Mean ±SD	Minimum	Maximum
Nature	4.44±1.129	1	7
Causes	3.61±1.393	0	6
After effect	3.95±1.056	0	6
Community Mental ideology	6.27±1.328	2	9
Stigma	4.54±2.168	0	10
Treatment	7.46±1.303	3	12
Total score	30.28±4.79 11		48

4. The correlation between the sociodemographic characteristics of the studied sample and total score of the scale subcategories.

Regarding the gender, the results of the current study revealed that there was only a significant difference .058 and .007 between female and male regarding the identifying causes and treatment of mental disorders respectively. Also the university educational level showed only significant difference among participants in expressing higher knowledge and positive attitude regarding P= .030,.039, and .041 natures, causes and stigma of mental illnesses as the P value is significant at the 0.05 level. With regard to the occupation, significant difference was found among people in non-professional work as it is significant with nature of mental illness, .044, .037 community ideology, and .011 treatments of mental illnesses. Also, there were significant differences among participants who had history (familiarity) of mental illness in reflecting knowledge and attitude in identifying the nature .053, .030, causes, .018 and treatment of mentally ill

patients. In addition, there was significant difference with the total score of scale (.004) People who had listen before in multiple resources like internet, books, social gathering and media showed significant difference in causes, stigma and treatment of mental disorders,.003,.002,.000 respectively. Finally, as age (r 0.5, $p < 0.05$) increases the knowledge and awareness is increased as well, the attitude become more positive toward people with mental disorders.

Discussion:

The objective of the current study was to investigate the Saudi people level of mental health literacy and attitudes towards mental disorders and those affected people.

With regard to the level of awareness among public toward mental disorders, the result of this study revealed that the majority of the studied group have little awareness regarding the nature and treatment modalities for mentally ill patients. This result is congruent with the work of Sadik et al (2010) who reported that understanding the nature of mental illness, its implications for social participation and management remains negative in general population. On the other hand, the studied group did have a fairly reasonable understanding of the aetiology of mental illness although the Evil Spirits was also viewed by the majority as a major cause of mental illnesses. This result is contradicting the results obtained from a study examining the Indian community beliefs about causes and after effect of mental disorders. The researchers found that the most commonly acknowledged causes were a range of socio-economic factors, while neither supernatural causes (evil spirit) nor biological explanation were widely endorsed (Kermode et al 2009). Furthermore, it was revealed that among marital and relationship problems were the most preferred cause of mental disorders (Table 2). These findings comply with the findings of Khan et al, (2010), that has demonstrated public belief in marital and conflict in family relationship ad possible causes of mental disorders

Most mental health literacy surveys have been largely conducted in western countries, with few studies in developing country contexts. Studies from western societies have shown that biological factors (diseases of the brain and genetic factors) and eventual factors (trauma and stress) are more likely to be considered causal (Gaebel et al 2002); Shibreetal,2001), while in Africa, supernatural causes are widely considered (Gureje et al, 2005). A recent Nigerian survey also found that urban dwelling, higher educational status, and familiarity with mental illness correlated with belief in biological and psychosocial causation, while rural dwelling correlated with belief in supernatural causes.

Recognition of mental illness is just one aspect of mental health literacy that influences behaviors and attitudes towards the mentally ill. The extensive influence of culture on mental health was found to play a critical role in predicting community attitudes towards mental illness (Gong et al.2003).

Furthermore, the results of the current study showed that the stigma toward mental disorders were still a very big problem among the studied group. The same results were obtained by Kumar et al, (2012); Smith et al (2012) and Antonia, Seth, and Dorothee, (2011). In addition**,** a study done by Al-Adawi et al. (2002) on the population of Oman reported that the extent of stigma varies according to the cultural and sociological background of each society. More ever, these results are compatible with the study of (Fung et al., 2007) in schizophrenia, as they reported that psychotic conditions are considered even more

stigmatizing because these conditions are perceived as signs of madness and denote a sense of unpredictability, danger, and bizarre and uncontrollable behaviors. In Saudi Arabia, it was observed that the reasons for these disparities (negative attitude, and stigmatization) in mental health might be due to the limitations of health services regarding the effects of having a serious mental illness, health behaviors and the effects of psychotropic medication added to the lack of educational resources about mental health and illnesses. Other causes that can explain these obtained results could be that , there is only one psychiatric hospital in Jeddah city with 2 million population , no post graduate studies in psychiatric nursing ,also there is no certification programs or special training programs for nurses working in psychiatric hospital setting as there are greater opportunities for mental health nurses to play a significant role in improving both the physical and mental health of people with serious mental illness along with changing the attitude of public attending to the hospital toward mentally ill patients. (Robson & Gray,2006). There is certainly an increased awareness in most Arab countries of the importance of mental health problems as part of the total health care picture. This awareness however is, rarely translated into action on the ground. Most medical schools in the Arab world have a rudimentary psychiatry programm, and it is mostly in the form of scattered lectures and short rotations in clinics or wards. (Yehya, 2012)

Furthermore, little attention is given to teaching interviewing skills or changing attitudes toward mental illness, the natural course of the illness and the effects of treatment by following the same patient over time. Little time was actually spent in dealing with the patient and his/her mental issues. Clinical research and supervision is generally lacking and scarce (Yehya, 2012).

Stigma has been described as "a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses" When stigma leads to social exclusion or discrimination, whether from mental illness or some other condition, it results in unequal access to resources that all people need to function well, adversely affecting their quality of life (President's New Freedom Commission on Mental Health, 2003).

Regarding the relationship between the sociodemographic characteristics and the level of mental health literacy, the current study revealed that females have more awareness level of mental health literacy and positive attitude towards mental illnesses in identifying causes and treatment of mental disorders than males. This goes in the same line with the study done by Beatrice, Torbjorn and Kim (2012) as they reported that females were found to hold a greater open-mindedness and were positive to pro-integration, but they were also fearful and avoidant, more than males in relation to persons with mental illness.

As regarding age, the study revealed that as the age increased, so did open-mindedness and awareness and a positive attitude towards persons with mental illness; on the other hand, as age increased, community mental health ideology decreased. This results are congruent with study done by Beatrice, Torbjorn and Kim (2012)

The other sociodemographic data of the respondents such as, occupational status and familiarity with mental disorders through different sources like, television, internet, social gatherings etc. are important independent correlates of multiple perceived causation, nature and treatment of mental illness. The same results were obtained by Adewuya et al (2008). Yet while there has been considerable research and analysis of media content of mental health coverage, there has been relatively little concrete research into the

effects: how media messages are received and interpreted, alongside other potential sources of evidence and experience in daily life. While the most comprehensive review of research in this area appears to confirm the view that 'negative' media coverage may reinforce fears that mental health users pose a public risk, and 'positive' images might have an opposite effect, the evidence is limited (McCracke, Carpenter, and Fabre 2008). In fact, the media and other resources of information can shape people' attitudes by exaggerating risks reinforcing rather than overcoming well documented stigma and discrimination.

Also the difference in the level of mental health literacy and attitudes towards mental illness was given for the participants from university educational level. This result is congruent with the work of Markstrom et al. (2009) and Antonia, Seth, and Dorothee, (2011) who found that higher education was accompanied by more positive attitudes towards mentally ill persons. In addition, participants with a family member diagnosed with a mental illness reported less social distance comfort as opposed to those without mental illness in the family. This result is congruent with the work of Smith et al, (2011). Within the same context, knowledge and family experiences about mental illness had similar effects on the level of mental health literacy and attitude as it was reported through the current study that those with higher knowledge and having previous family history of mental illnesses reported higher levels of awareness and positive attitudes toward the causes and necessity of treatment (i.e. fewer stigmas).

Conclusions and Recommendations:

The findings of the present study concluded that there was a decreased level of mental health literacy among studied population with regard to identifying the nature, the causes, the after effect and the treatment of mental disorders. By way of, some major deficits were highlighted in terms of information and knowledge about mental illness especially in the context of: mentally ill person could be easily discriminated in comparison to normal, and relatively less awareness in general population in term of Evil spirits as a causative factor of mental illness. More ever, mentally ill person should not get admitted in hospital until he/she does not harm to any one, mentally ill person should be treated within the society. In addition, the findings reported that social stigma is still a major problem as held by public, and may further increase the barriers and challenges for mentally ill people to survive and have normal functioning, as they had been perceived as unwanted load on the community. Negative attitudes exhibited by the studied group towards people with mental disorders represent an area in need of increased attention and examination.

Therefore, more work needs to be done to educate the public about the psychobiological underpinnings of psychiatric disorders and about the value of effective treatments. A better understanding of these disorders amongst the public would presumably lessen stigmatization and encourage the use of currently available and effective interventions. Also, different programs to fight stigma must be initiated to specify stigmatization as a factor that can obstruct the inclusion of people with severe mental illness as full members in the society. The ambition has been to increase public knowledge about mental illness and treatment and the possibilities for recovery through community campaigns for mental health and illnesses awareness in order to create more positive attitudes towards people with mental illness.

Acknowledgment

My sincere gratitude, and appreciation to my students, who helped me in collecting data of this research. Also, my thanks for the people who agree to participate in the study and gave me the opportunity to accomplish this research that shaded light on their level of awareness and attitude toward mental disorders and those affected people.

References

Adewuya A, Makanjuola R. Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. Social Psychiatry and Psychiatric Epidemiology. 2008; 43:336–341. doi: 10.1007/s00127-007-0305-x.

Al-Adawi S, Dorvio AS, Al-Ismaily SS, Al-ghafry DA, Al- Noofi BZ, Al-Salmi A, Burke DT, Shah MK, Ghasiany M & Chand SP, (2002) Perception and attitude towards Mental Illness in Oman. International Journal of Social Psychiatry; 48:305-317

Alem A, Jacobsson, Araya M, Kebede D, Kullgren G. (1999). How are mental disorders seen and where is help sought in rural Ethiopian community? Acta Psychiatrica Scand,;100:40-47.

Al-Khatami A, Ogbeide D. (2002). Prevalence of mental illness among Saudi adult primary-care patients in central Saudi Arabia. Saudi Medical Journal, 23:721–724.

Almutairi A., (2015) Mental illness in Saudi Arabia: an overview. Psychol Res Behav Manag. 2015; 8: 47–49. doi: 10.2147/PRBM.S79268 PMCID: PMC4321637

Al-Sughayr AM, Ferwana MS. Prevalence of mental disorders among high school students in National Guard Housing, Riyadh, Saudi Arabia. J Fam Community Med. 2012;19(1):47–51. [PMC free article] [PubMed]

Antonia B., Seth N, and Dorothee K, (2011). The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views Soc Psychiatry Psychiatr Epidemiol; 46(11): 1191–1202.

Arkar H.(1994).Effect of psychiatric labels on attitudes toward mental illness in a Turkish sample. Int J Soc Psychiatry. (3)p205-13.

Beatrice E., Torbjorn H. and Kim L. (2012) Impact of gender and age on attitudes towards mental illness in Sweden. Nordic Journal of Psychiatry, (doi:10.3109/08039488.2012.748827)

Commonwealth Department of Health and Aged Care, (2000a)

Corrigan, W. P. & Watson, C. A. (2002). The paradox of Self-Stigma and Mental Illness.*American psychological Association*, 9(1), 35-53.

Deribew.A , Shiferaw,Y.(2005) Tamirat, how are mental health problems perceived by a community in Agaro town?,Original article, 19(2),153-159.

Fung, K.,Tsang, H.,Corrigan, P., Lam, C. and Cheng,W. (2007) 'Measuring Self-Stigma of Mental Ill¬ness in China and its Implications for Recovery. International Journal of Social Psychiatry 53: 408–418.

Fung, M. T. K. Tsang, W. H. H. & Corrigan, W. P. (2008).Self-Stigma of people with Schizophrenia as Predictor of Their Adherence to psychosocial Treatment.*Psychiatric Rehabilitation Journal*, 32, 95-104.

Fung, M. T. K. Tsang, W. H. H. Corrigan, W. P. Lam, S. C. & Cheng, W. (2007). Measuring self-stigma of mental illness in china and its implications for recovery.*International Journal of Social Psychiatry*, 53(5), 408-418.

Gaebel W, Baunmann A, Witte A, Zaeske H. (2002) Public attitudes towards people with mental illness in six German cities. European Archives of Psychiatry Clinical Neuroscience; 252:278–287. doi: 10.1007/s00406-002-0393-2.

Gong F, Gage SL & Tacata LA (2003). Help seeking behavior among Filipino Americans: A cultural analysis of face and language. Journal of Community psychology.

Griffiths, M. K. Nakane, Y. Christensen, H. Yoshioka, K. Jorm, F. A. &Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BioMedCentral Psychiatry*, 23, Retrieved from http://www.biomedcentral.com/1471-244X/6/21

Haraguchi, K. Maeda, M. X. Y. Mei, &Uchimura, N. (2009). Stigma associated with schizophrenia: Cultural comparison of social distance in Japan and China. *Psychiatry and Clinical Neurosciences*, 63, 153-160.

Jenkins, J. & Carpenter-Song, E. (2008). Stigma Despite Recovery strategies for Living in the Aftermath of psychosis. *Medical Anthropology Quarterly,* 22(4), 381-409.

Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. (1997) "Mental health literacy": a survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. MJA; 166: 182-186.

Jorm AF, Korten, AE, Jacomb.PA, Christensen H, Rodgers B, Pollitt,P (1997) "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Med J Aust 166:182–186

Jorm.A.F. (2011). Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health, American Psychologist, doi: 10.1037/a0025957.

Kermode M, Bowen K, Arole S, Joag K, Jorm A. (2009). Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. Social Psychiatry and Psychiatric Epidemiology; 44:1087–1096. doi: 10.1007/s00127-009-0031-7.

Khan TM, Sulaiman SA, Hassali MA, Anwar M, Wasif G, Khan AH (2010). Community knowledge, attitudes and beliefs towards depression in the state of Penang, Malaysia. CMH, 46(1): 87-92.

Kleinman A. (1991)Rethinking psychiatry: from cultural category to personal experience,New York: Free Press.(3)

Kumar A. 2005 .District Mental Health Programme in India: acase study. Journal of Health and Development;1:24- 35.

Kumar D, Kumar P, Singh AR, Bhandari SS. 2012. Knowledge and attitude towards mental illness of key informants and general population: a comparative study. Dysphrenia. 3(1):57-64.

Kurihara,T.Kato,M. Sakamoto,SH. Reverger,R. Kitamura,T.(2000). Public attitudes towards the mental ill: A cross- cultural study between Bali and Tokyo, psychiatry and clinical neurosciences, 54,547-552.

Link, G. B. & Phelan, C. J. (2001). Conceptualizing Stigma.*Annu. Rev. Social*, 27, 363-85.

Markstrom U, Gyllensten A, Bejerholm U , Bjorkman T.,Brunt D., Hansson L., Leufstadius C,Sandlund.M,Svensson.B,Ostman.M, Eklund.M,.(2009). Attitudes towards mental illness among health care students at Swedish universities. Nurse Education Today, 660–665.

McCracken k., Carpenter M., and Fabre.M, (2008) Mental Health, the media and public perceptions Findings of exploratory focus groups

New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. (2003).

Robson.D,Gray.R (2006). Serious mental illness and physical health problems. International Journal of

Nursing Studies, (457–466).

Sadik.S, Bradle.M, Al-Hasoon. S., and Jenkins.R (2012). Public perception of mental health in Iraq. International Journal of Mental Health Systems. (4: 26).

Scheff T J. Accountability in psychiatric diagnosis: a proposal. In: Millon T, Klerman G, editors. Contemporary directions in psychopathology: toward the DSM-IV. New York: Guilford; 1986. p. 265-78.

Scheff TJ. 1966. Being mentally ill: a sociological theory. Chicago: Aldine Vol (31):469-488.

Shibre T, Negash A, G K, Kebede D, Alem A, Fkadu A, Fekadu D, Madhin G, Jacobsson (2001)Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. Social Psychiatry and Psychiatric Epidemiology; 36:299–303. doi: 10.1007/s001270170048.

Smith V, Reddy J., Foster K.,. Asbury E., Brooks J, (2011),"Public perceptions, knowledge and stigma towards people with schizophrenia", Journal of Public Mental Health, (10) Iss: 1, pp. 45 – 56

ureje O, Olley O, Ephraim-Olowanuga O, Olley B, Kola L. (2005) Community study of knowledge and attitude to mental illness in Nigeria. British Journal of Psychiatry; 186:436–441. doi: 10.1192/bjp.186.5.436.

Yehia M., (2012.) Interview: Dealing with mental illness in the Middle East. 103; Published, online doi: 10.1038/nmiddleea