# Mental health knowledge, attitude and help-seeking tendency: a Malaysian context

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## ABSTRACT

**Introduction: This study examines the general public's knowledge of mental health and explores effective tools to promote good mental health through a household survey of a representative sample of the Malaysian population residing in Klang Valley, Malaysia.**

**Methods: A total of 587 respondents, aged 18 years and older, responded to a series of questions in relation to mental health issues. Respondents were requested to specify how they learned about the information. Following that, an attitude scale was presented to the participants, and they were requested to rate how much they agreed to the statements.**

**Results: The findings indicated that the majority of the respondents did not have good knowledge of mental health. However, all respondents displayed a neutral attitude towards mental health issues. It was found that ethnic background, religion, educational level and residential location were the few demographic characteristics found to be significantly related to either the respondent's knowledge or attitude towards mental health issues. With regard to seeking help, while the respondents' ethnic background influenced their decisions, younger respondents and respondents with better attitude towards mental health were more willing to seek help.**

**Conclusion: This study has implications for promoting the understanding of the general mental well-being as well as the importance of seeking help for mental health in the local population. Steps should be taken to improve the public's understanding of, and attitude towards mental health. These include the presentation of a positive image and the dissemination of accurate information by the mass media, the primary source for information on mental health.**



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## INTRODUCTION

Mental health is defined as "*... a state of complete physical, mental and social well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*".[1] In other words, mental health involves finding a balance in all aspects of life: physically, mentally, emotionally and spiritually.[2] Although mental well-being is believed to be instrumental to quality living and personal growth, people often take mental health for granted and may not notice the components of mental well-being until problems and stresses surface.[3]

As a country develops and urbanises, life becomes more complex, and problems related to social, cultural, and economic changes arise. Malaysia, a fast-growing country, has embarked on an ambitious vision of becoming a developed country by 2020. With the rapid growth of the country, the population, especially those living in urban cities, often strives to cope with the fast pace of change, and the high stress and tension faced at work, in school and in society. Stress and unhealthy lifestyles often contribute to more complicated health problems, including mental health problems. Thus, achieving better mental health is one of the top priorities for the 9th Malaysian Plan.[4]

Studies aimed at mental health promotion and prevention have identified many strategies to maximise the public's mental health, such as increasing public awareness,[5] improving public knowledge about mental health problems,[5,6] reducing the stigmatisation and discrimination of individuals with mental health problems,[7] and enhancing public attitude towards seeking help from mental health professionals.[5,6,8] However, any strategy intended to initiate change will have to take into consideration the range of people's knowledge and perceptions.[9] In order to devise an effective mental health promotion campaign, assessing

**Table I. Responses to the ten items on the Mental Health Questionnaire.**

| Item | | No. (%) | | |
|---|---|---|---|---|
| | | True | False | Don't know |
| 1. | Only a small minority of people with psychological problems seek help from mental health professionals. | 410 (69.8)* | 44 (7.5) | 133 (22.7) |
| 2. | Eating disorders (e.g. anorexia nervosa, bulimia nervosa) are psychological disorders. | 164 (27.9)* | 93 (15.8) | 330 (56.2) |
| 3. | Psychiatric disorders are true medical illnesses, e.g. heart disease and diabetes mellitus. | 174 (29.6)* | 146 (24.9) | 267 (45.5) |
| 4. | Mental health is defined as the absence of mental disorders. | 218 (37.1) | 90 (15.3)* | 279 (47.5) |
| 5. | During psychotherapy, clients usually lie on a couch and talk about whatever comes to mind. | 308 (52.5) | 47 (8.0)* | 232 (39.5) |
| 6. | Psychological disorders like depression and anxiety disorders do not affect children. | 167 (28.4) | 246 (41.9)* | 174 (29.6) |
| 7. | Stress can lead to illness, e.g. cancer, hypertension, mental disorders. | 396 (67.5)* | 39 (6.6) | 152 (25.9) |
| 8. | A person who has recovered from mental illness will not be able to return to work. | 116 (19.8) | 329 (56.0)* | 142 (24.2) |
| 9. | A person with schizophrenia is a person with "split personality". | 125 (21.3) | 39 (6.6)* | 423 (72.1) |
| 10. | Psychiatrists primarily use psychoanalysis as a basis of therapy. | 136 (23.2) | 20 (3.4)* | 431 (73.4) |

* Correct answers

the public's knowledge and prevailing attitude would be the prerequisites. As many of the previously-published studies were conducted in the West, it is important for a local study to be conducted.

The present study examined the knowledge of mental health, mental health problems and mental illness, as well as the attitudes toward mental health, people with mental health problems/mental illness and help-seeking behaviour, among adults residing in the urban and rural areas in Klang Valley, Malaysia. Mental health here refers to the general mental well-being, not limited to the absence of a mental disorder; while mental health problems refer to changes in thinking, mood and behaviour that occur over a period of time or that significantly affect a person's ability to cope or function. Mental illness refers to a diagnosable illness based on the standardised criteria for diagnosis listed in the International Classification of Diseases (ICD-10)[10] or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[11]

## METHODS

Face-to-face interviews with a representative sample of the adult population (i.e. adults aged 18 years and older) were conducted in Klang Valley, Malaysia. Klang Valley, comprising Kuala Lumpur and its suburbs and adjoining cities in the state of Selangor, was selected as the sampling frame. A stratified multistage sample design was adopted. There were two levels of sample selection: selection of enumeration blocks (EB) in each stratum and selection of living quarters (LQs) within each selected EB. The EBs in the sampling frame were classified by urban and rural areas in accordance to the classification defined in the 2000 Population Census.[12] A total of 45 EBs, 15 EBs from Kuala Lumpur (100% urbanised) and 30 EBs from Selangor (15 urban areas and 15 rural areas), were randomly selected as sampling points with a probability proportional to the number of addresses. In each sampled EB, 16 addresses were selected. One adult resident, aged 18 years and older from each household, was interviewed. In cases where there was more than one eligible member from the selected household, the "next birthday technique" was employed. A final sample size of 720 adults was obtained.

A questionnaire comprising the following parts was developed: (1) Respondent demographical profile (i.e. gender, age, ethnic background, religion, highest educational level), personal experience and prior exposure to mental health issues; (2) A ten-item knowledge scale; (3) A nine-item attitude scale; and (4) One item of help-seeking tendency and reason for not seeking help (if applicable).

The knowledge scale required the respondents to rate each item as "true", "false" or "don't know". For each response, respondents were also requested to note where they learned the information. The total number of correctly-answered items for each participant was recorded. One mark was awarded to each correctly-answered item. Respondents could score between 0 and 10. A higher score meant a higher level of knowledge. The KR-20 coefficient for this scale was 0.746. The attitude scale consisted of nine items (Cronbach's $\alpha$ = 0.723) assessing the overall attitude towards mental health issues; e.g. people with mental health problems and treatment outcomes. Respondents were required to rate how much they agreed or disagreed with each statement. Each item was scored on a four-point Likert scale. The minimum possible score was four and the maximum was 36. A higher score indicated a better attitude towards mental health. The questionnaire, initially developed in English, was translated into Malay and Chinese to cater to a multicultural population. The questionnaire was piloted with 80 adults aged 18 years and older. On average, each

**Table II. Knowledge and attitude towards mental health in different sociodemographic groups.**

| Demographic | No. | Mean score ± SD of knowledge | | Mean score ± SD of attitude | |
|---|---|---|---|---|---|
| Gender | | | | | |
| Male | 321 | 3.29 ± 1.84 | $t(585) = 0.438, p = 0.662$ | 3.29 ± 1.84 | $t(585) = 0.704, p = 0.482$ |
| Female | 266 | 3.22 ± 1.87 | | 3.22 ± 1.87 | |
| Residential Location | | | | | |
| Urban | 389 | 3.47 ± 1.98 | $t(585) = 14.15, p < 0.001$ | 18.23 ± 2.38 | $t(585) = 18.72, p < 0.001$ |
| Rural | 198 | 2.86 ± 1.50 | | 19.14 ± 2.45 | |
| Age (years) | | | | | |
| ≤ 25 | 197 | 3.15 ± 1.85 | $F(4,582) = 2.265, p = 0.061$ | 18.82 ± 2.49 | $F(4,582) = 1.295, p < 0.271$ |
| 26–35 | 158 | 3.25 ± 1.83 | | 18.40 ± 2.55 | |
| 36–45 | 122 | 3.25 ± 1.84 | | 18.30 ± 2.22 | |
| 46–55 | 82 | 3.15 ± 1.93 | | 18.61 ± 2.28 | |
| ≥ 56 | 28 | 2.71 ± 1.85 | | 18.11 ± 2.78 | |
| Ethnic background | | | | | |
| Malay | 416 | 3.11 ± 1.68 | $F(3,583) = 6.314, p < 0.001$ | 18.85 ± 2.29 | $F(4,582) = 8.588, p < 0.001$ |
| Chinese | 118 | 3.91 ± 2.10 | | 17.84 ± 2.42 | |
| Indian | 51 | 3.02 ± 2.24 | | 4.37 ± 1.34 | |
| Others | 2 | 2.50 ± 2.12 | | 18.00 ± 5.66 | |
| Religion | | | | | |
| Islam | 418 | 3.11 ± 1.68 | $F(4,582) = 5.973, p < 0.001$ | 18.84 ± 2.30 | $F(4,582) = 10.859, p < 0.001$ |
| Buddhism | 53 | 4.25 ± 1.81 | | 16.91 ± 2.65 | |
| Hindu | 43 | 2.86 ± 2.36 | | 17.35 ± 3.08 | |
| Christianity | 65 | 3.65 ± 2.23 | | 18.65 ± 1.92 | |
| Others | 8 | 3.75 ± 2.12 | | 18.63 ± 2.56 | |
| Educational background* | | | | | |
| Primary | 81 | 2.68 ± 1.91 | $F(4,582) = 16.118, p < 0.001$ | 19.20 ± 2.05 | $F(4,582) = 3.650, p < 0.027$ |
| Secondary | 339 | 3.11 ± 1.82 | | 18.40 ± 2.63 | |
| Tertiary | 161 | 3.92 ± 1.70 | | 18.44 ± 2.13 | |

SD: standard deviation
* Five respondents did not indicate their educational level and one had no formal education

interview took approximately 20 minutes.

The household survey was carried out between late August 2007 and early October 2007, after obtaining ethics approval from the University of Malaya Medical Ethics Committee. The households were contacted mostly during the weekends and afternoons (from 1500 to 1930 hours). Each address received at least three visits (including at least one in the evening or during the weekend) before it was treated as a non-contact. After the objectives of the survey were explained, respondents were also assured that their participation remained anonymous. A consent letter was signed by each respondent prior to the interview. Interviewers manually checked the questionnaire after each interview before proceeding to the next household. Where possible, interviewers coded the reasons for refusal. A total of 651 respondents were interviewed, 69 less than the original target number, and 587 completed questionnaires were returned, achieving an overall response rate of 90.2%.

Among the 587 respondents, 321 (54.7%) were male and 266 (45.3%) were female, aged between 18 and 60 years (mean and standard deviation [SD] 33.9 ± 12.13) years. The majority of the respondents were Malays (70.9%), while 118 (20.1%) were Chinese and 51 (8.7%) were Indians. A large majority of the respondents were Muslims (71.2%), followed by Buddhists (9.0%), Hindus (7.3%) and Christians (11.1%). Slightly more than a quarter of the respondents had completed post-secondary education, while 57.8% of the respondents had completed secondary education, 13.7% had only primary education and one had no formal education. Less than 5% of the respondents (n = 29) indicated that they themselves, or someone they knew had mental health problems.

The total score for the knowledge and attitude scales were computed. An independent sample *t*-test was used to analyse the difference between the two groups, while the ANOVA test was used to analyse the differences among three groups or more. If more than two groups were compared, the Scheffe's Test was performed to analyse the differences among the means. The relationships between knowledge and attitude were determined using the Pearson's correlation coefficient. Logistic regression analyses were also performed to determine which factors were more important as predictors of the respondents' knowledge, attitude and tendency to seek psychological services. All tests of hypothesis were two-tailed with a type 1 error rate fixed at 5%.

**Table III. Attitude towards mental health issues: percentage breakdown by choice of response.**

| Item | | No. (%) | | | |
|---|---|---|---|---|---|
| | | Strongly disagree | Disagree | Agree | Strongly agree |
| 1. | If I suffer from mental health problems, I would not want people to know. | 31 (5.3) | 190 (32.4) | 256 (43.6) | 110 (18.7) |
| 2. | A person who has visited a psychologist's office is a person with mental disorder. | 16 (2.7) | 262 (44.6) | 273 (46.5) | 36 (6.1) |
| 3. | Anyone can suffer from mental health problems. | 95 (16.2) | 354 (60.3) | 127 (21.6) | 11 (1.9) |
| 4. | I would find it hard to talk to someone with mental health problems. | 15 (2.6) | 201 (34.2) | 326 (55.5) | 45 (7.7) |
| 5. | People are generally caring and sympathetic to people with mental health problems. | 67 (11.4) | 254 (43.3) | 257 (43.8) | 9 (1.5) |
| 6. | People with mental health problems are often dangerous/violent. | 20 (3.4) | 264 (45.0) | 257 (42.8) | 52 (8.9) |
| 7. | The majority of people with mental health problems recover. | 31 (5.3) | 257 (43.8) | 288 (49.1) | 11 (1.9) |
| 8. | People with mental health problems should have the same rights as anyone else. | 78 (13.3) | 273 (46.5) | 225 (38.3) | 11 (1.9) |
| 9. | People with mental health problems are largely to blame for their own condition. | 19 (3.2) | 308 (35.8) | 210 (52.5) | 50 (8.5) |

NB: Item 1, 2, 4, 6, 9 were scored with 4 points for strong disagreement, through to 1 point for strong agreement. Item 3, 5, 7, 8 were scored in the reverse.

## RESULTS

Each respondent was presented with ten statements related to mental health, in which respondents were requested to answer "true", "false" or "don't know". Each correctly-answered item was given one mark, up to a maximum of ten marks. Slightly more than a quarter (26.5%) of the respondents correctly answered 50% of the items, indicating that the majority of the respondents surveyed did not have good knowledge of mental health issues (mean 3.26, SD 1.853). Table I shows the respondents' responses on each item in the knowledge scale. No significant difference was found between the genders ($t$[585[ = 0.438, p = 0.662) and the ages (F[4,582] = 2.265, p = 0.061) in their knowledge level, but significant differences were found in their ethnic background (F[3,583] = 6.314, p < 0.001), religion (F[4,582] = 5.973, p < 0.001), educational background (F[2,578] = 16.118, p < 0.001), and residential location ($t$[585] = 14.15, p < 0.001) (Table II).

Respondents in this study generally subscribed to a neutral attitude towards mental health issues (mean 18.53, SD 2.439). The lowest score was eight and the highest was 24 from a maximum of 32. Table III shows the respondents' responses to each item in the attitude scale. No significant difference was found between the genders ($t$[585) = 0.704, p = 0.482) and ages (F[4,582] = 1.295, p = 0.271) in their attitude level, but significant differences were found in their ethnic background (F[3,583] = 8.588, p < 0.001), religion (F[4,582] = 10.589, p < 0.001), educational background (F[2,578] = 3.650, p = 0.027) and residential location ($t$[585] = 18.72, p < 0.001) (Table II). Pearson's correlation test results did not show any significant relationship between knowledge and attitude scores in general (r = –0.047, p = 0.257).

Among the 587 respondents who responded to the item on help-seeking tendency, 427 (72.7%) indicated that they would seek help when necessary. Of the 160 (27.3%) respondents who were asked to elaborate on the reasons for not seeking help, 114 (19.4%) respondents expressed that they did not know where to seek help and 118 (20.1%) respondents did not want others to know of their condition. Other factors included financial issues and religious beliefs. Multiple responses were recorded. Notably, among the 427 respondents who indicated that they would seek help, 25 (5.9%) respondents also mentioned financial issues as one of their concerns. They also preferred not to let others know (n = 13, 3.0%) and wished to receive more information on where to seek help (n = 25, 5.9%).

In an attempt to identify the factors that might predict the respondents' probability of having good mental health knowledge and attitude, multinomial logistic regression analyses were undertaken, where the knowledge score (of the mental health subscale) was recoded into categories, i.e. "high knowledge score" group for respondents with a knowledge score above five and "low knowledge score" group for respondents with a knowledge score below five, from a maximum total of ten. Similarly, the attitude score (of the mental health subscale) was recoded into "high attitude score" group (score below 18) and "low attitude score" group (score above 18), from a maximum score of 36. The predictors for this analysis included variables in relation to the demographic characteristics and prior exposure to mental health services. Tables IV and V show the multinomial logistic regression analyses of the general public's knowledge and attitudes toward mental health issues.

The results indicated that once all the explanatory variables had been controlled for, residential location, educational background and age of respondents were

**Table IV. Multinomial logistic regression analysis of the general public's mental health knowledge score (n = 578).**

| Reference group | | B | Standard error | Wald | df | Sig. | Exp (B) | 95% confidence interval for Exp(B) | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Lower bound | Upper bound |
| | Intercept | −2.025 | 1.072 | 3.568 | 1 | 0.059 | | | |
| Rural | Urban | 1.125 | 0.287 | 15.329 | 1 | 0.000 | 3.079 | 1.754 | 5.407 |
| Female | Male | −0.120 | 0.211 | 0.322 | 1 | 0.570 | 0.887 | 0.587 | 1.341 |
| Indian | Malay | 0.683 | 1.679 | 0.166 | 1 | 0.684 | 1.981 | 0.074 | 53.232 |
| | Chinese | 0.810 | 0.750 | 1.167 | 1 | 0.280 | 2.248 | 0.517 | 9.775 |
| Christian | Muslim | −0.768 | 1.523 | 0.254 | 1 | 0.614 | 0.464 | 0.023 | 9.178 |
| | Buddhist | −0.116 | 0.410 | 0.080 | 1 | 0.777 | 0.890 | 0.398 | 1.990 |
| | Hindu | 0.133 | 0.791 | 0.028 | 1 | 0.866 | 1.142 | 0.242 | 5.386 |
| Tertiary | Primary | −1.032 | 0.415 | 6.193 | 1 | 0.013 | 0.356 | 0.158 | 0.803 |
| | Secondary | −0.893 | 0.235 | 14.485 | 1 | 0.000 | 0.410 | 0.259 | 0.649 |
| Never sought help | Sought help | 0.272 | 0.463 | 0.344 | 1 | 0.557 | 1.312 | 0.530 | 3.250 |
| ≥ 56 years of age | 18–25 years | 0.029 | 0.637 | 0.002 | 1 | 0.964 | 1.029 | 0.295 | 3.589 |
| | 26–36 years | 0.285 | 0.630 | 0.205 | 1 | 0.651 | 1.330 | 0.387 | 4.574 |
| | 36–45 years | 0.693 | 0.638 | 1.182 | 1 | 0.277 | 2.001 | 0.573 | 6.983 |
| | 46–55 years | 1.589 | 0.645 | 6.066 | 1 | 0.014 | 4.901 | 1.383 | 17.364 |
| Low attitude towards mental health | High attitude towards mental health | 0.076 | 0.260 | 0.085 | 1 | 0.770 | 1.079 | 0.648 | 1.796 |

The reference category is low mental health knowledge score (< 5). The 'Others' group for ethnicity and religion was omitted from this analysis as the number of respondents belonging to these two groups was less than ten.

strongly associated with the mental health knowledge score; while residential location, religion, educational background and age were strongly associated with respondents' attitude towards mental health. Binomial logistic regression analysis was undertaken to identify the factors that might predict respondents' tendency to seek help for mental health issues when necessary. The results indicated that age, ethnicity and attitudes significantly influenced respondents' help-seeking tendency. While respondents' ethnic background influenced their decisions (odds ratio [OR] 0.569, $p = 0.032$), younger respondents (OR 0.811, $p = 0.038$) and respondents with better attitude towards psychology (OR 1.680, $p < 0.001$) and mental health (OR 1.200, $p < 0.001$) were more willing to seek help (Table VI).

## DISCUSSION

Overall, the level of mental health knowledge of the general public is considerably low. The current finding is not dissimilar to previous studies done on knowledge of mental health using different tools and different population groups,[13-15] which concluded that lay people generally have a poor understanding of mental illness; they were unable to correctly recognise and identify the mental problems, did not understand the underlying causal factors, were fearful of those perceived as mentally ill, had incorrect beliefs about the effectiveness of treatment interventions, and were often reluctant to seek help from mental health professionals. The majority of the respondents viewed mental health as freedom from psychiatric symptoms or did not know the meaning of the term. Recognising the true meaning of the term can be important to reduce the stigma and negative attitude towards the word, "mental". The general public should be made aware that a person with mental health problems may be currently undergoing a lot of stress or losing the capacity to cope efficiently, and they may not necessarily be displaying symptoms of psychosis or neurosis.

The general public also appeared to do poorer on items related to mental health problems and psychotherapy, one of which was the item, "A person with schizophrenia is a person with split personality", which was one of the most commonly-reported misconceptions about mental health, with only less than 7% of the respondents correctly answering "false". In the present study, the term "schizophrenia" was used in the English version of the questionnaire, while the term was translated into "skizofrenia" and "精神分裂症" for the Malay and Chinese versions, respectively. These terms are used in the Ministry of Health Malaysia, as well as the Malaysian Psychiatric Association websites. While the majority did not correctly answer the item, "A person with schizophrenia is a person with split personality", it was found that almost three-quarters of the participants responded "don't know", and more than half of the respondents from the rural areas did not understand the word "schizophrenia", or had never encountered the term. While it was thought that "schizophrenia", "psychotherapy" and "psychoanalysis" were jargons, a simple search conducted using Internet search engines (i.e.

**Table V. Multinomial logistic regression analysis of the general public's mental health attitude score (n = 578).**

| Reference group | | B | Standard error | Wald | df | Sig. | Exp(B) | 95% confidence interval for Exp(B) | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Lower bound | Upper bound |
| | Intercept | 0.261 | 1.064 | 0.060 | 1 | 0.806 | | | |
| Rural | Urban | −0.631 | 0.305 | 4.281 | 1 | 0.039 | 0.532 | 0.292 | 0.967 |
| Female | Male | −0.057 | 0.233 | 0.060 | 1 | 0.806 | 0.944 | 0.598 | 1.491 |
| Indian | Malay | 0.414 | 2.057 | 0.040 | 1 | 0.841 | 1.513 | 0.027 | 85.288 |
| | Chinese | 0.150 | 0.769 | 0.038 | 1 | 0.846 | 1.162 | 0.257 | 5.247 |
| Christian | Muslim | 0.027 | 1.930 | 0.000 | 1 | 0.989 | 1.027 | 0.023 | 45.173 |
| | Buddhist | −1.076 | 0.438 | 6.025 | 1 | 0.014 | 0.341 | 0.145 | 0.805 |
| | Hindu | −1.045 | 0.799 | 1.713 | 1 | 0.191 | 0.352 | 0.073 | 1.682 |
| Tertiary | Primary | 1.264 | 0.556 | 5.168 | 1 | 0.023 | 3.539 | 1.190 | 10.520 |
| | Secondary | −0.387 | 0.273 | 2.006 | 1 | 0.157 | 0.679 | 0.397 | 1.160 |
| Never sought help | Sought help | 0.674 | 0.429 | 2.466 | 1 | 0.116 | 1.963 | 0.846 | 4.554 |
| ≥ 56 years of age | 18–25 years | 1.361 | 0.592 | 5.279 | 1 | 0.022 | 3.901 | 1.222 | 12.459 |
| | 26–36 years | 1.002 | 0.582 | 2.965 | 1 | 0.085 | 2.723 | 0.871 | 8.520 |
| | 36–45 years | 0.952 | 0.601 | 2.512 | 1 | 0.113 | 2.592 | 0.798 | 8.418 |
| | 46–55 years | 0.629 | 0.621 | 1.023 | 1 | 0.312 | 1.875 | 0.555 | 6.337 |
| Low mental health score | High mental health score | 0.055 | 0.259 | 0.044 | 1 | 0.833 | 1.056 | 0.636 | 1.754 |

The reference category is low mental health attitude score (< 18). The 'Others' group for ethnicity and religion was omitted from this analysis as the number of respondents belonged to these two groups was less than ten.

Yahoo! and Google) using the keywords, "Malaysia" and "schizophrenia, psychotherapy, psychoanalysis", showed that all the keywords appeared in various articles posted on the Malaysian Psychiatric Association, Malaysian Mental Health Association, Department of Psychiatry and Mental Health and Hospital Kuala Lumpur websites, as well as in news archives in different languages, with the aim to disseminate information about schizophrenia and mental health to the general public. Although many studies in the literature[15,16] reported that most members of the public could not correctly recognise specific mental health problems and did not understand the meaning of the psychiatric terms, what is most worrying was that although information about schizophrenia and mental health (including treatment options) is widely available, the general public's knowledge remains low.

The other misconception held was that mental health problems like depression and anxiety disorders do not affect children, with slightly over half the respondents being unaware that children are also vulnerable to mental health problems. The Malaysian 2nd National Morbidity Survey showed that the psychiatric morbidity prevalence rate in the children aged 5–15 years was about 13.0%.[17] According to Toh et al, the age group reported to have the most acute mental health problems was the 10–12 years group (15.5%), followed by the 13–15 years group (13.4%).[18] Stress at school (e.g. the examination-oriented educational system, peer pressure) and at home (e.g. parents' high expectations, conflicts) were among the reasons for the increase in mental health problems among children.[19] If the understanding of mental health issues remains low among the general public, this may cause caregivers to overlook the symptoms displayed by children, resulting in many symptoms being mislabelled as misbehaviour.

With regard to attitudes towards mental health, over half the respondents agreed that a person who had visited a psychologist's office was a person with mental disorder, that people with mental health problems were often dangerous or violent, and that it was not easy to talk to someone with mental health problems. Many also agreed that people were generally uncaring and unsympathetic toward people with mental health problems, and that people with mental health problems should not have the same rights as others. Although similar to the previous literature,[20] these findings are disappointing, as respondents in this study had subscribed to the common misconception about mental health, leading to a negative attitude towards people with mental health problems and discriminative reactions.

Among the 427 respondents who would consider seeking help, 49.4% (n = 211) of the respondents answered "doctor" (general practitioner [GP]) or hospitals, when asked from whom they would seek help. Less than 10% (n = 38) of the respondents claimed that they would seek help from psychiatrists. Psychologist was only mentioned three times. 12.2% (n = 52) of the participants, of which the majority were Malays (n = 48), mentioned seeking help from traditional healers, e.g. *bomoh* and *sinseh*. 7.78% (n = 332) of the respondents

**Table VI. Logistic regression on the analysis of the relationship of the independent variables to help-seeking tendency/ behaviour (n = 587).**

| Demographic | B | Standard error B | Wald | df | p-value | Exp(B) | 95% confidence interval for Exp(B) |
|---|---|---|---|---|---|---|---|
| Residential location | −0.347 | 0.257 | 1.813 | 1 | 0.178 | 0.707 | 0.427–1.171 |
| Age | −0.210 | 0.101 | 4.302 | 1 | 0.038 | 0.811 | 0.665–0.989 |
| Gender | −0.102 | 0.213 | 0.229 | 1 | 0.632 | 0.903 | 0.595–1.370 |
| Ethnicity | −0.563 | 0.263 | 4.600 | 1 | 0.032 | 0.569 | 0.340–0.953 |
| Religion | 0.134 | 0.171 | 0.615 | 1 | 0.433 | 1.144 | 0.818–1.599 |
| Educational level | 0.186 | 0.205 | 0.829 | 1 | 0.362 | 1.205 | 0.807–1.799 |
| Prior exposure to mental health services | −0.639 | 0.454 | 1.980 | 1 | 0.159 | 0.528 | 0.217–1.285 |
| Mental health knowledge | 0.102 | 0.065 | 2.482 | 1 | 0.115 | 1.107 | 0.975–1.257 |
| Attitude towards mental health | 0.182 | 0.048 | 14.332 | 1 | 0.000 | 1.200 | 1.092–1.318 |

Gender (Male: 1, Female: 2), Age (1 ≤ 25 years; 2: 26–35 years; 3: 36–45 years; 4: 46–55 years; 5 ≥ 56 years), Ethnicity (1: Malay; 2: Chinese; 3: Indian; 4: others), Religious beliefs (1: Islam; 2: Buddhism; 3: Hinduism; 4: Christianity; 5: others), Educational level (1: Primary; 2: Secondary; 3: Tertiary), Experience with mental services (0: No; 1: Yes).

believed that drugs seemed to be the only treatment, and were concerned about the side effects and long-term use of the drugs. Besides cultural influences, this concern could be another reason why a substantial number of people in Malaysia still prefer traditional remedies.

These findings implied that the general public is not well informed about the mental health services in Malaysia and lacks the ability to recognise the need for seeking help. One possible reason for the preference to seek help from GPs could be that visiting the GP's office is less stigmatising, compared to visiting a psychiatrist's or a psychologist's office. Patients generally feel more comfortable with doctors working outside the psychiatric unit.[21] Secondly, the general public, particularly those who reside in the rural areas and those with lower academic qualifications, may not recognise the symptoms of a mental health problem, or lack the ability to recognise the need for psychological services. Hence, many patients who attend mental health services are referred by GPs. Thirdly, members of the general public who believe that a person with mental illness can never recover may also believe that mental health services are either ineffective or long-term treatments are required. In Malaysia, all private insurers exclude mental health services from their plans.[22] People with existing mental health problems seeking insurance for the first time are likely to be refused insurance coverage. Although certain mental health problems may not require long therapy sessions and a majority of the government hospitals offer mental health services at a reasonable and affordable fee, financing mental health services can still be a burden to many families.

Several limitations in the present study should be taken into consideration for future research. First, the study explored the public's understanding and attitude toward the psychology profession and mental health in general. Our aims were to identify where the general public obtained information about the aforementioned and to identify how demographical characteristics affect a person's beliefs, attitudes and help-seeking decisions. As such, the questionnaire designed consisted of questions related to mental health in general. Future research to examine public knowledge of, and attitude towards specific mental health problems is suggested. It is also important to note that public knowledge about mental health was fairly low. Furthermore, with only less than 5% of the respondents indicating that they themselves or someone they knew had mental health problems, it was not possible to draw a conclusion based on the current findings. It is recommended that a survey be conducted incorporating more respondents with prior experience with mental health problems, to determine if prior exposure would enhance their knowledge and attitudes toward mental health problems.

To improve public knowledge about mental health, information should be disseminated through the right medium. The mass media is a dominant influence that has been identified as the primary source for information about mental illness for Americans,[22] likewise for the general public who had responded to this study. Some of the recommendations include reporting success stories of individuals who have undergone treatment for mental health problems and individuals who are currently living with mental health problems. The "voices" of those who have been affected by mental health issues must be prominent in order to impact negative perceptions.[23] Thus, the general public would receive the message that people with mental health problems do recover and can live normally, dispelling the misconceptions that mental health patients are possessed. Mental health professionals

can also play an important role in facilitating public awareness by translating research findings into plain language to be disseminated through the media.

Help-seeking behaviour can be influenced by how people define a problem, and by what they perceive to be the cause and the anticipated prognosis.[5] In order to promote better understanding, the ability to recognise specific and common mental health problems, including early signs and symptoms, interventions, cost, outcomes and coping strategies, should be introduced to the general public. With the increased popularity and easy access to the Internet, the World Wide Web can certainly be a useful source of health information and can provide interactive self-help interventions which can reduce social and attitudinal barriers.[24] At present, the Malaysian Mental Health Malaysia Association, Malaysian Psychiatry Association and the Ministry of Health Malaysia host informational websites in different languages to disseminate mental health information to the general public. However, due to the lack of publicity, members of the general public are not aware of the availability of such information. Quality websites related to mental health issues should be promoted through other media to further encourage accessibility.

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