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KNOWLEDGE AND ATTITUDES OF PUBLIC TOWARD MENTAL DISORDERS AT OUTPATIENT CLINICS IN ASSIUT UNIVERSITY HOSPITAL

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Abstract:

Background: Mental disorders are more common in developed world than in developing world**.** Community, attitude and beliefs play a role in determining behavior of seeking help and successful treatment of patient with mental disorder. It is worth noting that ignorance and stigma prevent the mentally disordered patient from seeking appropriate help. The study aimed to investigate knowledge and attitudes of public toward mental disorders in outpatient clinics at Assiut university general hospital. This study was conducted in outpatient clinics at Assiut university general hospitals. Descriptive study was performed and multi stage sample (first, clinic choose by Random and second, patient's relatives choose by Convenience sampling was used for sex month. The total sample of this study was 1000 person from those attending to outpatient clinics with their relative patients, aged from 18 or more. The present study shows that the majority (84.7% and 83.9%) respectively of the studied sample had unsatisfactory total knowledge scores, and negative attitudes about mental disorders. Also, there is a highly statistical significant difference between total knowledge scores and age, residence, education level and occupation of study participants with P=0.000. Also, between total attitudes level, residence and educational level (P= 0.000 as well as between attitudes toward mental disorders and family history of mental disorders (P= 0.000). The study recommended that we must increase awareness and improve public's knowledge and attitude towards mental disorders through, health education for public in every health care setting that provides care for mentally disordered patients.

Keywords: Knowledge, Attitudes, Public, Mental disorders

Introduction:

Mental disorders are more common in developed world than in developing world[1]. A major contributor (14%) is widely recognized to the global burden of disease worldwide[2], about 450 million people suffer from mental disorders, but only a small minority receives basic treatment. They are likely to increase due to aging populations and deteriorating infrastructure and public health services[3]. Mental disorders are known to have a greater negative impact on the performance of roles than many serious chronic physical diseases[4].

In general, the prevalence of mental disorders varies widely among countries in the world; the rate is found to be the lowest in China and the highest is in the United States of America (USA) [5], the overall prevalence rate 16.95% was similar to that in other Arab countries such as Dubai (UAE) 18.9%[6], Lebanon 16.9%[5], and Egypt 16.93%[7]. It was similar to some European countries such as France 18.4%, the Netherlands 14.9%[5]. Although from that in most parts of the world, mental health and mental illness are largely neglected, leading to an

increased burden of mental disorders in the community and a widening "therapeutic gap"[8].

Mental disorder is a relatively state of mind where a person is unable to cope with and adapt to the repeated stresses of daily life in an acceptable manner[9]. It also refers to a range of disorders causing severe disturbances in thinking, feeling and relating, resulting in a significant contraction in the ability to cope with the normal demands of life[10]. Over the past 50 years, biological and genetic factors have been promoted as underlying causes, and people with mental disorders are considered to be "sick" in the same sense as those with medical conditions[11].

The lack of information on mental health statistics is one of the most prominent problems in Arab countries[6]. We need such information as the basis for future mental health planning, development, training and integration of mental health in primary health care[7]. A persistent negative attitude and social rejection of people with mental disorder throughout history has prevailed in every social and religious culture[9]. Culture may provide unique explanatory models, beliefs or attitudes related to mental disorder and can identify motives, barriers and pathways to help[12,13].

The concept of mental health or disease has a problematic definition because it is largely subjective[14]. Therefore, community reaction to mental patients varies from society to society, because people's culture is also a model of human behavior[15,16,17]. Mental disorder is among the most stigmatizing conditions around the world[18]. Patients with mental disorder have been stigmatized since long back in any society, and this stigma is just simply "labeling" the patients[19].

Stigma and negative attitudes towards people with mental disorder have been found to be common throughout the world among trained health workers as well as the general population[20]. The relationship between culture and stigma associated with the disease is rather complex, and may be more complex in developing countries[21].

The role of community in the prevention and care of persons with mental disabilities has been widely recognized and is considered the most appropriate basis for the development of mental health programs. Many studies have shown that knowledge of public attitude to mental disorders and its treatment is a vitally important prerequisite for achieving successful community programs[22]. In addition, the community's attitude and beliefs play a vital role in determining the behavior of seeking help and success in treating mental patients. It is worth noting that ignorance and stigmatization prevent mental patients from seeking appropriate assistance[23].

Traditionally people did not understand mental disorder well, resulting in poor attitudes towards persons with mental disorders and stigmatization[24], about 90% of suicides are attributable to underlying mental disorder[25]. In Egypt, as in other countries of the Eastern Mediterranean Region, mental health remains a neglected priority, as evidenced by the huge treatment gap caused by the incompatibility of needs and resources[7,26,27], also there is a scarcity of community surveys in the field of psychiatry[27]. In the original global estimates developed for 1990, mental and neurological disorders were 10.5% (expected to increase to 15% in 2020) [28], of the total disability adjusted life years lost due to all diseases and injuries. It ranked first among the20 main causes of the disability adjusted life years rate for all ages and in the highest 6 in the age group 15-44 years[29].

Nurses must be able to provide psychosocial education and care with a

positive attitude in society, as community care is the most accessible form of care around the world[30].

No existing research outcomes were found on community's knowledge and attitudes toward mental illness in Assiut governorate. The study was therefore expected to explore public's knowledge and attitudes related to mental disorder in Assiut community.

Research questions: 1. Is there a lack of knowledge and negative attitudes among public in Assiut city about mental disorders?

2. Is there a significant relationship between socio-demographic variables, knowledge and attitude about mental disorders among public in Assiut city?

3. Is there a significant relationship between family history of mental disorders, knowledge and attitude among public in Assiut city?

The present study aims to investigate the public's knowledge and attitudes towards mental disorders in outpatient clinics at Assiut University General Hospital. The aim is achieved by assessing knowledge and attitudes, studying the relationship between knowledge and attitudes towards mental illness, and examining the relationship between socio demographic characteristics, knowledge and attitude.

Subject and methods: - The present study was conducted in outpatient clinics at Assiut university general hospital. Assiut university general hospital is the main hospital in Assiut and it receives patients form all districts and villages of Assiut Governorate. Descriptive study was performed and Multi stage sample was used first, random sample for choose the outpatient clinics (General surgery, ophthalmic, General medicine and Ear nose and throat clinics) and second, convenience sampling for choose of patient's relative who attended at this clinic during six months, period from the beginning of January 2016 till the end of July 2016, was used. The total sample of this study was 1000 person aged from 18 years or more who attending to outpatient clinics with their relatives in this time, and who agreed to participate in the study, selection of sample was based on their oral consent to participate in the study and they do not have any health complaints.

Two study tools were designed by the researchers after reviewing literature to collect related data. The first tool is an interview questionnaire form to assess public knowledge about mental illness. It consists of three parts: *part I*, Demographic characteristics of the sample such as age, sex, residence, level of education, marital status, number of family members, family income……etc., *part II***:** family history about mental disorders , types of mental disorders.….etc.

and *Part III***:** Knowledge about mental disorders as definition (1 grad), interpretation of the concept of mental health(4 grads) ,causes(8 grads), early signs(3 grads), symptoms(16 grads), how to diagnose(1 grad), method of treatment(7 grads), places for treatment(5 grads), how to help mental ill patients(2 grads) ,how to deal with the mental stress(10 grads), relationship between mental stress and mental illness and source of knowledge.

Scoring system for knowledge was used, each correct answer took one grade and wrong answer or don't know took zero grade and total knowledge scores (57 grades) was converted to percent and judged as the following: unsatisfactory <50% and satisfactory from50 % and more.[31]

Second tool to investigate attitudes by modifying((**Likert))** scale developed by Ahmed (2009).[32], which used to measure the attitude of public toward mental illness. It contains 23 items (statement) about positive attitudes toward mental

disorders, the responses were based on three-point Likert scale and were scored as agree (2 grades), uncertain (1 grade), and disagree (0 grade) [33], and total attitude scores (46 grades) were converted to percent and judged as the following negative attitude < 60% and positive attitude from 60% and more.[34]

An official permission will be obtained from the Faculty of Nursing and director of outpatient clinics in Assiut university general hospital. Finally, oral consents were taken from patients' relatives.

A pilot study was performed to evaluate the clarity of interview questionnaire validity and reliability. It was carried out on a sample (10% from the total number of the sample). This sample was excluded from the total sample. Then the necessary modifications were done and final form was developed and used in data collection.

Validity of the sheet was established by a panel of 5 experts from community health nursing and Psychiatric nursing staff in Assiut University who revised the tools for clarity, relevance, applicability, comprehensiveness, understanding and ease for implementation. Modifications were done according to the directions of the experts committee.

Reliability **t**est was done by ((Cronbach's)) Alpha test =0.640.

After that data were collected during the morning, three days per week from January 2016 to July 2016 through interviewing the relatives who attend with the patients to outpatient clinics chosen previously in Assiut university general hospital. The interview questionnaire sheet was filled by the researchers; it took from 10 to 15 minutes on average for each person.

The obtained data were coded, analyzed by using SPSS version 20, tabulated, descriptive statistics as percentages., Cross tabulation and chi square test(χ**2**) and correlation were used and p value equal or less than 0.05 were considered as statistically significant.

Limitations of the study: most patient relatives refused to participate in this study.

Results:

Table (1) Shows that the mean age of studied sample is 33.26±11.16, and more than half (56.8%) of them live in rural community while 60.8% of them were males. Also, this table found that 35.5% of studied sample finished university while 6.8 % and 2.6% respectively were illiterate and had post graduate.

According to the occupation this table revealed that 28.6% and 25.2% respectively were employees and had technical work, also 59.2% of the sample was married, and 46.8% of them were living with family ranged from 4 to 6 members, while 3.5% of them were living alone. Regarding to the family income, it was found that 43.7% of the sample had income more than 1600 pound per month, while 8.2% had income less than 600 pound per month.

Regarding family history of mental disorders (as shown in table 2) 37.3% of studied sample had family history of mental disorders, 25.0% of them had depression, and 22.5% of them live in the same house.

Figure (1) illustrated that 84.7% of studied sample had unsatisfactory total knowledge scores while 15.3% of them had satisfactory total knowledge scores about mental disorders.

Figure (2) revealed that 83.9% of sample had Positive attitudes while 16.1% of them had negative attitudes toward mental disorders.

Figure (3): Illustrated that slightly 60.7% of studied sample reported that their main source of knowledge was mass media, while 19.0% of them reported that their source of their knowledge were family member and friends.

Figure (4) shows that: there is a statistical significant positive correlation (r=0.59) between total knowledge scores and total attitude with P= 0.001.

Table (3) reflected that 86.9% of the studied sample reported that there is a relationship between stress and mental disorders, and 39.1% of them seeking help from psychiatrist, while 79.6% of the studied sample has a stigma from mental disorders, and the 95.2% of them told a stigma because of shame of mental illness.

Table (4) illustrated that there is a statistical significant difference between total knowledge scores and age group, residence, education level and occupation with P= 0.000, also this table reflected that there is a statically significant difference between total attitudes with residence and educational level at P= 0.000.

Table (5) Showed that there is a highly statistical significant difference between attitudes toward mental disorders and family history of mental disorders (P= 0.000).

Table (1) Sociodemographic characteristics of the study sample (n=1000).

Sociodemographic characteristics	**No**	**%**
- 18< 30 years	407	40.7
- 30 < 40	297	29.7
- 40 < 50	205	20.5
- >50 years	91	9.1
Mean ±SD	33.26±11.16	
***Sex**		
- Male	608	60.8
- Female	392	39.8
***Residence**		
- Urban	608	43.2
- Rural	392	56.8
***Education level**		
- Illiterate	68	6.8
- Read and write	295	29.5
- Secondary school	258	25.8
- University	353	35.5
- Post graduate	26	2.6
***Occupation**		
- Employee	286	28.6
- Worker	252	25.2
- Farmer	77	7.7
- Student	205	20.5
- House wife	180	18.0
***Marital status:**		
- Married	592	59.2
- Single	355	35.5
- widow	32	3.2
- Divorced	21	2.1
***Number of family:**		
- Alone	35	35
From 2 to3 member -	319	319
- From 4 to 6 member	468	468
- More than 6 member	178	178
***Family income\ pound:**		
- Less than600	82	8.2
- From 600 to 1000	237	23.7
- From 1000 to1600	244	24.4
- More than 1600	437	43.7

Table (2): Distribution of the study sample by family history of mental disorders (n=1000)

Family history	No	%
*** Family history of mental disorders?**		
Yes	373	37.3
No	627	62.7
*** Mental disorders type (373):**		
Depression		
Stress	250	67.0
Obsessive compulsive	161	43.2
Phobia	64	17.2
Panic	10	2.7%
* More than one	48	12.9
*** Live in the same house(373):**		
Yes	84	22.5
No	209	77.5

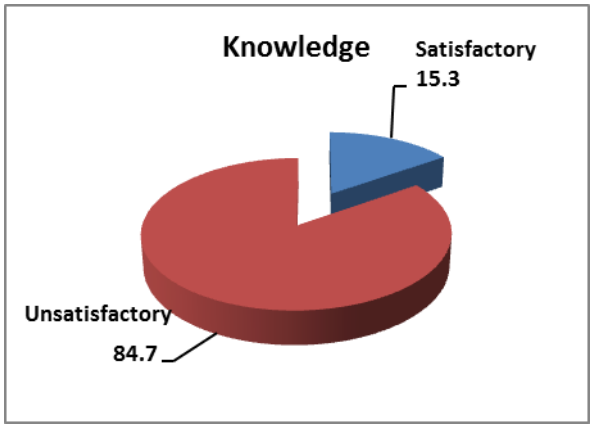

Fig (1) Distribution of the study sample by total knowledge scores

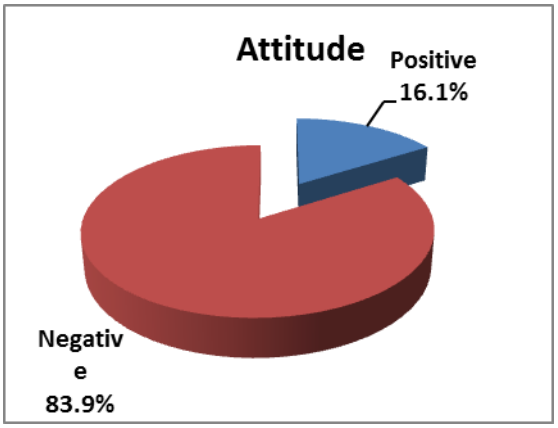

Fig (2): Distribution of the study sample by attitudes scores

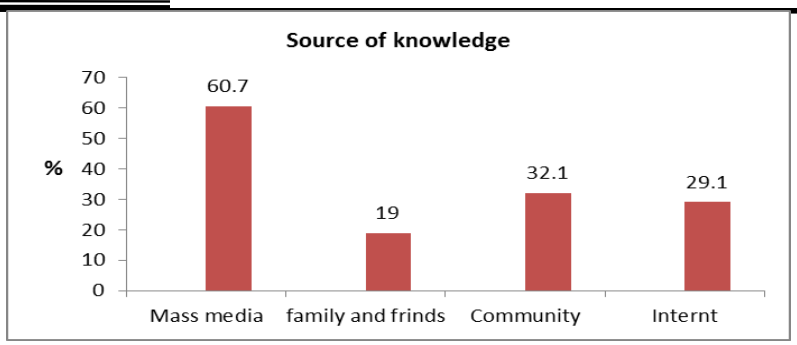

Figure (3) Source of knowledge among study sample

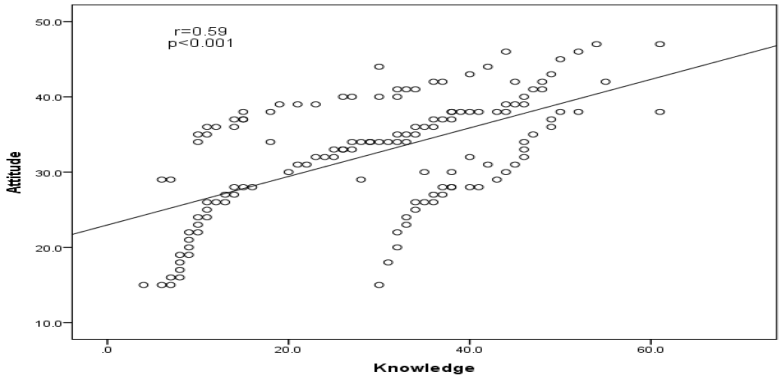

Fig (4): Correlation between total knowledge score and total attitude among study sample

Table (3): Distribution of knowledge about how to deal with mental problems and stigma among study sample (n=1000)

Knowledge	No	%
*** Relation between mental stress and mental disorders**		
Yes	131	13.1
No	869	86.9
*** Seeking help if there is mental problem from:**		
Psychiatrist	391	39.1
Psychiatric nurse	10	1.0
Family member	249	24.9
Friends	201	20.1
Man, of religion	117	11.7
Do not know	32	3.2
*** Mental disorders are a stigma**		
Yes	796	79.6
No	204	20.4
*** Causes to consider mental disorders is a stigma (796**)		
Community problems	38	4.8
Shame of mental illness	758	95.2

Table (4): Relation between total knowledge scores, total attitudes level scores and sociodemographic characteristics of the study sample about mental disorders (n=1000)

Sociodemographic characteristics	Knowledge						Attitude					
	Satisfactory)(n=153		Unsatisfactory (n=847)		χ^2 1	P1-value	Negative (n=839)		Positive (n=161)		χ^2 2	P2-value
	No	%	No	%			No	%	No	%		
***Age\years**												
- <30 years	41	26.8	366	43.2	22.1	**0.000***	338	40.3	69	42.9	0.90	**0.823**
- 30-40	66	43.1	231	27.3			251	29.9	46	28.6		
- 40-50	38	24.8	167	19.7			171	20.4	34	21.1		
- >50 years	8	5.2	83	9.8			79	9.4	12	7.5		
***Sex**												
- Male	84	54.9	524	61.9	2.63	**0.104**	513	61.1	95	59.0	0.25	**0.610**
- Female	69	45.1	323	38.1			326	38.9	66	41.0		
***Residence**												
- Urban	105	68.6	327	38.6	47.6	**0.000***	422	50.3	10	6.2	107	**0.000***
- Rural	48	31.4	520	61.4			417	49.7	151	93.8		
***Education level**												
- Illiterate	0	0.0	68	8.0	200	**0.000***	48	5.7	20	12.4	94.5	**0.000***
- Read and write	17	11.1	278	32.8			203	24.2	92	57.1		
- Secondary school	27	17.6	231	27.3			232	27.7	26	16.1		
- University	83	54.2	270	31.9			330	39.3	23	14.3		
- Post graduate	26	17.0	0	0.0			26	3.1	0	0.0		
***Occupation**												
- Employee	80	52.3	206	24.3	72.0	**0.000****	240	28.6	46	28.6	4.28	**0.369**
- Worker	8	5.2	244	28.8			214	25.5	38	23.6		
- Farmer	6	3.9	71	8.4			59	7.0	18	11.2		
- Student	39	25.5	166	19.6			177	21.1	28	17.4		
- House wife	20	13.1	160	18.9			149	17.8	31	19.3		

***Statistical significant difference (P= or<0.05)**
P1 (χ2 1): Relation between knowledge and sociodemographic characteristics
P2 (χ2 2): Relation between attitude and sociodemographic characteristic

Table (5): Relation between total knowledge and attitudes and family history of mental disorders of the study sample about mental disorders (n=1000)

Family history	Knowledge						Attitude					
	Satisfactory)(n=153		Unsatisfactory (n=847)		χ^2 1	P1-value	Positive (n=839)		Negative (n=161)		χ^2 2	P2-value
	No	%	No	%			No	%	No	%		
Family history of mental disorders	53	34.6	320	37.8	0.54	0.459	336	40.0	37	23.0	16.82	0.000***
Yes	100	65.4	527	62.2			503	60.0	124	77.0		
No												

***Statistical significant difference (P= or<0.05)**
P1 (χ2 1): Relation between knowledge and family history of mental disorders
P2 (χ2 2): Relation between attitude and family history of mental disorders

Discussion:

Mental disorder has a universal character that affects people in all countries and societies, individuals of all ages, women and men, rich and poor, from the urban and rural environment. They have an economic impact on communities also on quality of life for individuals and families[35]. Communities are essential for providing primary care to people with mental illness, but they often require knowledge[36,37].

The present study aims to investigate knowledge and attitudes of public toward mental disorders in outpatient clinics at Assiut university General hospitals.

The current study demonstrates that slightly more than two fifth of studied sample were in the age group of 18 to 30 years old. About three fifth and slightly less than three fifth of them were male and married; while more than half of them were from rural areas. Data also confirm that (35.5% and 43.7%) respectively of the study sample had university education

and had income more than 1600 pounds per month (table 1)

This study was in the same line at age group and in contrast at sex with the previous study done by Genesh 2011[38]and Chikomo 2011[36] who studied knowledge and attitude of mental illness among general public of Southern India, and Kinondoni, found that 46% % and50.6% respectively of the subjects were in the age group of 18 to 30 years, more than two third and more than half of them were females, and also disagree with Aruna et al 2016[39] who studied perception, knowledge, and attitude toward mental disorders and psychiatry among medical undergraduates in Karnataka, and found that more than two fifth of the study samples were males and more than half of them were females. The study also supported by Chikomo 2011[36]who showed that more than half of respondents were married.

About one quarter of people in both developed and developing countries suffer from one or more mental or behavioral disorders at some point in their life[40], 154 million of people suffer from depression, 25 million people with schizophrenia, and 91 million of people with alcohol abuse, and 15 million suffer from drug abuse[5]. Depression and anxiety are the most common mental disorders[41]. The present study agrees with the previous discussion and explore that more than one third of the study sample had family history of mental disorders, depression reported by more than two third of them (table 2). This depression may be due to life stress.

In contrast, Soliman et al (2015) [42] studied attitude of medical students toward mentally ill patients, who found that less than two third of the studied sample were female, and most of the studied sample had no family history of mental illness (83%).

Mental health knowledge was defined by Jormfeldt (2006) as "the knowledge and beliefs about mental disorders which aid in recognition, management or prevention". This includes the ability to identify specific disorders, learn how to obtain mental health information about risk factors, causes, self-treatment and professional help[43]. Although mental health was an integral part of overall health, in many countries it had been a largely neglected area[44].

Communities are essential components in giving primary care for people with mental disorders[37], and are highly likely to have contact with a person who has a mental disorder, but they often need knowledge and skills to support these people[45]. The current study reflects that the majority of study sample had unsatisfactory total knowledge score about mental disorders. This may reflect educational level, which more than three fifth of the study sample had education level ranged from illiterate to secondary school. This study is in the same line with the previous study done by Ghuloum et al. (2010)[46] and Bener and Ghuloum (2011)[47] about mental illness in Qatar who reported that a large proportion of the community had poor knowledge of mental illness, and only a few had average knowledge. They believe that mental illness can result from punishment from God. Also, they were in agreement with the previous study done by Genesh 2011[38] who found that the mean knowledge score of the subjects was 5.90 ± 1.22 about mental disorders and about three fifth of subjects were afraid to someone with mental illness as neighbor.

Community knowledge of mental health problems has been found to be insufficient, while this lack of knowledge is fertile soil for the development of negative behavior towards mental illness[48,49]. Angermeer et al. (2009) [50] added that better knowledge leading to more favorable attitudes.

The current study revealed that the majority of the study sample had negative attitudes toward mental disorders. This negative attitude is due to unsatisfactory knowledge of the participants and behave without understanding. Also, the participants believe that the patient with mental disorder is considered a mental retarded person. From the above discussion, we can infer that there was lack of knowledge and there is a definite negative attitude regarding mental disorder because more than half of the studied sample is from rural areas.

Consequently, the attitudes of present study people were unsurprising because they were in the same line with Ghuloum et al. (2010) [46] who found that the majority of Qataris held a negative attitude towards people with mental disorders. The current study was in agreement with More et al 2012[1], who studied knowledge and attitudes concerning mental disorders in adults, and found 78% of participants had poor knowledge and 86% had a negative attitude toward mental disorder among participants.

Also, More et al 2012[1], was in agreement with this study which showed that there is a significant positive correlation between knowledge and attitude score of adults in urban areas. Patients with mental disorders are part of society, but are perceived differently by society. Different societies have different patterns of seeking help, and some countries include traditional healers in their health care systems[17,18,19] .

Itzahak 2004 and Jugal et al 2007[51,52] mention that most subjects were uncomfortable in visiting a psychiatrist if they had any emotional problem and only a few visited the traditional healer for consultation; this reflects the stigma associated with mental illness and hindering treatment seeking. The current study reflects that (39.1% and 1.0%) of the study sample were seeking help from psychiatrist and psychiatric nurse while more than two fifth of them were seeking help from family member and friends and few of them were seeking help from traditional healer as man of religion and moshaozeen. (table5). This result reflects attitudes of upper Egyptians toward mentally disordered patients.

Al-Adawi et al. (2002) [53] reported that the stigma varies depending on the cultural and social background of each community. The present study showed that the majority of studied sample considered mental disorder is a stigma.

This results supported by Al-Krenwi 2001[54] and Norman et al 2008[55] who reported that In Egypt, as elsewhere, one of the most common reasons for not using psychological services available to the general public is stigma.

The media can play a significant role in any movement for change and in determining community attitudes towards mental disorder[56]. Bener and Ghuloum 2011[47] who studied ethnic differences in the knowledge, attitudes and beliefs towards mental illness in a traditional fast developing country, and showed that the source of knowledge about mental illness, less than two third in non-Qatari Arabs gained their knowledge from the media, whereas the percentage of Qataris learnt from family members and friends was more than one third. The present study is in the same line with the previous study which reflects that slightly more than three fifth of studied sample reported that the source of their knowledge is from mass media and less than one fifth get their knowledge from family member and friends.

The present study also illustrated that there is a statistical significant relation between knowledge and age P=0.001, which noticed that more than two fifth of study sample had satisfactory scores who aged from 30 to less than 40 years old

while there was no significant relation between attitude and age P=0.823, which more negative attitudes among the study sample who aged from 18 to less than30 years old may be due to less life experiences.

Also, the current studies reflect that male and urban sample have more knowledge than female and rural sample with significant relation between residence and total knowledge scores P=0.000 as well as with attitudes P= 0.000. While insignificant relation between knowledge, attitude and sex were observed

Concerning to educational level, the present study reflects that education had an effect on knowledge which is noticed among all postgraduate who had satisfactory knowledge with statistical significant difference between educational level and knowledge, also with knowledge and attitude P=0.000, as well as between knowledge and occupation P=0.000, while there is no statistical difference between occupation and attitude P=0.369. The rural participants have more positive attitude toward mental illness. This is because behaviors of rural participant without understanding and they believe that mentally ill patient consider the person close from God to become sheik (mabrok).

The present study supported by More et al 2012.[1], who studied knowledge and attitudes concerning mental illness in adults which compare knowledge score and attitude toward mental disorders of rural and urban adults, the mean knowledge score among rural participants was 7.78 ±2.62 and among urban area was 16.16±3.6. There was a significant difference between mean score of knowledge among rural and urban adults. Also, the attitude mean score among rural participants was 33.7±12.5 and among the urban area was 81.2±12.8.

Studied done by Ganesh 2011who.[38] reported that participants who aged less than30 years and male had more knowledge compared to participants who aged more than 30 years and female. There was a significant difference in knowledge and attitude scores of sample residing in the urban and rural areas. The urban participants were more knowledgeable and having more positive attitude than the rural participants regarding mental disorder.

Mahto et al, (2007) [57] did not find any significant level of difference between male and female students' attitude regarding mental disorder. While Momi &Saikia 20017[58] find a significant difference between knowledge and attitude of rural and urban college students. Also, no significant association was found between knowledge of both rural and urban family members by Gogoi and Baruah 2011[59].

The current study also shows there is no significant relation between family history and total knowledge score P=0.459 while, there's highly statistical significant difference between attitudes and family history of mental disorders P= 0.000.

The present study is in contrast with Momi &Saikia 20016[58] who found that there is a significant relation of knowledge with family history of mental disorders among urban respondents. Also, it was in contrast with Youssef et al,2014.[26] who found that higher knowledge score among those people who knew someone with mental disorder.

This study was in the same line with Chikomo 2011[36] who studied knowledge and attitude of mental illness among general public in Kinondoni, and found that there is no relationship between knowledge and gender as well as between knowledge and age group while there is a statistical significant difference between knowledge and education with P <0.032. Also it showed that males have more negative attitude toward mental disorder than females P<0.010, there is a statistical

significant difference between attitude and education P< 0.011 and insignificant difference between attitude and age group.

Based on the results of present study, it can be **concluded** that the majority of studied sample had unsatisfactory knowledge scores and had negative attitude toward mental disorders. The present study **recommended that,** increase awareness and improve public's knowledge and attitude towards mental disorders through, health education for public in every health care setting that provides care for mentally ill patients. Also, prepare guide line for improving mental health literacy in the community about mental disorders, as well as teaching family members about how to adjust to mental disorders because it is life-long problem. Furthermore, researches are needed to do a bigger sample and represent all governorates to identify knowledge and attitude of all community to help the health decision maker.

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