Abstract

Background

To assess the level of awareness, knowledge and help-seeking attitudes and behaviours in relation to mental health conditions (MHCs) and associations with socio-demographic characteristics of a rural district of Bangladesh.

Methods

We recruited 2425 adult samples (18–90 years) from a Cross-sectional study in Narial district of Bangladesh. Data on awareness, knowledge, help-seeking attitudes and practice in relation to six MHCs were collected. The MHCs were classified as common (depression, anxiety and drug addiction), and severe (psychosis, dementia and bipolar disorder). Associations of MHCs with socio-demographic characteristics were assessed using Chi-square tests. Rasch analysis was performed to transform the latent attribute (awareness) of MHCs from ordinal to interval scale. Multiple regression analysis was performed to determine how the socio-demographic characteristics contribute to the combined awareness score of MHCs.

Results

Of 2425 participants, 17 (0.7%) were cognizant of all the awareness construct of MHCs, and 1365 (56.28%) were not aware of any of MHCs. The prevalence of awareness of MHCs such as depression (8.5%), anxiety (6.2%), psychosis (3.5%), and bipolar disorder (3.3%), was found to be very low. Awareness was significantly lower in older adults, and in women. Higher levels of education (β 1.77, 95% confidence interval (CI): 1.58–1.97) associated with common MHCs and (β 0.81, 95% CI: 0.67–0.95) those associated with severe MHCs contributed significantly to increased awareness as opposed to having no or primary level of education. Availability of sufficient funds when applied to common MHCs (β 0.43, 95% CI: 0.26–0.61) and severe MHCs (β 0.25, 95% CI: 0.13–0.38) appeared to be more effective in boosting awareness compared to unstable financial situations. Almost 100% of the participants who were aware of the MHCs demonstrated positive attitudes towards seeking medical or psychological counselling.

Conclusions

Awareness of MHCs appeared to be very limited. However, knowledgeable participants were found to be very receptive to medical or psychological

counselling. For improving awareness of MHCs need to conduct various intervention programs in particular those campaigns that focus on women, older adults, low SES and people up to the primary levels of education.

Introduction

Approximately 7.3% of the global burden of disease has been attributed to mental and behavioural disorders. Most of this burden is related to unipolar depressive disorders and other mental health conditions (MHCs) including anxiety, psychosis and substance use [1]. Currently, approximately 450 million people suffer from such conditions, and it is projected that one in four individuals in the world will be affected by MHCs at some point in their lifetimes. MHCs are amongst the leading causes of ill-health and disability worldwide [2]. Globally, approximately 20% of the adults have MHCs, and low and middle-income countries have only one psychiatrist for every 1 to 4 million people [3, 4]. People with MHCs experience disproportionately higher rates of disability and mortality [5]. Individuals with major depressive disorders and schizophrenia had 40 to 60% greater chance of dying prematurely than the general population [6].

Mental health literacy (MHL), defined as "knowledge and attitudes about MHCs which aid their recognition, management and prevention" is low worldwide, but specifically low in developing countries [7]. In such societies, MHCs are believed to be consequences of familial imperfection and evil spirits [8]. Such beliefs have been purported to lead to poor utilisation and negative stigma about mental health services and treatment [9]. Unsurprisingly, poor health literacy is associated with negative disease outcomes, especially in developing countries [10,11,12,13].

The importance of health literacy on physical health is widely acknowledged in the world [14]. However, the literacy about MHCs has been neglected in both developed and developing countries [15]. The common myths in developing and developed countries are that the MHCs are not curable, caused by personal weakness, and that people with MHCs are usually violent or unstable [16]. A study from Germany reported that people were more reluctant to discuss MHCs than physical disorders with relatives and friends [17]. In the USA, many public servants did not seek treatments because they feared that MHCs would create the negative impact on their employment [18]. In developing countries, utilising services for MHCs are further blocked by stigma and beliefs about MHCs being due to sorcery or spiritual punishment, possessions by spirits and demons, genetic or family inheritance, social or moral disobediences towards ancestors or wraths of Gods [19]. A study from Nigeria showed that women in the community would be afraid to have a conversation with someone known to have mental disorders [20]. In the United Arab Emirates (UAE), women were ashamed to mention that they had a family member with mental illness, but this attitude was lower in men [21]. Moreover, a study from India reported that women thought that MHCs were family matters and should not be disclosed to other people [22]. However, in developing countries including Bangladesh and India, visiting a traditional healer for emotional problems was more common in women than in men [23]. A study revealed that in Qatar men possessed better knowledge, beliefs, and attitudes towards mental illness than women [21].

Despite the association between MHL and diseases outcomes, levels of MHL in rural regions of Bangladesh are unknown. Studies are needed to understand the level of MHL in the population and to develop targeted programs to address such levels. In the last decade, several studies have reported the prevalence of and contributing factors for depression and anxiety both in urban and rural areas in Bangladesh [24,25,26,27,28,29,30,31,32]. However, no study has assessed awareness, knowledge, and attitudes of seeking medical treatment regarding MHCs in Bangladesh. Rural areas in Bangladesh are characterised by traditional healing practices and an absence of mental health facilities and care. Therefore, studies on MHL are imperative to gauge and increase the level of awareness of MHCs in rural populations in Bangladesh.

The current study had two aims. First, it aimed to estimate the level of MHL in a typical rural district of Bangladesh. Second, it aimed to identify socio-demographic characteristics associated with MHL in order to identify the factors that affect rural communities and therefore inform potential interventions for improving MHL.