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Investigating the relationship between mental health literacy and psychiatric disorders among students of Ghalib University in Herat, Afghanistan

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Abstract

Introduction: Mental health literacy, which refers to the knowledge, attitudes, and beliefs regarding mental disorders, facilitate the symptoms recognition, management, and prevention. The aim of this research was to investigate the relationship between mental health literacy and psychiatric disorders.

Materials and Methods: This is a correlational-descriptive study that was conducted on 310 students of Ghalib University in Herat-Afghanistan in 2024. To collect data, the O'Connor and Casey Mental Health Literacy Scale and the Symptom CheckList-25 were utilized.

Results: The results indicated a significant relationship between the mean scores of mental health literacy and psychiatric disorders ($P< 0.05$, r= -0.132). The mean score of mental health literacy and psychiatric disorders was 85.96 and 35.67 respectively. The findings showed that mental health literacy of students had a significant correlation with two sub-scales of anxiety (r= 0.126) and paranoid thoughts (r= 0.167).

Conclusion: The use of counseling centers and educational workshops are recommended for the development of mental health literacy.

Keywords: Health knowledge, Literacy, Mental disorders, University students

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Introduction

Psychiatric disorders, which include significant disruptions in thought, emotional regulation, and behavior, encompass various conditions such as anxiety, depression, bipolar disorder, Post-Traumatic Stress Disorder (PTSD), schizophrenia, eating disorders, destructive behaviors, social disorders, and neurodevelopmental disorders (1). These disorders are often accompanied by feelings of distress or disability in social, occupational, and other important activities (2). In 2019, one in eight people—approximately 970 million individuals—lived with mental disorders, with

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anxiety and depression being the most common disorders. In 2020, the number of people living with anxiety and depressive disorders sharply increased due to the COVID-19 pandemic. Initial estimates indicate an increase of 26% for anxiety disorders and 28% for major depressive disorders within just one year. Although there are effective options for prevention and treatment, many individuals with mental disorders do not have access to effective care (3). Psychiatric disorders carry a significant burden of disability and functional impairment. Estimates regarding mental disorders in Europe indicate that approximately 27% of the adult population are affected by mental disorders each year. The highest prevalence of mental disorders is reported for anxiety disorders, mood disorders—particularly major depression—somatic disorders, and substance abuse. This issue results in a disability burden of 25% - 30% of the total years of disability-adjusted life lost (DALYs) in Europe (4). According to the reports of Ministry of Health in Afghanistan, one in every two individuals suffers from mental health issues (5). There is no precise data on the number of people with psychiatric disorders in Herat province of Afghanistan. In the etiology of mental health issues, particularly in Asia, economic and relational factors such as poverty and family discord have consistently been identified as important elements (6). Mental disorders are prevalent in human societies and, lead to reduced social functioning for those affected, while imposing significant costs on governments and support systems (7). These disorders, as the most prominent challenge to global health today, have raised significant concerns for health systems, professionals, and policymakers, serving as a major contributor to the growth of disorders and disabilities stemming from poor health worldwide (7). Despite this, there has been limited research conducted on this issue at cultural level. This is particularly important because cultural issues affect the definition of mental health, and therefore, culture plays a crucial role in defining what is considered a mental health problem (8). Untreated mental disorders can be partly attributed to self-limiting factors such as fear of stigma, discrimination, and lack of mental health awareness (3). Additionally, since three-quarters of reported disorders belong to the age groups of 18 and 25, coinciding with the student years, universities at national level can play a significant role in increasing mental health literacy (9). Mental health is defined as a mental state characterized by emotional well-being, appropriate behavioral regulation, relative lack of anxiety and debilitating symptoms, and the ability to establish constructive relationships while coping with the normal demands and stresses of life (10). Mental health literacy, which refers to the knowledge, attitudes, and beliefs regarding mental disorders, facilitate the recognition, management, and prevention of mental disorders (9). Mental health literacy encompasses three interconnected concepts: knowledge, attitudes, and help-seeking behavior (11). Mental health literacy comprises six components including: the ability to recognize specific disorders, awareness of how to seek information related to mental health, understanding the risk factors and causes of mental illness, knowledge of self-help strategies, knowledge of available professional help; and attitudes that facilitate recognition and appropriate use of assistance (12). Research indicates that the general population, particularly young people, has a very low level of mental health literacy. They often struggle with recognizing mental disorders and their underlying causes, risk factors, and preventions. Additionally, misconceptions about the effectiveness of medical interventions can frequently reduce the likelihood of seeking help (9). In a study by Turgut et al. at Ankara Health University, variables such as field of study, level of education, and mental health status significantly affected the students' general health perception scores (13). In a cross-sectional study by Harisa et al. access to information had a statistically significant impact on the mental health knowledge of health sciences students (14). There is lack study to assess mental health literacy and reveal the statistics of mental disorders in Herat Province. So, we aimed to determine the relationship between mental health literacy and psychiatric disorders among students of Ghalib University in Herat, Afghanistan 2024.

Materials and Methods

In this correlational-descriptive study, considering the total number of 1500 students enrolled at Ghalib University at the time of this study, the required sample size was determined to be 310 students using the Cochran formula. The participants were selected by random quota

sampling and included 159 from the faculty of medicine, 31 from dentistry, 82 from computer engineering, 10 from law and political science, and 28 from the faculty of economics. Inclusion criteria included students who were studying in the academic year 2024 and exclusion criteria was incomplete completion of the questionnaires.

To collect data, in addition to demographic information (age, field of study, marital status, occupation, and place of residence), the O'Connor and Casey Mental Health Literacy scale and the SCL-25 (Symptom Checklist-25) were utilized.

Research instruments

A) The Mental Health Literacy Scale: O'Connor and Casey developed this scale in 2015. This scale consists of 35 items, which were reduced to 29 items (15) after translation and psychometric evaluation by Nejatian et al. (16). This scale has six subscales, the first of which with 8 items is the "individuals' ability to recognize mental disorders". This subscale is based on a 4-point Likert scale (very unlikely, unlikely, likely, very likely) with a score range of 8 to 32. The second subscale with 10 items is the "attitudes that facilitate appropriate help-seeking behavior". This subscale is based on a 5-point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree) or (definitely willing, probably willing, neither willing nor unwilling, probably unwilling, definitely unwilling), with a score range of 3 to 12. The third subscale with 2 items is "knowledge of self-treatment" which is based on a 4-point Likert scale (very unhelpful, unhelpful, helpful, very helpful) with a score range of 2 to 8. The fourth subscale with 3 items is the "knowledge of available professional help" and is based on a 4-point Likert scale (very unlikely, unlikely, likely, very likely) with a score range of 3 to 12.

The fifth subscale with 4 items is the "awareness of where to seek information" and is based on a 5-point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree) with a score range of 4 to 20. The sixth subscale with 2 items is the "awareness of risk factors and causes" consists of 2 items, assessed with a 4-point Likert scale (very unlikely, unlikely, likely, very likely) with a score range of 2 to 8. The total score of this tool is obtained by summing the scores of all subscales. The minimum score is 35 and the maximum is 160, with higher score indicating higher mental health literacy. Given that this study utilized the 29-item Mental Health Literacy scale, the range of the score on this scale was from 29 to 130, with a score of 96.5 being determined as the cutoff score (between average and good) for mental health literacy (16-18).

B) Symptom Checklist-25 (SCL-25): This is a shortened 25-item psychological test designed to assess mental health issues. It is a brief version of SCL-90, originally developed by Najarian and Davoodi in 2001. The SCL-25 consists of 25 items across nine dimensions, utilizing a 5-point Likert scale (none, a little, somewhat, much, very much). The components of SCL-25 include six items for somatic complaints or somatization, one item each for paranoid thoughts and additional concerns, three items for obsessive-compulsive symptoms, interpersonal sensitivity, anxiety (19), phobic or anxiety-related fears, and psychosis (2), and two items for depression. There are no items specifically designated to hostility and aggression, but a high correlation exists between the hostility and SCL-25 (19). The validity of this tool has been assessed and confirmed in Iran by Reshvanloo and Saadati Shamir (20). In the present study, the reliability of data collection tools was assessed by internal consistency using Cronbach's alpha, which was found to be 0.78 for the Mental Health Literacy scale and 0.92 for the SCL-25.

Data analysis was done by descriptive (frequency percentages, means, and standard deviations) and inferential statistics (t-tests, Pearson correlation, and analysis of variance), using SPSS 28 software.

Results

The demographic characteristics of the participants are presented in Table 1. The mean score of mental health literacy of the participants was 96.85, which is lower than the criterion of 5.96. This means that there was a significant difference between the students' mean score of mental health literacy and the criterion of 5.96 ($P< 0.05$). In this regard, it can be said that, since the mean score of students is lower than the threshold value and falls within the moderate range of mental health literacy (63 to 96), the mental health literacy of students is believed to be at moderate level. However, considering that the students mean score was closer to 96 than 63, it can be inferred that their mental health literacy was moderately high.

Therefore, the majority of respondents fall into the moderate category for mental health literacy (77.7%), followed by high mental health literacy (18.4%) and low mental health literacy (3.9%). To facilitate comparison between the components of mental health literacy, the score of each component was divided by the number of questions it contained. Consequently, the scores obtained ranged from 1 to 4 for four components and from 1 to 5 for two components (knowledge of where to seek information and knowledge of risk factors), allowing comparison between the mean scores of mental health literacy components. The median or theoretical average was also found to be 2.5. The percentage score ranged from 0 to 100. The percentage score for the component of attitudes that promote the recognition or appropriate help seeking behavior was 46.06, which was below the 50% mark and represented the lowest percentage score among the components of mental health literacy.

The other five components of mental health literacy had percentage scores of above 50%, with the highest percentage scores being 65.27% for Knowledge of risk factors, and 64.70% for Knowledge of where to seek information (Table 2). The mean score of psychiatric disorders scale was 35.67, with the range of mean scores extending from a minimum of 1.56 for paranoid thoughts to a maximum of 9.09 for somatic complaints. The skewness and kurtosis values for all variables fell within the range of +2 to -2, indicating no significant deviation from a normal distribution. The mean scores for all eight psychiatric disorders were below the theoretical average of 2. Comparison of mean scores for the components indicated that the mean scores of all psychiatric disorders fell below the average range. The lowest mean score (1.12) was associated with the component of phobic anxiety followed by psychosis (1.22). Conversely, the highest mean scores were related to obsessive-compulsive disorder (1.61), and paranoid thoughts (1.56). The mean scores were also calculated for psychiatric disorder components. To facilitate comparison among the components, the score of each component was divided by the number of questions it contained, resulting in scores that ranged from 0 to 4. This allowed for a comparison of mean scores across the components. The median or theoretical average was set at 2 (Table 3).

Statistically, there was a significant relationship between the total scores of mental health literacy and psychiatric disorders (r= -0.132, $P< 0.05$).

The direction of relationship was negative, indicating that an increase in mental health literacy was associated with a decrease in psychiatric disorders. The findings indicated that the total score of mental health literacy had a significant correlation with both anxiety (r= 0.126) and paranoid thoughts (r= 0.167), with $P< 0.05$.

The direction of relationship between mental health literacy and both anxiety and paranoid thoughts was positive. Additionally, an examination of relationship between components of mental health literacy and the total score of psychiatric disorders revealed positive correlations between psychiatric disorders and two components of attitudes that promote recognition or appropriate help seeking behavior and knowledge of risk factors (Table 4).

Table 1. Demographic characteristics of the participants (n = 310)

Feature	Category	Frequency	Percentage
Marital status	Single	236	83.1
	Married	48	16.9
	No response	26	8.4
Field of study	Medicine	159	51.3
	Computer science	82	26.5
	Dentistry	31	10
	Economics	28	9
	Law	10	3.2
Employment status	Freelance	171	55.2
	Employee	93	30

Table 2. Descriptive indicators of mental health literacy and its components

Descriptive statistics					One-sample T-Test			
Variable	**Range of scores**	**Mean**	**Standard deviation**	**Percentage score**	**Criterion**	**Mean difference**	**P**	**Level**
Mental health literacy	29-130	85.96	12.28	56.40	96.50	-10.53	< 0.001	Average

Components of mental health literacy	Percentage score	Mean	Standard deviation
Ability to recognize disorders	63.55	2.91	0.57
Attitudes that promote recognition or appropriate help seeking behavior	46.06	2.84	0.73
Knowledge of self-treatment	60.75	2.82	0.75
Knowledge of professional help available	59.71	2.79	0.61
Knowledge of where to seek information	64.70	3.59	0.93
Knowledge of risk factors	65.27	2.96	0.76

Table 3. Descriptive statistics of the SCL-25 score and its components

One-sample T-Test				Descriptive statistics			
Variable	**Range of scores**	**Mean**	**Standard deviation**	**Criterion**	**Mean difference**	**P**	**Level**
Psychiatric disorders	0-100	35.67	19.05	33.50	2.17	0.124	Marginal (Low to moderate)

Components of psychiatric disorders	Mean	Standard deviation
Somatic complaints	1.51	0.87
Obsessive-Compulsive Disorder (OCD)	1.61	1.01
Interpersonal sensitivity	1.49	0.98
Depression	1.26	1.07
Anxiety	1.53	1.02
Phobia	1.12	0.89
Paranoid thoughts	1.56	1.26
Psychosis	1.22	0.92

Table 4. Results of the correlation test between the mental health literacy scale and SCL-25 and its components

Variable	**Individuals' ability to recognize mental disorders**		**Appropriate attitudes toward seeking help**		**Self-therapy knowledge**		**Knowledge of available professional help**		**Awareness of where to search for information**		**Awareness of causes and Risk Factors**		**Mental Health Literacy (Overall)**	
	Coefficient	**P**	**Coefficient**	**P**	**Coefficient**	**P**	**Coefficient**	**P**	**Coefficient**	**P**	**Coefficient**	**P-value**	**Coefficient**	**P-value**
Somatic complaints	-0.014	0.807	0.121	0.033	-0.007	0.899	0.014	0.801	-0.017	0.765	0.027	0.633	0.059	0.297
Obsessive-Compulsive Disorder (OCD)	-0.059	0.301	0.043	0.456	0.022	0.701	0.043	0.448	-0.044	0.442	0.026	0.648	-0.001	0.992
Interpersonal sensitivity	-0.002	0.976	0.123	0.030	0.076	0.185	0.054	0.344	-0.069	0.224	0.063	0.267	0.077	0.174
Depression	-0.047	0.408	0.124	0.029	0.001	0.981	0.033	0.567	-0.043	0.449	-0.008	0.890	0.038	0.505
Anxiety	0.052	0.359	0.102	0.073	0.026	0.653	0.111	0.050	-0.056	0.324	0.110	0.053	0.126	0.024
Phobia	-0.001	0.979	0.170	0.003	0.034	0.556	-0.017	0.766	-0.042	0.456	0.054	0.346	0.089	0.119
Psychosis	0.027	0.641	0.144	0.011	0.121	0.033	0.081	0.157	0.052	0.363	0.190	0.001	0.167	0.003
Psychiatric disorders (Overall)	-0.038	0.507	0.118	0.038	0.086	0.130	0.046	0.417	0.025	0.667	0.092	0.105	0.089	0.118

Discussion

The aim of this study was to determine the relationship between mental health literacy and psychiatric disorders among students of Ghalib University in Herat, Afghanistan. The results showed that the average mental health literacy among students was 85.96, which is lower than the criterion of 96.5, showing a significant difference between the two values. In a cross-sectional study conducted by Gorczynski and Sims-Schouten, the mean score of mental health literacy was 123.96 (standard deviation 16.01), (21). Simões de Almeida et al. found that a higher level of mental health literacy exists among professionals and educated individuals (18). The findings of another study by Hyseni Duraku et al. indicated that students had an average awareness of mental health issues (22). Additionally, the average level of mental health literacy among students in the research of Reichel et al. was reasonably high (42.65 out of 75 points) (23). Female students, students in health-related programs, and non-smokers had a higher level of mental health literacy compared to their peers, which is consistent with the findings of Rababah et al. (24). In this study, we found that attitudes that promote recognition or appropriate help seeking behavior was correlated to somatic complaints and phobic anxiety. This may be attributed to several possible reasons, including students' reluctance to seek appropriate help from friends and the university environment due to social stigma and fear of rejection by peers. Other reasons include limited access to the internet and online resources, the absence of local media programs addressing mental health literacy, lack of psychological counseling workshops at the university, and various social and cultural challenges.

The findings also indicated that the level of psychiatric disorders among students of Ghalib University in Herat had a mean score of 35.67 on the psychiatric disorders scale. The score range of psychiatric disorders scale was from 0 to 100, with a score of 33.5 being a borderline score (between low and moderate) for psychiatric disorders. The mean score of components ranged from a minimum of 1.56 for paranoid thoughts to a maximum of 9.09 for somatic complaints. In terms of percentage scores, all components obtained a score of below 50%, with the highest percentages being related to obsessive-compulsive disorder at 40.3% and paranoid thoughts at 39%. The lowest mean score among the components was also elated to phobic anxiety with a score of 1.12, and psychosis with a score of 1.22, while the highest mean scores were related to obsessive-compulsive disorder (1.61) and paranoid thoughts (1.56). In the study of Sheldon et al., the cumulative prevalence of depression was estimated at 25%, while the cumulative prevalence of suicidal outcomes was 14% (25). Additionally, Dessauvagie et al. identified the average prevalence of mental disorders among students at 29.4% for depression, 42.4% for anxiety, 16.4% for stress, and 13.9% for eating disorders, with suicide ranging from 7% to 8% (26). In the study by Sivertsen et al. the prevalence of mental disorders among students was found to be 39.7% (95% CI) for women and 25.7% (95% CI) for men (27). It may be possible to attribute the difference in the prevalence of psychiatric disorders in the present study compared to the above research to several potential reasons, for instance, the weakness of social information dissemination, social stigma, insufficient advertising and media programs, religious beliefs, and a shortage of professional staff such as psychologists and psychiatrists.

Regarding the relationship between mental health literacy and psychiatric disorders, the findings indicated a significant correlation between the total scores of mental health literacy and psychiatric disorders. Furthermore, the findings revealed a significant correlation between the total scores of mental health literacy and two components of anxiety and paranoid thought. Additionally, examining the relationship between the subscales of mental health literacy and the total score of psychiatric disorders revealed a correlation between two subscales of attitudes that promote recognition or appropriate help seeking behavior and psychiatric disorders. We also found a significant relationship between paranoid thoughts, knowledge of self-treatment, recognition of causes and risk factors. In the study of Clough et al., international students reported a lower intention to seek help regarding suicidal thoughts and faced more barriers to seeking assistance (28). Low mental health literacy is associated with poorer mental health, which aligns with the findings of Jeong et al. (17). Jafari et al. found that low levels of mental health literacy were associated with high levels of depression, anxiety and stress. A strong relationship has also been found between

attitudes toward mental illnesses and overall mental health literacy, which is consistent with the findings of Baklola et al. (29).

The side findings of this research regarding the background variables indicated a significant relationship between age, academic semester and mental health literacy respectively. The direction of this relationship was positive, showing that an increase in age and academic semester was associated with an increase in mental health literacy. These findings are in line with the results of Özbıçakçı and Salkim's study (30). Olyani et al. also found that students in higher academic levels whose fathers were graduates and employed had significantly higher mental health literacy than their peers (31). In general, this study had some limitations, including low participation rate of students in studies, lack of complete understanding of questionnaires, fear of disclosing mental health status, changes in behavior towards them, and fear of being marginalized by the university. Additionally, the political conditions and developments in Afghanistan, the shortage of specialized mental health professionals, lower level of awareness, social stigma, and religious beliefs were among other limitations of this study.

Conclusion

The findings indicated that the mean score of mental health literacy in students was 85.96. Also, and their mean score of psychiatric disorders was 35.67, reflecting a moderate level of psychiatric disorders and an average level of mental health literacy among them. The results also showed a statistically significant relationship between the total scores of mental health literacy and psychiatric disorders. Based on these findings, qualitative interviews are recommended to be used as a method of data collection to better examine the presence of psychological disorders among students and obtain more accurate results. Educational workshops are also recommended to be held for students to increase their mental health literacy. Mental health literacy can be improved at both individual and community levels through interventions, mass media, and online channels.

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Conflict of Interest

The authors declare no conflict of interest.

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Ethical Considerations

This article is derived from the master's thesis in psychiatric nursing at Islamic Azad University of Medical Sciences in Tehran, which was approved by the Ethics Committee. After coordinating with the officials of Ghalib University in Herat, the study method and objectives were explained to the students and they were assured about the confidentiality of their personal information. Ethical principles, according to the Helsinki Declaration (World Medical Association Declaration of Helsinki, 2013) was followed during the process. A written informed consent was obtained from participants before completing the questionnaires.

Code of Ethics

IR.IAU.TMU.REC.1403.280.

Authors' Contributions

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Wahid Ahmad Naseri, Jamileh Mohtashami, and Mohammad Hossain Beheshti. The first draft of the manuscript was written by Wahid Ahmad Naseri and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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