Razi International Medical Journal
RIMJ
Journal homepage: www.rimj.org/pubs/index.php/journal

RESEARCH ARTICLE

Mental health literacy among Afghan adults: A community-based cross-sectional survey study in Herat city

Abdul Qadim Mohammadi [1]✉, **Laura Johnston** [2], **Kartikeya Ojha** [3]

[1] Mental Health Ward, Herat Regional Hospital, Herat, Afghanistan.
[2] Department of Neuroscience, George Mason University, Fairfax, VA, United States.
[3] Sikkim Manipal Institute of Medical Sciences, Sikkim Manipal University, Gangtok, Sikkim, India.

ARTICLE INFO

Open Access

Received:
2023-03-14
Accepted:
2023-05-27
Published:
2023-05-30

Keywords:
Mental health
Literacy
Disorders
Herat-Afghanistan

ABSTRACT

Background: Health literacy has been defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health. The significance of mental health literacy (MHL)is evolving as a modifiable contributing factor to mental health. This study was undertaken to assess the awareness and attitudes of Afghans on mental disorders.

Methods: A cross-sectional survey was administered in August 2022 among Afghans (N=768) living in the Herat province of Afghanistan. The survey examined knowledge and attitude of participants on mental disorders.

Results: Generally, most of the participants (99.1%) had poor mental health literacy. 99.4% of participants with an age range of 36-90 years had poor mental health literacy. Almost three-quarter of the participants had poor knowledge of the ability to recognize disorders (72.5%). Less than one-thirds of the participants had good knowledge of where to seek information (29.4%).

Conclusion: Mental health literacy rate was found very low among Afghan population. Socio-economic variables found significantly associated with MHL was educational level, economic status, and employment status. Considering the high prevalence of mental disorders in Afghanistan, the government and related non-governmental organizations should implement awareness campaign to increase the knowledge of Afghan people on mental disorders.

Introduction

Health literacy has been defined as "the ability to gain access to, understand, and use information in ways which promote and maintain good health" (1). Jorm et al introduced and defined the term 'mental health literacy' as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention".

Several elements make up mental health literacy, including (a) the capacity to identify particular disorders or numerous different forms of psychological distress; (b) belief and knowledge about risk determinants and causes; (c) beliefs and knowledge about self-help interventions; (d) beliefs and knowledge about the availability of professional help;

✉ Corresponding Author: Abdul Qadim Mohammadi
Email address: qadimmohammadi@gmail.com

Cite this article as: Mohammadi et al. Mental health literacy among Afghan adults: A community-based cross-sectional survey study in Herat city. *Razi International Medical Journal, 3(1).* DOI: 10.56101/rimj.v3i1.91

(e) attitudes that support recognition and relevant help-seeking; and (f) knowledge of how to access mental health care (2).

The significance of mental health literacy (MHL) is evolving as a modifiable contributing factor to mental health (3). Individuals will try to control their symptoms if they have debilitating psychological symptoms or are close to people who do. The degree of people's mental health literacy will affect how they manage their symptoms. If these symptom-management techniques are effective, they decrease symptoms that are incapacitating, as well as enhance mental health literacy (4).

The high lifetime prevalence of mental disorders—up to 50%—which means that almost everyone will either develop a mental condition or be in close touch with someone who does—highlights the need for the general public to be more mentally literate (5). Due to stigmatizing ideas that are mostly socio-culturally formed, individuals, suffering from mental illness face prejudice (6). The term "mental health literacy" suggests that it is essential to raise people's awareness about mental health issues and mental disorders since doing so will enable them to identify problems early and seek treatment (7).

Researchers have attempted to broaden the idea, and later four areas were proposed to build the MHL: [8] Knowledge of good mental health, also known as mental health promotion or positive MHL; (9) Awareness of mental disorders and therapies; (10) Stigma associated with mental disease and treatment; (11) and Competency and help-seeking behavior (10).

Numerous detrimental outcomes for mental health are associated with low MHL (8). However, inadequate MHL is a rampant problem, particularly in the developing world (11, 12). Afghanistan is one of the countries that presents extremely difficult research obstacles. To the best of our knowledge, no study on mental health literacy has been conducted since the start of this study. The literacy rates of Afghan women refugees who have been resettled in Australia (13, 14) were found to be lower when compared to other nations worldwide, according to two separate studies respectively (13, 14).

Therefore, this study was undertaken to assess the awareness and attitudes of Afghans on mental disorders.

Materials and methods

Participants and procedure

This cross-sectional study was conducted between August 05, 2022, to December 15, 2022, in Herat province of Afghanistan. A print-based questionnaire was used to interview the participants. The non-probability-based convenience sampling method was used to find the participants of this study. More specifically, a total of 1000 male and female aged over 18 years old in 15 districts of Herat city were approached face-to-face in a community-based setting and were asked to take part in the study, and a total of 768 male and female voluntarily participated in the present study (response rate = 76.8%). Participants who agreed to participate in the study answered the questions asked by the researchers. Providing verbal consent and being aged above 18 years were the pre-requisites for participation in the study.

Measures

The questionnaire used in the present study consisted of two sections: questions relating to socio-demographic and related variables and questions for the assessment of mental health literacy. The socio-demographic information and related variables section included questions on age, gender, marital status, educational level, economic status, employment status, and feeling sick (mentally). In order to assess mental health literacy among participants, the 35-item of the “Mental Health Literacy Scale” MHLS was used (15).

The scale comprises six attributes. The first attribute is the ability to recognize disorders, which is assessed using a 4-point Likert scale ranging from 'very unlikely' to 'very likely.' An example item is: 'If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have Social Phobia?'

The second attribute is knowledge of risk factors, also measured using a 4-point Likert scale. An example item is: 'To what extent do you think it is likely that in general in Afghanistan, women are MORE likely to experience a mental illness of any kind compared to men?'

The third attribute is knowledge of self-treatment, assessed with a 4-point Likert scale. An example item is: 'To what extent do you think it would be helpful for someone to avoid all activities or situations that made them feel anxious if they were having difficulties managing their emotions?'

The fourth attribute is knowledge of professional help, measured using a 4-point Likert scale. An example item is: 'To what extent do you think it is likely that Cognitive Behaviour Therapy (CBT) is a therapy based on challenging negative thoughts and increasing helpful behaviors?'

The fifth attribute is knowledge of where to seek information, rated on a 5-point Likert scale ranging from 'strongly disagree' to 'strongly agree.' An example item is: 'I am confident that I know where to seek information about mental illness.'

The sixth attribute is attitudes that promote recognition or appropriate help-seeking behavior, assessed using a 5-point Likert scale. An example item is: 'How willing would you be to have someone with a mental illness marry into your family?' The response options range from 'definitely unwilling' to 'definitely willing.'

Scores on the scale range from 35 to 160. The cutoff scores for good literacy are considered to be at or above 75%, while a score below 75% is considered poor literacy.

Data analysis

Microsoft Excel 2016 was used for data entry and IBM SPSS version 26 was used for data analysis. Descriptive statistics were presented as means, standard deviations, frequencies and percentages of the socio-demographic variables and mental health literacy. We used the Pearson chi-square test to assess the association between categorical variables; we used the exact chi-square test. If the statistically significant association was found after chi-square test, multiple logistic regression analysis was used to report the predictors of mental health literacy. A p-value of less than 0.05 was considered significant in the present study.

Results

A total of 346 males and 422 females participated in the present study with an age range of 18 to 90 years. The mean age of the participants was 37.37 years. Almost four-fifth of the participants were married (81.8%). Over half of the participants were illiterate (51.8%). Almost half of the participants reported that they had low income (51.8%). **[Table 1]**

Table 1. Characteristics distribution of the study sample by gender (Afghanistan-2022)

Characteristic	Categories	Male		Female		Total	
		N	%	N	%	N	%
Age group	18–35-years	190	44.0	242	56.0	432	56.3
	36–90-years	156	46.4	180	53.6	336	43.8
Marital status	Single	54	45.8	64	54.2	118	15.4
	Married	292	46.5	336	53.5	628	81.8
	Widow/divorced	0	.0	22	100.0	22	2.9
Education level	Illiterate	162	40.7	236	59.3	398	51.8
	School	137	50.7	133	49.3	270	35.2
	University	47	47.0	53	53.0	100	13.0
Economic status	High income	2	28.6	5	71.4	7	.9
	Middle income	157	43.3	206	56.7	363	47.3
	Low income	187	47.0	211	53.0	398	51.8
Employment status	Employed	69	62.7	41	37.3	110	14.3
	Not-employed	277	42.1	381	57.9	658	85.7
Feeling sick (mentally)	Ex-patient	15	36.6	26	63.4	41	5.3
	Patient	53	24.9	160	75.1	213	27.7
	No	278	54.1	236	45.9	514	66.9
Total		346	45.1	422	54.9	**768**	**100.0**

Of all the participants only 27.5% had good knowledge of mental disorders. The mean and standard deviation of total score of MHLS for knowledge on disorders was 23.053 (5.356). 72.4% of the participants had poor knowledge on social phobia, poor knowledge of generalized anxiety disorder was

found among 67.6%, and 64.1% of the participants had poor knowledge of persistent depression disorder. The mean and standard deviation of total score of MHLS for attitude was 100.866 (14.655). **[Table 2]**

Table 2. Ability of recognizing disorder and attitude of the participants on mental diseases (Afghanistan-2022)

Disorder	Mean/SD	Knowledge of disorders	
		Poor	Good
Social phobia	2.93 ± .935	556 (72.4)	212 (27.6)
Generalized anxiety disorder	2.97 ± .952	519 (67.6)	249 (32.4)
Major depressive disorder	3.03 ± .942	492 (64.1)	278 (35.9)
Personality disorder	2.64 ± 1.081	566 (73.7)	202 (26.3)
Persistent depression disorder	2.90 ± 1.052	492 (64.1)	276 (35.9)
Agoraphobia	2.94 ± 1.033	489 (63.7)	279 (36.3)
Bipolar disorder	2.67 ± 1.194	517 (67.3)	251 (32.7)
Substance abuse disorder	2.96 ± 1.106	438 (57.0)	330 (43.0)
Total	23.053 ± 5.356	557 (72.5)	211 (27.5)

Almost three-quarter of the participants had poor knowledge of the ability to recognize disorders (72.5%). Less than one-thirds of the participants had good knowledge of where to seek information (29.4%). A very small number of participants had good knowledge of risk factors of mental health (0.9%). Poor attitudes that promote recognition or appropriate help seeking behavior was found among almost all of the participants (99.1%). **[Table 3]**

Table 3. Descriptive statistics of the MHLS and its attributes

Attributes	Literacy	
	Poor	Good
Ability to recognize disorders	557 (72.5)	211 (27.5)
Knowledge of where to seek information	542 (70.6)	226 (29.4)
Knowledge of risk factors	761 (99.1)	7 (0.9)
Knowledge of self-treatment	724 (94.3)	44 (5.7)
Knowledge of professional help	562 (73.2)	206 (26.8)
Attitudes that promote recognition or appropriate help seeking behavior	709 (92.3)	59 (7.7)
Total	761 (99.1)	7 (0.9)

Generally, most of the participants (99.1%) had poor mental health literacy. 99.4% of participants with an age range of 36-90 years had poor mental health literacy. Less than one percent of the female participants had good mental health literacy (0.7%). One-twentieth of the participants with a university level education had good mental health literacy. There was a significant relationship between education level, economic status, and employment status with the mental health literacy. **[Table 4]**

Table 4. Association of mental health literacy with participants socio-demographic characteristics (Afghanistan-2022)

Characteristic	Categories	MHL		*p*-value
		Poor	Good	
		N (%)	N (%)	
Age group	18–35-years	427 (98.8)	5 (1.2)	.416
	36–90-years	334 (99.4)	2 (0.6)	
Gender	Male	342 (98.8)	4 (1.2)	.518
	Female	419 (99.3)	3 (0.7)	
Marital status	Single	116 (98.3)	2 (1.7)	.330
	Married	645 (99.2)	5 (0.8)	
Education level	Illiterate	396 (99.5)	2 (0.5)	**.002**
	School	269 (99.6)	1 (0.4)	
	University	96 (96.0)	4 (4.0)	

Table 4. *(continued)*

Characteristic	Categories	MHL		*p*-value
		Poor	Good	
		N (%)	N (%)	
Economic status	High income	6 (85.7)	1 (14.3)	**<.001**
	Middle income	358 (98.6)	5 (1.4)	
	Low income	397 (99.7)	1 (0.3)	
Employment status	Employed	105 (95.5)	5 (4.5)	**<.001**
	Not-employed	656 (99.7)	2 (0.3)	
Feeling sick (mentally)	Yes	40 (97.6)	1 (2.4)	.290
	No	721 (99.2)	6 (0.8)	
Total		**761 (99.1)**	**7 (0.9)**	

Multiple logistic regression was run to predict mental health literacy comprising the following variables: age group, gender, marital status, educational level, economic status, employment status, and feeling sick mentally. Analysis indicated that only the socio-economic variable employment status [employed vs not-employed] (AOR=0.109, *p*=.035), was significantly associated with mental health literacy. **[Table 5]**

Table 5: Multiple logistic regression analysis of mental health literacy on participants' characteristics (Afghanistan-2022)

Variable	Low Quality of Life	
	AOR [95% CI]	*p*-value
Age group (Ref: 36-90 years old)		
18 – 35 years old	0.953 [0.132, 6.885]	.962
Gender (Ref: female)		
Male	0.593 [0.110, 3.192]	.543
Marital status (Ref: married)		
Single	0.869 [0.125, 6.052]	.887
Educational level (Ref: university)		
Illiterate	0.949 [0.082, 10.920]	.966
School	2.906 [0.263, 32.076]	.384
Economic status (Ref: high income)		
Moderate income	0.039 [0.001, 1.233]	.066
Low income	0.367 [0.032, 4.255]	.423
Employment status (Ref: not-employed)		
Employed	0.109 [0.014, 0.857]	**.035**
Feeling sick mentally (Ref: No)		
Yes	0.248 [0.025, 2.489]	.236

Discussion

The survey results showed that a large number of the participants (99.1%) had poor MHL and very few of the participants (0.9%) had good MHL. In comparison, the health literacy rates of Afghan refugees in Sweden were very low with only 15.2% having sufficient functional health literacy and 29.6% having sufficient comprehensive health literacy (16). Likewise, in a 2021 survey, only 22.7% of Afghan women were found to have sufficient health literacy (13). University-educated people tend to have better MHL than those who cannot read or write (illiterate), which suggests that MHL is related to education level. Likewise, being literate, having a high economic status, and having a job (employed employment status) were associated with high MHL. Overall, participants were knowledgeable about mental health disorders, and 27.5% of participants had a good ability to recognize mental disorders. The present study shows a lower rate of MHL than expected from previous studies, and less than one-tenth of the participants (7.7%) had good attitudes towards help seeking behaviors (13, 14, 16).

Overall knowledge of mental disorders was low with 27.5% of participants having a good knowledge of social phobia, generalized anxiety disorder, major depressive disorder, and agoraphobia. Participants were least knowledgeable on personality

disorders with only 26.3% of participants having good knowledge of them. In another study looking at Afghan refugees in Australia, 31.0% of the participants were able to recognize PTSD at a higher rate as Australians and twice the rate of Iraqi refugees in Australia (14). Likewise, in the same study, the Afghan refugees were able to identify the severity of mental disorders at a higher rate than Iraqi refugees. In the present study, 27.5% of the participants were able to recognize disorders. While Afghans appear to have a lower rate of identifying mental disorders compared to Australians, individuals who live in conflict zones or have experienced trauma are more susceptible to mental disorders (17, 18). Given that many Afghans have experienced conflict and trauma due to two decades of war and the subsequent Taliban takeover in 2021, they are at a higher risk of developing mental disorders compared to some other groups, such as Australians. Therefore, due to the conflicts they have faced, preventing them from acquiring knowledge and the ability to recognize mental disorders, the inability of about three-quarters of the participants to identify disorders has a more significant impact on the population compared to a place like Australia.

While some Afghans appear to be knowledgeable and can recognize mental disorders, many lack knowledge of risk factors and have poor attitudes towards seeking help. Only 0.9% of the participants had good knowledge of risk factors for mental health disorders. This is especially important because many Afghans are exposed to risk factors, including conflict. Only 5.7% of participants had good knowledge of self-treatment options, whereas 26.8% of participants had good knowledge of how to seek professional help. It appears that a few of the participants were familiar with professional help than self-treatment. Accessing mental health help can be challenging for many Afghans, as not everyone has access to healthcare, particularly mental health professionals. Additionally, seeking professional help can be associated with higher social pressures, as individuals may feel uncomfortable going to a provider instead of practicing self-treatment in the comfort of their own homes. In this study, 92.3% of participants had poor attitudes towards seeking help, which could be related to their lack of knowledge about self-treatment and the social stigma attached to mental health issues. Previous research on Afghan refugees in Australia found that they believed mental health disorders were hard to treat (14), and that seeking help was associated with embarrassment, humiliation, and shame. These findings could also explain why the majority of participants in this study had negative attitudes towards seeking help.

As stated earlier, less than one percent of participants had good MHL. Of the socio-demographic characteristics analyzed in this study, education was associated with MHL. Unlike some studies, age was not significantly associated with MHL in this survey, however, economic status was found significant just like other studies found. Over one-half (51.8%) of the participants were illiterate. Only 0.5% of them had good MHL, indicating that literacy is can be a sole factor determining MHL. Likewise, 4% of participants with university level education had good MHL. These results are similar to a previous study examining general health literacy in central Afghanistan, which also determined that health literacy was associated with literacy and education level but not age (19). In another study, health literacy of Afghan women was also associated with education, but age, marital status, and not working at home were also found to be associated with health literacy (13). This study also found that only 0.7% of women had adequate mental health literacy. In comparison. These numbers are widely different and further studies should be conducted to analyze the health and MHL of women in Afghanistan, especially under Taliban rule. However, it should be noted that the scales used to determine these values are different. When looking at socio-demographic characteristics as a predictor of MHL, education level, employment status, and economic status was significant.

Moving forward, MHL of women should be monitored closely, as their ability to access education has decreased under Taliban rule. As education is associated with MHL, the findings of this study may be used to compare the effects of lack of education in the future. Likewise, access to healthcare and increasing knowledge of self-treatment options should be explored. Not everyone has access to healthcare, especially mental health professionals. Mental health disorders are more common in conflict zones and in people who have experienced a traumatic event. It may also be helpful to examine the factors that cause Afghans to be hesitant towards getting help for mental

health disorders. Some previous studies have suggested social stigma, lack of access, or even the belief that mental health disorders are hard to treat. However, further studies may be able to determine actionable causes.

Limitations

There are a number of limitations. The study included participants from all of the 15 districts of Herat city. However, the convenience sampling technique of this study makes it weak. Also, due to the cross-sectional design of the study, the causality between mental health literacy and other variables could not be determined. The high number of illiterate people in Afghanistan is another limitation of this study. The other limitation of this study is the instrument used to conduct it. The study instrument has not been validated in the Dari language, and there have been limited studies conducted to evaluate people's mental health literacy using the MHLS.

Conclusion

Mental health literacy rate was found very low among Afghan population. Socio-economic variables found significantly associated with MHL was educational level, economic status, and employment status. Considering the high prevalence of mental disorders in Afghanistan, the government and related non-governmental organizations should implement awareness campaign to increase the knowledge of Afghan people on mental disorders.

Competing interests

The authors declare that they have no competing interest.

References

1. *Nutbeam D, Wise M, Bauman A, Harris E, Leeder S. Goals and targets for Australia's health in the year 2000 and beyond. Report to Commonwealth Department of Health, Housing, and Community Services Canberra. Australia: Australian Government Publishing Service. 1993.*
2. *Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. "Mental health literacy": a survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. Medical journal of Australia. 1997 Feb;166(4):182-6.*
3. *Mahmoodi SM, Ahmadzad-Asl M, Eslami M, Abdi M, Kahnamoui YH, Rasoulian M. Mental Health Literacy and Mental Health Information-Seeking Behavior in Iranian University Students. Frontiers in Psychiatry. 2022;13.*
4. *Jorm AF. Mental health literacy: Public knowledge and beliefs about mental disorders. The British Journal of Psychiatry. 2000 Nov;177(5):396-401.*
5. *Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Archives of general psychiatry. 1994 Jan 1;51(1):8-19.*
6. *Kermode M, Bowen K, Arole S, Pathare S, Jorm AF. Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. Social psychiatry and psychiatric epidemiology. 2009 Dec;44(12):1087-96.*
7. *Colizzi M, Lasalvia A, Ruggeri M. Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care?. International journal of mental health systems. 2020 Dec;14(1):1-4.*
8. *Spiker DA, Hammer JH. Mental health literacy as theory: current challenges and future directions. Journal of Mental Health. 2019 May 4;28(3):238-42.*
9. *Jorm AF. Mental health literacy. American psychologist. 2012;67(3):231-43.*
10. *Wei Y, McGrath PJ, Hayden J, Kutcher S. Mental health literacy measures evaluating knowledge, attitudes, and help-seeking: a scoping review. BMC psychiatry. 2015 Dec;15(1):1-20.*
11. *Furnham A, Swami V. Mental health literacy: A review of what it is and why it matters. International Perspectives in Psychology: Research, Practice, Consultation. 2018 Oct;7(4):240.*
12. *Venkataraman S, Patil R, Balasundaram S. Why mental health literacy still matters: a review. Int J Commun Med Public Health. (2019) 6:2723.*
13. *Harsch S, Jawid A, Jawid E, Saboga-Nunes L, Sørensen K, Sahrai D, Bittlingmayer UH. Health literacy and health behavior among Women in Ghazni, Afghanistan. Frontiers in Public Health. 2021 Mar 4;9:629334.*
14. *Yaser A. Mental health literacy of resettled Afghan refugees in Australia: an exploration of how*

resettled refugees understand post-traumatic stress disorder and its treatment (Doctoral dissertation, Western Sydney University (Australia)).

15. *Nejatian M, Tehrani H, Momeniyan V, Jafari A. A modified version of the mental health literacy scale (MHLS) in Iranian people. BMC psychiatry. 2021 Dec;21:1-1.*
16. *Wångdahl J, Lytsy P, Mårtensson L, Westerling R. Health literacy among refugees in Sweden – a cross-sectional study. BMC Public Health. 2014 Oct;14.*
17. *Kovess-Masfety V, Keyes K, Karam E, Sabawoon A, Sarwari BA. A national survey on depressive and anxiety disorders in Afghanistan: A highly traumatized population. BMC Psychiatry. 2021;21(1):314.*
18. *van Ommeren M. Mental health conditions in conflict situations are much more widespread than we thought. World Health Organization. 2019. Available from https://www.who.int/news-room/commentaries/detail/mental-health-conditions-in-conflict-situations-are-much-more-widespread-than-we-thought*
19. *Harsch S, Jawid A, Jawid M E, Nunes L S, Sahrai D, Bittlingmayer U H. The relationship of health literacy, wellbeing and religious beliefs in neglected and unequal contexts—Results of a survey study in central Afghanistan. Health Promotion Journal of Australia. 2020 Sep;32(S1):80-87.*