

ORIGINAL ARTICLE

Sociodemographic Factors of Mental Health Literacy Among Housewives Living in Low Cost Apartments in Puchong, Selangor, Malaysia

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ABSTRACT

Introduction: Evaluation of mental health literacy is important in assisting the development of intervention and policies toward preventing mental health problems. This study aims to explore mental health literacy and its socio-demographic predictors in a group of housewives living in low-cost apartments in Selangor, Malaysia. **Methods:** A Malay version of the self-administered Mental Health Literacy Scale (MHLS) was used in this cross-sectional study. Age, ethnicity, religion, educational level and family income were tested using one-way ANOVA and independent t-test. **Result:** A total of 103 eligible respondents participated in the study. Most respondents were from the age group of 30 and above, from the Malay ethnic group, Muslims, had formal education up to secondary level with a monthly family income below RM4000 (USD980). The overall mean (sd) mental health literacy score was low 106.65 (11.21) and was significantly associated with ethnicity, religion, educational level and family income ($p > 0.05$). **Conclusion:** Mental health literacy scores were low and showed variations within sociodemographic groups.

Keywords: Socio demographic factors, Mental Health Literacy, Housewife, Low cost apartment

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INTRODUCTION

Malaysia's National Health and Morbidity Survey 2015 revealed that the prevalence of mental health predicaments among adults rose from 10.7% in 1996 to 29.2% in 2015 (1). This survey also reported that females, younger adults and adults from low-income families seem to be at risk of developing mental health problems (1). The prevalence of mental health challenges amongst Malaysian children and adolescents is also on the rise from 13.0% (95% CI: 11.5–14.6) in 1996 to 20.0% (95% CI: 18.8–21.3) in 2011 and this was attributed partly to the children growing up in a socially and economically disadvantaged families (2).

Health literacy revolves around one's capacity to obtain, communicate, process, and understand basic health information and services needed to make appropriate health decisions. A couple of studies have shown that low functional health literacy result in substandard health outcomes (3,4). Although there is no consensus about the definition of health literacy, attempts have been made to quantify the term to allow evidence-based decisions (5). Mental health literacy on the other hand

concerns about obtaining and maintaining positive mental health. Mental health literacy can also be about understanding mental disorders in general, whether to address the stigma that comes with the disease or to enhance individuals help-seeking efficacy and self-management capabilities (6,7). Improved understanding of mental health literacy helps in the development of appropriate interventions to prevent and control mental health problems. However, measuring mental health literacy is a challenge given the limitations of current tools to assess the relevant attributes of mental health literacy. One of the latest instruments available is the mental health literacy scale (MHLS) developed by O'Connor and Casey (8). It assesses all attributes of mental health literacy which had been tested across several populations and communities. It has also demonstrated good internal and test-retest reliability in gauging mental health literacy among individuals or at population level as well as estimating the efficacy of mental health literacy programmes (9).

Globally, low mental health literacy has not always been viewed as a public health concern. Though this may not be the case for developed countries such as Australia, which had launched nationwide mental health literacy campaign since two decades ago, developing countries are still struggling to acknowledge the importance of mental health education to this day (10). A person's mental health and mental health literacy may be shaped

by various social, economic, and environmental factors functioning at different stages of life and thus could be influenced by social inequalities (11). In view of the mental health predicaments surrounding Malaysian children and adolescents, this study therefore aims at exploring the mental health literacy of housewives as most of them are caregivers to these children and adolescents. Epidemiological data showed that the prevalence of mental health problems in 2006 was lowest amongst children of caregivers with no formal education (12.4 (9.6-15.9)) but this estimate almost tripled in 2011 (33.5(24.1-44.3)). Prevalence of mental health problems was also lowest for children of families with the lowest household incomes (17.2(16.0-18.4)) but increased to 24.6(21.1-28.5)) over the course of 5 years (2). Since the prevalence of mental health problems in Malaysia is higher among less affluent families, the low-cost apartment was chosen as the setting for the study. This study explored mental health literacy among a group of housewives living in low-cost apartments in Puchong, a district in Selangor, Malaysia and the sociodemographic factors associated with it. Although improving mental health literacy would not necessarily improve mental health, data on mental health literacy however may help in the development of mental health policies and programs.

MATERIALS AND METHODS

A cross sectional study was carried out among housewives in two low-cost apartment complexes in the district of Puchong in the state of Selangor, Malaysia. Data was collected using a self-administered mental health literacy scale (MHLS) adapted from O'Connor and Casey (8). The questionnaire consists of several sections. The first section covered information on sociodemographic data which include age, ethnic group, religion, educational level and monthly family income in Malaysian ringgit (RM). The second section screened the housewives' awareness about mental health issues while the third section consists questions (35 items) that assessed mental health literacy. The mental health literacy section was divided into components such as the ability to recognize disorder, knowledge of risk factors and causes of mental health illness, knowledge of self-treatment, knowledge about professional help available, knowledge of where to seek information and attitude that promotes recognition or help seeking behaviour. Prior to data collection, MHLS was translated into Malay and back-translated to determine its content and face validity. Pilot testing was carried out on 35 housewives from a different low-cost apartment who are not part of the final study respondents. The MHLS Cronbach's alpha recorded for this study was 0.759, slightly lower than the original version of 0.873.

The respondents were recruited through random sampling from the list of residential units within the apartments. Housewives, who were non-Malaysians and

have never heard about mental illness were excluded. Written consent was obtained following detailed explanation about the research objectives and risks to the housewives. Data were collected over the span of two weeks in June 2018 by three researchers. Responses were assessed using 4- and 5-points Likert scales. For questions with 4-points scale, the options include "very unlikely/unhelpful" = 1, "unlikely/unhelpful" = 2, "likely/helpful" =3 and "very likely/helpful" = 4. For the 5-points scale, the options were "strongly disagree/definitely unwilling" = 1, "disagree/probably unwilling" = 2, "neither disagree nor agree/ unwilling nor willing" = 3, "agree/probably willing" = 4 and "strongly agree/definitely willing" = 5. Points were given according to the predetermined scores for positive statements and reversed for negative statements. Scoring range was from 35 to 160. Statistical analysis was performed using IBM Standard Statistical Software Package (SPSS) version 23. One-way ANOVA and independent t-test were used to determine associations. The Universiti Putra Malaysia Ethics Committee for Research Involving Humans Subject (JKEUPM-2018-152) approved the research.

RESULTS

A total of 103 housewives participated in this study (i.e. response rate= 92.79%). Table I shows majority of the respondents were between 30 to 64 years old (62.1%), Malay (77.7%) and Muslims (81.6%). Most had formal

Table I: Socio-demographic characteristics of the respondents (N=103)

Variable	Frequency (n)	Percentage (%)
Age		
17-29 years old	39	37.8
30-64 years old	64	62.1
Ethnic group		
Malay	80	77.7
Chinese	9	8.7
Indian	9	8.7
Others	5	4.9
Religion		
Islam	84	81.6
Buddhism	6	5.8
Hinduism	9	8.7
Christianity	3	2.9
Others	1	1.0
Educational Level		
No formal education	4	3.9
Primary education	8	7.8
Secondary education	57	55.3
Tertiary education	34	33.0
Family Income*		
Below RM 4000	96	93.2
RM 4000-RM 8000	7	6.8
Above RM 8000	-	-

Note * RM= Ringgit Malaysia

education up to secondary school (55.3%) and with family income below RM4000 (93.2%).

The mean MHLS score among the 103 respondents was 106.65 (sd= 11.21). Table II shows that the mental health literacy was highest among the 30-64 age group, Malay, and Muslims. It was also highest among those with tertiary educational level and among those with monthly family income of RM4000 (USD970) to RM8000 (USD1940). There were significant associations between mental health literacy score with the respondents' ethnicity, religion, educational level and monthly family income.

Table II: The mean MHLS score according to sociodemographic factors (age, ethnicity, religion, educational level and monthly family income) and its associations (N=103)

Variable	n	Mean (sd)	t/F	df	p
Age group					
17-29 years old	39	105.64 (11.30)	-0.071 ^a	101	0.478
30-64 years old	64	107.27 (11.19)			
Ethnic group					
Malay	80	107.98 (10.21)	2.283 ^a	101	0.025*
Non-Malay	23	102.04 (13.39)			
Religion					
Islam	84	107.96 (10.26)	2.570 ^a	101	0.012*
Non-Islam	19	100.84 (13.50)			
Educational Level					
No formal education	4	103.25 (3.86)	4.553 ^b		0.005*
Primary education	8	104.25 (12.00)			
Secondary education	57	103.93 (11.07)			
Tertiary education	34	112.18 (10.06)			
Monthly Family Income					
Below RM 4000	96	106.04 (11.23)	-2.075 ^a	101	0.041*
RM4000-RM8000	7	115.00 (7.19)			

Note: (*) Significant $p < 0.05$; ^aIndependent t-test; ^bOne-way ANOVA; Non-Malay = Chinese (9), Indian (9), and others(5); Non-Islam = Buddhism(6), Hinduism(9), Christianity(3) and others (1).

DISCUSSION

The MHLS mean score in this study was lower compared to a study conducted in Australia using the same instrument (9). This is probably following the housewives lack of exposure to mental health discussions and conversations due to their limited education compared to the Australian psychology students in their first semester. The two other mental health literacy studies known to have been conducted in Malaysia used two different instruments (12,13). The first was among non-medical students and focused more on

depression. The study revealed that there was adequate knowledge about the symptoms of depression and that the majority were motivated towards using traditional or complementary medicines and treatments for the condition. Since there was an intrinsic risk in opting for traditional and complementary medicines, thus it was less favourable to seek evidence-based mental health care (12). The second study was carried out among secondary school children and the study revealed that the ability of these students to recognize depressive and schizophrenic symptoms was moderate and very low respectively (13). Although these studies are not comparable with the current study, it concurs with the fact that in general, mental health literacy is still low among several subdivisions of Malaysian population.

The MHLS score in this study was higher among the older age group albeit not statistically significant. However, studies in Australia, Sweden, China and United States of America (USA) showed that the younger populations have better mental health literacy and recognition of mental health disorders compared to the older populations (14-18). Beside the fact that exposure towards mental health literacy varies between developed and developing countries, it is also important to note that the current study had small sample size and narrow age range. This limits the grouping to only two categories which might have prevented us from eliciting the age group differences. Nevertheless, among the explanation offered for age differences was that mental health information was mainly delivered through media more common or accessible to younger age group such as the internet and school programs (17). It was also reported that better health literacy among the Americans and Australian youths were due to the affinity of younger age group to over identify signs and symptoms of mental health problems such as depression and anxiety disorder (17,18). Older age group on the other hand had better understanding about personality disorders and stated more optimistic attitudes about depression and mania than younger adults despite generally having poor mental health literacy (18).

The mean MHLS score was significantly higher among the Malay ethnic group and Muslims. These variations could be ascribed to the fact that the questionnaire was in Malay language and thus Malay native speakers (who were also Muslims) would be able to comprehend better as compared to other race or ethnic groups. Alternately, investigating mental health literacy using English language questionnaire showed otherwise (19,20). A study on depression among non-medical students at a Malaysian university showed that Chinese females had a comparatively better knowledge of the symptoms of depression in comparison with Malays and Indians (19) and another study in Singapore reported that recognition of dementia was significantly lower among those of Indian and Malay ethnicity compared to Chinese (20). This also verifies the ethnic-based variation of general

health literacy in a study among adolescents in Klang Valley (21) which precipitated not only by the language used in the study but also differences in cultural or religious background and education level (22).

Since most of the respondent were Muslim, it is essential to highlight that Muslims in the United Kingdom believed linking religion to mental health has the potential to promote utilization of mental health services among them (23). Though this may not be the case in Malaysia, spreading awareness using religious approaches could be an alternative option to improve mental health literacy. A recent study on online subscription to religious contents showed that most Malaysians who engaged in educational classes, forums, talks, Quran recitations, and religious rulings share similar characteristics with the current study population (e.g. Muslim, 21-40 years old, females, completed secondary education) (24). Given that they spent about 25 hours weekly accessing these contents (24), bridging religion and mental health using the internet in the hope of improving mental health literacy is not an impossible task to achieve, at least for this particular population.

In this study, the mean MHLS score was higher among those with advanced education. This is consistent with a few other studies on different samples such as the rural population in China, students in Australia, the Canadians, and parents in the United States of America (16, 25-27). This could be because individuals with higher education are generally more exposed and well informed about mental health than its counterparts. A national survey in Australia reported that having tertiary education was significantly associated with higher mental health literacy scores particularly on depression, chronic schizophrenia and post-traumatic stress disorder (28). Additionally, a population-based study in Japan reported that low mental health literacy strongly linked to being male and having low level of education. The study further elaborated that having poor mental health literacy could influence vulnerability to commit suicide (29).

Mental health literacy in this study population was also associated with monthly family income. This concurs with other studies mentioned earlier as well (16,25,26). A study among about 1000 adolescents in Sri Lanka showed that there is significant association between appropriate appreciation of mental health problems and family income (30). Many studies had also shown that lower income is associated with common mental conditions (31), thus emphasizing the importance of ensuring good mental health literacy among the lower income group.

This study is one of the early studies that looked at mental health literacy of Malaysian housewives. However, the sample size was small and represents only residents of selected low-cost apartments in one district (out of 9) in

Selangor, Malaysia.

CONCLUSION

This study has shown that the MHLS score among this study population is low and is associated with ethnicity, religion, educational level and monthly family income. Further studies to assess mental health literacy among this study population and among Malaysian in general should be carried out to aid in the formulation of the country's mental health policies. Although this study cannot be generalized to the rest of the Malaysian population, it provides key insights to policy makers.

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