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Evaluation of awareness, attitude and practice of mental health conditions in sample of Iraqi students in Najaf city

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ABSTRACT

Emotional, psychological, and social health all contribute to overall mental health. What we think, feel, and do are all impacted by this. As a result, it plays a role in influencing our stress resilience, social connections, and dietary preferences. Maintaining one's capacity for happiness via care for one's mental health is important. This research aims to examine the relationship between a student's socioeconomic background and his or her knowledge, attitudes, and behaviors about mental health issues among a representative sample of Iraqi college students in the city of Najaf. A descriptive cross-sectional institutional-based study was conducted in AL-Najaf city for pharmacy, medicine, nursing, dentistry and science college students from both kufa and alkafeel university. Study conducted from the period of December 2021 to May 2022. the total number of participants was 1693. The students were asked to fill a hard copy of questionnaire. The study included more females than males and most of participants were between 20-30 years of age. Most of participants were single, under graduates and most of them were within good economic status. The results indicated that more than third of medical students or one of their family members has mental problem also the study identified several deficiencies in public knowledge, attitude and practice. In summary, More over a third of residents said they or a close family suffered from a mental disease, with depression, anxiety, and other serious mental illnesses being the most often diagnosed. In addition, there were significant gaps in knowledge, attitude, and practice across the spectrum of community members surveyed.

1. Introduction

Emotional, psychological, and well-being in other areas of life, including work and relationships. In turn, this affects our mental processes, emotional responses, and behavioral responses. As a result, it plays a role

in influencing our stress resilience, social connections, and dietary preferences. Sustaining positive mental health is essential at every age, from childhood through adulthood.

Poor mental health and mental illness are not the same, despite common use. A person's mental health might be in decline without being diagnosed with a mental disorder. Similarly, a person with a mental disease may go through times of relative health on all fronts. One in two people may experience mental illness throughout their lifetime, and this can have far-reaching consequences for individuals, families, and communities [1]. The state of one's mind is affected by their emotional, psychological, and social well-being. This affects our mental processes, emotional states, and behavioral choices. Therefore, it affects how well we deal with stress, the quality of our relationships, and the foods we choose to eat. Sustaining positive mental health is essential at every age, from childhood through adulthood.

Economically, the cost of mental illness may equal up to four percent of GDP, and those who struggle with mental health tend to do worse in life than those who are mentally well in terms of school performance, job prospects, and overall health [2].

1.1 Why is mental health important for overall health?

To be healthy, one must pay attention to both their mental and physical well-being. Examples of physical health issues for which depression is a risk factor include diabetes, heart disease, and stroke. Similarly, having many chronic health problems might raise one's risk for mental illness [3].

Though the phrase "mental health" is often used, many medically recognized psychiatric diseases have biological underpinnings [4].

Maintaining one's capacity for happiness via care for one's mental health is important. Developing psychological resilience necessitates striking a balance between other life pursuits, duties, and these.

Disorders of the mind have a profound impact on a person's ability to think clearly, feel emotionally, and behave responsibly. A person's ability to deal with daily challenges, hold down a job, and maintain meaningful relationships may all suffer as a result of one of these conditions [5]. Countries with protracted conflicts have a higher incidence of mental health issues, such as low self-esteem, poor health, alcohol and drug abuse, depression, feelings of insecurity, social isolation, self-harm, and suicide. These issues stem from the prolonged exposure to violent and upsetting events. This means that almost everyone in Iraq is affected by mental health and psychosocial problems, either directly or indirectly [6].

The aim of this study is to assess the awareness, attitude and practice of mental health conditions and its association with socio-demographic characteristics in asample of Iraqi college students In Najaf city

2. Method and study design

A descriptive cross-sectional institutional-based study was conducted in AL-Najaf city for pharmacy, medicine, nursing, dentistry and science college students from both kufa and alkafeel university. Study conducted from the period of December 2021 to May 2022. the total number of participants was 1693. The students were asked to fill a hard copy of questionnaire. The students were informed about the purpose, the anonymity and the voluntary nature of the questionnaire. All the students' data were treated as confidential and were never used outside of research purposes.

Medical students were chosen because with patients directly after graduate and their wellbeing is obligatory

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for their efficient work

2.1 questionnaire

Randomly selected students were asked to fill in a confidential self-administered questionnaire prepared using hard copy. The questionnaire has been used quoted from previous studies conducted in Saudi Arabia [7].

Semi-"mixed model" refers to the fact that the questionnaire included both open-ended items and those with or without a Likert scale. In fact, a mixed-model questionnaire gives respondents more room to answer questions on their knowledge, perception, attitude, and practice in a way that is consistent with the questions being asked yet doesn't require too much of their time. The overall mixed model captures quantitative and qualitative aspects; we only used a few free-form questions to get at this. The questions on this 17-item survey (of which 6 dealt with participants' knowledge/practice and 11 addressed their views) were simple and straightforward.

2.2 Data Collection

We introduced ourselves and explained the reason for phoning the participant before beginning the interview. The interviewer then explained the goals of the survey in layman's terms and answered any questions the respondent had. We assured the participant that the interview would be no more than 15 minutes and that their information would be kept confidential. The interviewer next inquired whether or not the respondent was participating in the survey out of their own free will.? If the respondent indicated their willingness to take part in the survey by answering "yes," the interviewer continued by asking questions, and the participant's responses were written down. Every single one of the contributors was given the assurance that nobody would ever find out who they are or what information they gave. It was made clear to the students that the data they supplied for their capstone projects would be anonymised for both academic and administrative purposes.

2.3 Data analysis

Microsoft Office Excel 2007 and SPSS version 16 were used for data collection, summarization, analysis, and presentation. Quantitative factors were reported as numbers and percentages, while qualitative variables were classified into categories.

3. Result

Demographic characteristics of subjects enrolled in this study are shown in table 3.1. The study included more females than males and most of participants were between 20-30 years of age. Most of participants were single and were under graduates and enrolled in governmental educational program. The rate of employment was very low and most of them were within good economic status. The participants were mostly from urban residency.

Table 3.1: Demographic characteristics of subjects enrolled in this study

Characteristic	n	%	Characteristic	n	%
Gender			**Job**		
Male	624	36.9	Employee	121	7.1
Female	1067	63	No job	1567	92.6
Missing	2	0.1	Missing	5	0.3

Age			**Family income**		
20-30	1688	99.7	Excellent	121	7.1
30-40	4	0.2	Very good	403	23.8
Missing	1	0.1	Good	726	42.9
Social status			Average	403	23.8
Single	1372	81	Poor	34	2
Married	296	17.5	Missing	6	0.4
Divorced	15	0.9	**Residence**		
Widowed	9	0.5	Urban	1453	85.8
Missing	1	0.1	Rural	237	14
Level of education			Missing	3	0.2
Undergraduate	1677	99.1			
M.Sc.	12	0.7			
Ph.D.	3	0.2			
Missing	1	0.1			
Type of study					
Governmental	1257	74.2			
Parallel	202	11.9			
Private	208	12.3			
Evening	22	1.3			
Missing	4	0.2			

n: number of cases

Response to section 2, information related to psychological health is shown in table 3.2. Response to question 1 was almost comparable with respect to yes or no answer. Regarding question 2, depression, anxiety, sleep disorders, social phobia, schizophrenia, acute psychosis were identified with the following frequencies: 23 %, 16.1 %, 7.2 %, 1.9 %, 1.1 % and 0.6 %. With respect to question 3, Ignorance, Reading Quran, Spiritual therapy, Herbal medicine, Psychiatrist consultation, Treated by Psychiatrist or behaviorist were seen with the following frequencies: 14.6 %, 41.6 %, 5.1 %, 1.4 %, 15.2 % and 6.6 %. Regarding question 4, we obtained the following answers: Private clinics and hospitals and Governmental clinics and hospitals with the following frequencies: 22.8 % and 64.6 %. Regarding question 5, the following responses were obtained There are no clinics in governmental psychiatry hospitals (35.9 %), No enough beds for patients in need for admission (10.2 %) and High cost of treatment in private clinics (38 %). Responses to question 6 were as following: Excellent, Poor and Don't know as 1.8 %, 72.2 % and 11.5 %, respectively.

The details of responses to questions 7 through 17 are shown in table 3.2 (continuation). These responses were reported as Strongly agree, Agree, Neutral, Don't agree and Strongly don't agree, respectively.

Table 3.2: Response to section 2, information related to psychological health

Question	**n**	**%**	**Question**	**n**	**%**

ISSN: 0005-2523
Volume 62, Issue 10, December, 2022

Q1 Have you or one of your family members ever experienced a psychological problem?			Treated by Psychiatrist or behaviorist	111	6.6
Yes	798	47.1	Others	100	5.9
No	892	52.7	Missing	163	9.6
Missing	3	0.2	**Q4 In the event that you or a loved one needs to see a mental health professional, where would you prefer to go?**		
Q2 If the answer to the first question is yes, what kind of problem did you encounter?			Private clinics and hospitals	386	22.8
No	1	0.1	Governmental clinics and hospitals	1094	64.6
Depression	390	23	Others	189	12.0
Anxiety and obsession	273	16.1	Missing	24	1.4
Sleep disorders	122	7.2	**Q5 In your opinion, what are the obstacles that prevent the use of psychiatric services in mental health care settings?**		
Social phobia	32	1.9	There are no clinics in governmental psychiatry hospitals	608	35.9
Schizophrenia	19	1.1	No enough beds for patients in need for admission	173	10.2
Acute psychosis	11	0.6	High cost of treatment in private clinics	643	38
Missing	845	49.9	Others	184	10.9
Q3 If you or a member of your family suffers from a psychological problem, what will be the first option to deal with the mental			Missing	85	5

problem?					
Ignorance	247	14.6	**Q6 In general, how do you rate mental health services in Iraq?**		
Reading Quran	705	41.6	Excellent	31	1.8
Spiritual therapy	87	5.1	Poor	1223	72.2
Herbal medicine	23	1.4	Don’t know	195	11.5
Psychiatrist consultation	257	15.2	Missing	17	1.0

Table 3.2: Continuation

Question	**Q7.Are you embarrassed if someone finds out that a member of your family has a mental illness?**		**Q8. It is embarrassing if someone finds that you or a family member is visiting a psychologist?**		**Q9. Do you think that a mentally ill person suffers from social isolation and lack of acceptance by society?**		**Q10. By inappropriate description, social media contributes to the poor image of psychopaths?**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Strongly agree	445	26.3	224	13.2	375	22.2	375	22.2
Agree	294	17.4	411	24.3	690	40.8	536	31.7
Neutral	354	20.9	269	15.9	374	22.1	489	28.9
Don’t agree	324	19.1	413	24.4	171	10.1	204	12
Strongly disagree	264	15.6	364	21.5	59	3.5	64	3.8
Missing	12	0.7	12	0.7	24	1.4	25	1.5

Question	**Q11 Do you think that healing with religious beliefs is the best treatment**	**Q12 Do you think that psychoactive drugs lead to**	**Q13 The level of improvement among psychiatric patients who use**	**Q14. Are psychiatrists and psychiatrists easily accessible**

ISSN: 0005-2523
Volume 62, Issue 10, December, 2022

	formental patients than other mental health services?		addiction?		medication is poor?		in clinics and hospitals?	
	n	%	n	%	n	%	n	%
Strongly agree	292	17.2	537	31.7	325	19.2	246	14.5
Agree	384	22.7	594	35.1	403	23.8	412	24.3
Neutral	549	32.4	308	18.2	607	35.9	343	20.3
Don't agree	272	16.1	181	10.7	279	16.5	486	28.7
Strongly don't agree	176	10.4	43	2.5	54	3.2	185	10.9
Missing	20	1.2	30	1.8	25	1.5	21	1.2

Question	Q15 Do you think that qualified psychiatrists are available in publichospitals?		Q16. Can a person control his reaction to psychological problems		Q17. Do you think that integrating people with psychological problems with society and treating them as normal people will have a positive impact on them			
	n	%	n	%	n	%		
Strongly agree	74	4.4	124	7.3	533	31.5		
Agree	214	12.6	329	19.4	591	34.9		
Neutral	386	22.8	528	31.2	263	15.5		
Don't agree	565	33.4	508	30	204	12		
Strongly don't agree	433	25.6	179	10.6	88	5.2		
Missing	21	1.3	25	1.1	14	0.9		

4. Discussion

The purpose of this national survey was to inquire about medical students' perspectives on mental health care in Iraq and their actual involvement in such care. The demographics of the study showed that females outnumbered males and that the majority of participants were college freshmen from kufa and alkafeel universities. These results corroborate those of prior research that examined public knowledge, beliefs, and attitudes about bipolar illness in Saudi Arabia and found it to be unsatisfactory [8].

Based on these findings, it is critical to break down cultural barriers that keep women from filling out surveys, boost enrollment in graduate and professional programs, and get to work on preventing mental health problems and promoting public mental health in Iraq before young adults reach their 20s. Depression (23.2% of participants) and anxiety disorders (16.1% of participants) were the medical issues perceived to

be the most common, while sleep difficulties (7.2% of participants) were the least common. More than half of those who participated or who are directly related to them reported having some kind of mental illness. Several studies have also observed this epidemiological pattern [9- 11]. Some studies of young people's mental health have shown that anxiety disorders are more prevalent than depression, however this may be due to variations in interviewers and diagnostic methods [12].

Students who take part in MH surveys usually mention many distinct and convoluted methods to get support. [7] findings from this cross-sectional study also show that a large proportion of respondents rely on faith healers (41.6%), seek professional help from psychiatrists (15%), or do nothing at all (14.1%). A psychotherapist helps the remaining 6.6%. Many kinds of psychotherapy are not employed in the iraqi MH care system because they are not culturally acceptable, and the therapists also face additional challenges, as shown by various research [14], [15]. Many Iraqis, both those with and without mental health issues, seek out religious faith healers, while others self-medicate with traditional medicines and roqaya recited water (i.e., reciting the Holy Quran while blowing on oneself and into water). Participants' perceptions of multiple obstacles to accessing mental health hospitals and related services in Iraq corroborated the findings of other research, including the high cost of and lack of knowledge about psychiatric services, the absence of MH clinics in public general hospitals, the scarcity of beds, and the associated feelings of shame and stigma [16], [17].

Access to mental health care is a problem all throughout the world, but in Canada, just 33 percent of young people who have one or more mental health diagnoses get treated [18]. Furthermore, 72% of participants' perceptions of the quality of MH services were unfavorable or bad, which tends to deter the public from going to MH hospitals early. The grade of MH care requires additional development not just in Iraq but globally [19]. Survey results show that over 62% of those who either have or have had a family member with a mental health diagnosis also experienced social isolation as a result of seeking help from a mental health professional. These results suggest that stigma towards mental health conditions and a variety of stakeholders and MH settings is detectable in Iraqi society, highlighting the need of ongoing anti-stigma programs aimed at the general populace. It is widely acknowledged that stigma against the general public who are experiencing mental health issues or who use psychotropic drugs has far-reaching implications and disadvantages, such as a greater contribution to the burden of diseases on the society and exchequer, a delay in contacting health professionals, a lack of progress in developing MH services, and ultimately, a poor outcome [20]. Of 53% of participants (compared to 15.2%) felt that incorrect reporting about mental patients and MH institutions through social media adversely effects the image of mental patients [21]. Training programs aimed at the general public are needed to help bridge the mental health care gap, and those working in the media should avoid portraying mentally ill people, mental health facilities, and mental health professionals in an unfavorable light.. Social networking platforms, which have been linked to increased risk of tech addiction, depression, poor self-esteem, and even suicide, should be used appropriately [22]. About 40% of respondents believed that prayer, reading the Holy Quran, and drinking water that had been recited from the Quran had a positive influence on their mental health, whereas 26% disagreed. As an interesting aside, Awaad (2015) addressed the mental health (MH) needs of the Muslim community in the United States by discussing the significance of connectivity between community partnerships and academics as an effective strategy in working in a faith-based community that favors religion-based therapies over the western model of MH services [23]. Respondents shared several misconceptions and negative attitudes regarding psychotropic drugs and MH services, such as the belief that drugs are addictive and are linked to weak or mild improvement, and the difficulty of gaining access to MH services in hospitals, which is consistent with the findings of other studies [24], [25]. Constant public awareness efforts are required to counteract these and other misperceptions about mental diseases, which

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may be impacted by a wide range of factors, including an individual's own character [26]. The findings of the current study, together with those of previous studies, suggest that, globally, the average person's proficiency in certain forms of MHL is lower than in others and calls for more development [26]. Overall, the results of the current study highlighted a number of gaps in public MHL understanding, belief, and behavior, highlighting the need for further research aimed at enhancing public MHL in Iraq. Inadequacies in this research can't be ignored. A standardized MHL questionnaire was not employed in this public opinion poll. Nonetheless,. Our community survey was designed to be representative of the population in terms of age, race/ethnicity, sexual orientation, and area, and we grouped respondents by these factors. Because we were not trying to identify the causes of MHL, only descriptive statistics were employed in our research. This research may have limitations due to the fact that participants in polls and surveys report feeling well and having no major mental or physical illnesses.

5. Conclusion

In summary, More than a third of residents said they or a member of their immediate family suffered from a mental disease, with depression, anxiety, and other serious mental illnesses being the most often diagnosed. It was also found that community members had varying degrees of gaps in their knowledge, attitudes, and practices.

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