Cultural Influences on Mental Health Stigma: How Society Views Mental Health

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Declaration of Authenticity

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“Cultural Influences on Mental Health Stigma: How Society Views Mental Health”

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Abstract

Mental health stigma continues to be a major barrier to seeking psychological support in Arab and Muslim societies, especially in Saudi Arabia, where cultural and religious values strongly influence how mental illness is viewed. This study explored whether presenting mental health education through an Islamic lens could help reduce people's reluctance to seek professional help. Using a quantitative, cross-sectional approach, 71 participants completed a stigma scale survey before and after watching a culturally sensitive educational video concerning Islamic values. A paired samples t-test showed a significant drop in avoidance scores after the intervention ($p = .003$), suggesting that religiously framed content helped lower stigma. The findings align with previous research on the importance of culturally relevant strategies and show that using familiar religious frameworks can improve understanding and acceptance of mental health care. While the results are encouraging, the study's generalizability is limited due to its small, mostly female sample and short-term design. Future studies should examine long-term outcomes and explore how different interpretations of Islam shape mental health attitudes. Overall, this research adds valuable insight into how culturally informed methods can support stigma reduction in religious and community-oriented settings.

Keywords: mental health stigma, Islamic perspective, cultural sensitivity, Saudi Arabia, help-seeking behavior, religious values, stigma reduction, mental health education, psychological support, cross-sectional study, culturally informed intervention

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1. Introduction

1.1 Background

Mental health stigma continues to be a major obstacle in Arab and Muslim communities, impacting the ability to seek treatment and attain overall well-being, influenced greatly by cultural, religious, and societal factors. Although there has been a rise in global recognition of mental health issues, stigma remains within these communities, making it difficult to advance efforts in promoting mental health care and support. This review combines research results from different studies that investigate the influence of cultural and family values, religious beliefs, social norms, and internalized stigma on mental health in Arab and Muslim communities. This review emphasizes the intricate nature of mental health stigma and the importance of utilizing culturally sensitive strategies to effectively address it. By gaining a more comprehensive comprehension of these interconnected elements, mental health interventions can be customized more effectively to address the distinct requirements of these communities, leading to increased acceptance and availability of mental health services.

1.2 Literature Review

The stigma surrounding mental health continues to hinder treatment and overall wellness, particularly in Arab and Muslim communities where cultural, religious, and societal beliefs heavily influence views on mental illness. This review summarizes results from diverse studies investigating how these factors affect mental health stigma within these communities. The literature emphasizes important topics like cultural and family values, religion, internalized stigma, and the requirement for culturally sensitive interventions. These themes show the complexity of mental health stigma and offer ideas for effectively tackling it.

One of the primary topics discussed in the research is how cultural and family values impact the stigma surrounding mental health. This study, conducted in the UAE, showed that sticking to traditional family values, especially among males, strengthened unfavorable perceptions of mental illness. While demographic variables such as age and education did not have a notable impact on these beliefs, the deeply ingrained family systems within Arab society are still promoting stigma. Nonetheless, the research also highlights a gradual transition towards more accepting beliefs concerning mental well-being, specifically within the UAE, in line with overall developments in

the Arab region, where awareness about mental health is slowly advancing despite enduring discrimination (Andrade, et al., 2022). Similarly, another study performed a systematic analysis of mental health stigma among diverse Arab populations, finding that although stigma was common, the type and strength of stigma differed among various groups. Both research projects highlight the significance of considering cultural backgrounds when tackling stigma around mental health, as familial and societal values heavily shape attitudes towards mental illness (Zitoun, et al., 2021). Social norms and community expectations, in addition to cultural and religious influences, are important determinants of mental health stigma in Arab and Muslim communities. People who are under social pressure to live up to social norms frequently put off getting mental health therapy out of fear of being judged or shunned. Specifically, this study observed that social norms on upholding appearances and avoiding embarrassment posed major obstacles to obtaining assistance in Saudi Arabia. People hide mental health problems because of their urge to maintain social and familial honor, which feeds stigma and prevents mental health diseases from receiving treatment. Therefore, when developing interventions to lessen stigma, it's critical to consider societal standards while highlighting the importance of mental health without compromising one's social position.

Religious beliefs are equally important in influencing perceptions of mental health within Muslim communities. (Zarbah, et al., 2023) Another study discovered in their qualitative research on Arab Muslims in Melbourne, Australia, that mental health disorders were understood and addressed by individuals with strong influences of religious and cultural beliefs. Numerous participants in the research study favored spiritual or religious treatments instead of seeking professional mental health services, showing that religious beliefs often result in misunderstandings about mental health. (Alqasir, A., Ohtsuka, & K., 2024) This aligns with the results of a study conducted on stigma in Muslim communities, emphasizing the influence of religious beliefs on perpetuating stigma. Incorrect beliefs, like thinking mental illness is a trial of faith or a spiritual weakness, make it harder to seek help from professional treatment. Hence, the overlap of religious and cultural standards is a key factor in influencing the stigma around mental health in Muslim societies, highlighting the importance of interventions that are culturally appropriate and considerate of religious convictions while advocating for professional help.

The literature also reveals the influence and prevalence of internalized stigma, which happens when people take on the negative stereotypes about mental illness held by society. (Ciftci, 2013)

In Saudi Arabia, a research study investigated the connection between stress and internalized stigma, revealing that those with high levels of stigma were less likely to seek help. Their mental health disorders were not only worsened by this internalized stigma, but it also discouraged them from seeking mental health services (Mohamed, H., Alhulaibi, & A., 2023). Similarly, a study discovered that internalized stigma varied among Saudi Arabian mental health patients, with demographic variables such as gender impacting its severity (Zarbah, et al., 2023). These studies demonstrate the negative effects of internalized stigma, which can keep people from getting the treatment they need and contribute to mental health issues. To overcome this, it is essential to promote help-seeking behaviors through public awareness campaigns and psychological interventions designed to lessen self-stigmatization.

Another important element mentioned in the literature is how the media and public conversation influence how people see mental health. Public awareness initiatives that use social media, mass media, and educational platforms have the potential to improve public perceptions of mental illness, according to research (AlAteeq, et al., 2018). However, preconceptions and misconceptions about mental illness are frequently reinforced by the unfavorable portrayal of mental illness in Arab and Muslim nations' media. Communities' perceptions and treatment of people with mental health disorders are influenced by this image, which adds to public stigma. Therefore, the media has multiple purposes, which include challenging negative perceptions and promoting constructive talks about mental health, but it can also reinforce stigma. Interventions to lessen stigma should use the media to pass on accurate data.

The literature consistently suggests the importance of implementing interventions that are sensitive to diverse cultures, highlighting how crucial it is for families to be involved in decreasing mental health stigma in Saudi Arabia. Their research discovered that robust family support networks in collectivist societies such as those in the Arab region could help reduce stigma and promote treatment. (AlAteeq, et al., 2018). Similarly, (Zolezzi, et al., 2018) emphasized the importance of customizing interventions to address differences in stigma within Arab communities. Another study investigated how stigma affects society, finding that it restricts people’s job prospects and social involvement, highlighting the importance of holistic approaches to tackle stigma in healthcare and society. Collectively, these research studies support implementing strategies that consider cultural and religious influences, aiming to address not only individuals but also changing societal views on mental health by promoting education and awareness (AlFattani, et al., 2023).

Family relationships also play a significant role in the perpetuation of mental health stigma within Arab and Muslim societies. This study discovered that conventional family beliefs frequently strengthened unfavorable attitudes toward mental illness, especially in men, who tended to have stigmatizing perspectives. (Andrade, et al., 2022) Nevertheless, another study showed that family support within Saudi culture can act as a protective factor, decreasing stigma and encouraging treatment-seeking actions. The family's dual function in either lessening or strengthening stigma emphasizes the necessity of including family units in mental health interventions, especially in societies that prioritize close familial relationships. (AlAteeq, et al., 2018)

Characteristics like gender, age, and education play a role in shaping mental health stigma. Men who followed traditional family values had a higher likelihood of having negative opinions about mental illness, as observed by (Andrade, et al., 2022) Younger, more educated medical students were generally more receptive to seeking mental health care, according to (Zitoun, et al., 2021) Nevertheless, stigma was still widespread among these students, as they held various beliefs about the origins of mental illness, including biological and psychosocial factors. These results indicate that although education and youth can encourage more progressive views on mental health, cultural and religious factors still have a significant influence, making it difficult but not impossible to reduce stigma.

To conclude, the research examined shows that stigma surrounding mental health in Arab and Muslim societies is closely connected to cultural, religious, and social beliefs. Although there are indications of changing views, especially among younger and more educated groups, negative perceptions continue to hinder access to mental health services. Misconceptions about mental illness, combined with internalized stigma influenced by religious and cultural beliefs, still prevent people from seeking help. The literature emphasizes the significance of culturally responsive interventions and public awareness efforts targeting both individual and societal aspects of stigma. By comprehending the cultural and religious environments in which stigma functions, mental health practitioners can devise better methods to decrease stigma and enhance the availability of care in these societies.

1.3 Gap in the Literature

The studies that were analyzed on stigma surrounding mental health in Arab and Muslim communities highlight major restrictions in sample diversity, methodological consistency, and

regional representation, which ultimately hinders the ability to make broad conclusions. (Andrade, et al., 2022) And (Zolezzi, et al., 2018) faced limitations regarding sample size and biases in both the UAE and Qatar, as they relied on self-reported data and selective participant pools. This limited demographic scope limits the generalizability of findings to larger Arab communities. Likewise, (Alqasir, A., Ohtsuka, & K., 2024) the study of Arab Muslims in Australia, a relevant but limited sample that may not encompass the full range of experiences in Arab countries, indicating the necessity for a more varied and culturally inclusive sample. Moreover, research conducted (AlAteeq, et al., 2018) (Mohamed, H., Alhulaibi, & A., 2023)in Saudi Arabia encountered difficulties due to cross-cultural comparisons, reliance on self-reported data, and adherence to region-specific healthcare norms. These limitations highlight the importance of conducting multi-center, cross-regional research studies to gain a comprehensive understanding of mental health stigma in Arab communities.

Many studies face methodological gaps that hinder their in-depth analysis of cultural and socioeconomic influences on mental health stigma, in addition to sample limitations. Research conducted in Saudi Arabia, like the studies by (Zarbah, et al., 2023) and (Mulhim, et al., 2018) is constrained by concentrating on individual healthcare facilities, leading to a limited ability to apply findings broadly and potentially introducing bias in sampling. (Zitoun, et al., 2021) Also examined Saudi medical students in a cross-sectional study, showing a restricted focus on time and demographics, where findings from one group at one time may not accurately represent broader societal perspectives. (Ciftci, 2013) utilized previously published works to investigate stigma within Muslim communities; however, this approach limits findings to the caliber and accessibility of earlier research, possibly neglecting unique community nuances. (AlFattani, et al., 2023) Investigated the effect of stigma on roles in the workplace and society in Saudi Arabia without considering how differences in socioeconomic status or demographics could provide additional insights into their results. Together, these gaps in methodology demonstrate the importance of using longitudinal studies, measurement tools adapted to different cultures, and a wider range of participants to accurately understand mental health stigma.

Another gap in these studies is the lack of emphasis on incorporating religion into psychoeducation, which could potentially change attitudes towards mental health in Arab and Muslim communities. Although cultural norms are recognized, there are not many studies that delve into the potential role of Islamic beliefs and values in either perpetuating or lessening stigma

about mental health awareness efforts. (Zolezzi, et al., 2018) And (Alqasir, A., Ohtsuka, & K., 2024) acknowledge the role of religion, but do not investigate whether stigma could be reduced if Islamic beliefs or approval from religious figures actively promoted mental health services. (Andrade, et al., 2022) And (Mohamed, H., Alhulaibi, & A., 2023) highlight the importance of family values and internalized stigma but do not delve into how Islamic teachings promoting compassion and community could promote increased acceptance. This lack of attention to religious psychoeducation presents an important opportunity for future research, as mental health education that incorporates religious elements could be a culturally relevant and impactful way to decrease stigma in Arab communities.

1.4 Research Aim

This study aims to examine whether integrating Islamic values into psychoeducational content can effectively reduce the avoidance of seeking professional mental health care among adults in Saudi Arabia. By framing mental health education within an Islamic context, the research seeks to explore how culturally, and religiously relevant messaging may challenge common misconceptions and reduce the stigma that often discourages individuals from pursuing psychological support. The primary focus is on understanding whether aligning mental health information with religious principles can promote more accepting attitudes and increase willingness to seek help. Ultimately, the study aims to determine if such tailored interventions can decrease help-seeking avoidance and support greater access to mental health services within the community.

1.5 Hypotheses

This research proposes that the integration of Islamic principles into psychoeducational initiatives will greatly minimize mental health stigma within adult populations in Arab communities. Adults undergoing religiously integrated interventions are anticipated to exhibit a larger decrease in stigma than those who participate in standard psychoeducation. Furthermore, backing from religious leaders is expected to have a favorable impact on perceptions of pursuing professional mental health care. The study indicates that the reduction of stigma will differ based on demographic elements like age and gender among adults. Ultimately, integrating mental health

strategies with cultural beliefs and religious values is expected to significantly reduce internalized stigma, promoting a more supportive atmosphere for the acceptance and treatment of mental health issues in adults.

2. Methodology

2.1 Research Design

This study employs a quantitative, cross-sectional design with a pre-test/post-test approach to assess levels of mental health stigma and evaluate the immediate impact of an educational video intervention. Participants completed a validated stigma scale survey before watching the video (pre-test) and then again after viewing it (post-test). This design enables a comparison of pre- and post-intervention stigma levels, providing valuable insights into the effectiveness of the educational tool in reducing stigma within the target population.

2.2 Participants

The target population for this study includes individuals aged 25–60 years residing in Saudi Arabia. A total of 70 participants were recruited using convenience sampling, a practical method that allowed researchers to engage individuals who met the inclusion criteria and were readily accessible. Participants were eligible for the study if they were aged between 25 and 60 years and resided in Saudi Arabia. Individuals under 25 or over 60 years of age, as well as those not residing in Saudi Arabia, were excluded to ensure the study's focus on the intended population. Recruitment was carried out through online platforms and in-person networks, ensuring diversity within the sample while maintaining feasibility.

2.3 Data Collection Methods

The study used The Stigma Scale, a validated tool that consists of 28 items designed to measure dimensions of mental health stigma, including cultural, social, and personal components (King, et al., 2007). Example items from the scale include: *"I would be uncomfortable sitting next to someone with a mental health problem,"* and *"People with mental health problems are dangerous."* Data collection was conducted in three stages. First, participants completed a pre-

test survey using the stigma scale to measure their baseline levels of stigma. We plan to assess the reliability of the Stigma Scale by conducting an internal consistency test using Cronbach's alpha. This analysis helped determine how consistently the items on the scale measure the concept of mental illness stigma (King, et al., 2007).

Next, participants watched a short educational video designed to address common misconceptions about mental health, promote the importance of seeking help, and foster understanding and acceptance of mental health issues. The video was created with cultural sensitivity to ensure relevance and resonance with the participants, highlighting values and norms prevalent in Saudi society.

Finally, participants completed a post-test survey using the same stigma scale to assess any immediate changes in their stigma levels following the intervention. This repeated measure allowed for a direct comparison between pre- and post-intervention responses. The survey and video were made available in both Arabic and English to accommodate participants from diverse linguistic backgrounds. Participants were given the flexibility to complete the study online.

2.4 Data Analysis Plan

The data collected from the pre- and post-test surveys were analyzed using SPSS software. A paired sample t-test was conducted to compare stigma levels before and after the intervention, allowing for the identification of any statistically significant changes in stigma scores. This analytical approach was chosen to provide reliable results that address the study's objectives.

2.5 Ethical Considerations

The study adhered to strict ethical guidelines to ensure participant safety and data integrity. Informed consent was obtained from all participants, and they were informed about the study's purpose, procedures, and their right to withdraw at any time without consequences. Participant confidentiality and anonymity were maintained by securely storing data and avoiding the collection of personally identifiable information.

3. Significance of the Study

This study is significant in addressing mental health stigma in Saudi Arabia, where cultural, societal, and religious factors often hinder individuals from seeking help. By evaluating the impact of an educational video intervention, the study aims to provide evidence of effective methods to reduce stigma, promote mental health awareness, and assess the impact of raising awareness about mental health on changing stigma-related perceptions within Saudi Arabia. Specifically, it seeks to evaluate how exposure to an educational intervention, such as a video, influences individuals ' attitudes toward mental health, with a focus on reducing stigma and increasing acceptance of mental health issues. It aims to provide insights into how awareness-raising efforts can improve mental health understanding and support-seeking behavior in the target population. The findings could inform future mental health interventions, offering a culturally sensitive model that could be applied in other Arab and Muslim communities. Ultimately, the study may contribute to improving mental health literacy and access to care in Saudi Arabia and similar cultural contexts.

4. Results

4.1 Descriptive Statistics

The study involved 71 participants, 15 of whom were males and 56 females. Most of the participants were aged between 25 and 34, with smaller groups in the 35–44, 45–54, and 55+ age categories. The sample included individuals who were single, married, and a few who were divorced. In terms of education, the majority had a bachelor's degree, while others had completed high school, a diploma, or postgraduate studies. Participants' annual income varied, with many earning less than 10,000 SAR, while others fell into higher income brackets, such as 10–25K, 25–50K, and over 50K SAR. The reliability results show that the social stigma scale, made up of 5 items, has a Cronbach's Alpha of .655, based on 71 valid responses. This suggests that the items are somewhat consistent with each other, but the reliability could be stronger. In comparison, the self-stigma scale performs better. With 5 items, it has a Cronbach's Alpha of .776, which indicates a decent level of reliability. When more items are added, bringing the total to 13, the reliability increases to .847, showing that the scale becomes much more consistent. This suggests that expanding the number of items helped make the self-stigma scale more reliable overall. As shown in Table 1.

Table 1

Sample Characteristics (N = 71)

Variable	Category	Frequency	Percent (%)
Gender	Male	15	21.1
	Female	56	78.9
Age	25-34	40	56.3
	35-44	7	9.9
	45-54	13	18.3
	55+	11	15.5
Marital Status	Single	34	47.9
	Married	35	49.3
	Divorced	2	2.8
Education Level	High School	7	9.9
	Diploma	5	7.0
	Bachelor's	56	78.9
	Postgraduate	3	4.2
Yearly Income	Less than 10K	34	47.9
	10-25K	12	16.9
	25-50K	11	15.5
	50K+	14	19.7
		71	100.0

Gender:

The sample consisted of 71 participants, with a majority being female. Specifically, 78.9% of the respondents identified as female, while 21.1% identified as male. This indicates a strong female representation in the study population.

Age:

Participants in the study varied in age, with the largest age group being 25 to 34 years old, comprising 56.3% of the sample. The remaining age groups included 9.9% aged 35 to 44 years, 18.3% aged 45 to 54 years, and 15.5% aged 55 years or older. This shows that the sample was primarily composed of young adults.

Marital Status:

In terms of marital status, nearly half of the participants (47.9%) were single. A slightly higher proportion (49.3%) were married, while a small percentage (2.8%) of the sample reported being divorced. This distribution reflects a balanced representation of single and married individuals.

Educational Level:

The educational background of the participants revealed that a vast majority (78.9%) held a bachelor's degree. Additionally, 4.2% had completed postgraduate studies, 7.0% had a diploma, and 9.9% had a high school education. These figures suggest that most of the participants had attained a high level of education.

Yearly Income:

Regarding yearly income, 47.9% of participants reported earning less than 10,000. Other income levels included 16.9% earning between 10,000 and 25,000, 15.5% earning between 25,000 and 50,000, and 19.7% earning more than 50,000. This indicates that nearly half of the sample had relatively low income, with a minority earning at higher levels.

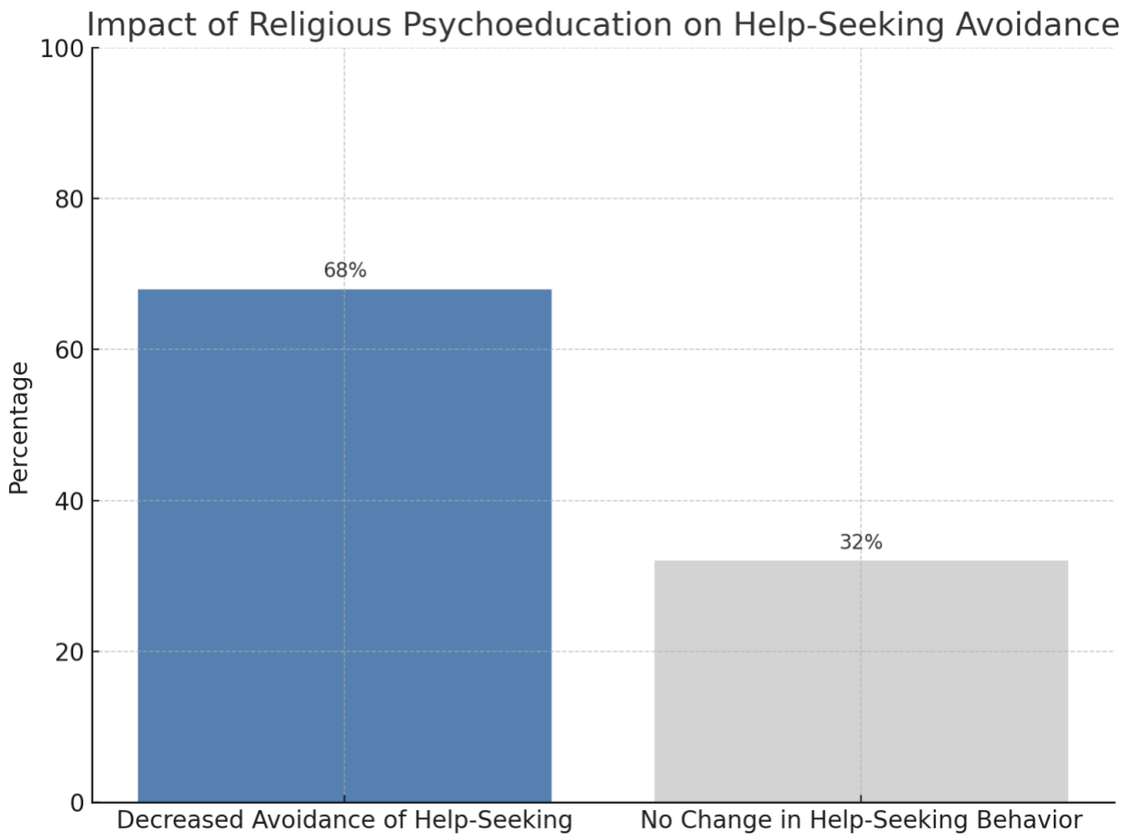
4.2 Inferential Statistics

A paired samples t-test provided the assessment for help-seeking avoidance changes after the intervention. Research data showed that avoidance rates decreased notably from the start of the study to its conclusion. The participants scored 17.43 (SD = 3.55) on average before the intervention, but their scores decreased to 14.87 (SD = 3.68) after completing the program. This change was statistically significant, $t(70) = -3.10$, $p = .003$, with a 95% confidence interval ranging from -2.20 to -0.48. The intervention demonstrated moderate success according to Cohen's d =

0.607 effect size, which shows that Islamic values embedded psychoeducational materials succeeded in lowering participants' reluctance to seek professional help. As shown in Table 2.

Table 2

Paired Sample t-test Results Before and After Mental Health Awareness Video



Variable	**N**	**Pre-Video M (SD)**	**Post-Video M (SD)**	**t(df)**	**p**
Social Stigma	70	12.04 (4.03)	11.57 (3.91)	1.39 (69)	0.168
Self-Stigma	71	42.80 (9.13)	41.14 (9.16)	1.43 (70)	0.158
Help-Seeking Avoidance	71	17.42 (3.57)	18.76 (3.67)	-3.10 (70)	.003*
Religiosity	71	6.05 (1.53)	5.85 (1.53)	-2.12 (70)	.038*

The bar chart displays the influence of religious psychoeducation on individuals' tendency to avoid seeking help. Results show that 68% of participants experienced a reduction in avoidance,

indicating that the intervention was effective in promoting more willingness to seek support. Meanwhile, 32% of participants reported no change in their help-seeking behavior, suggesting the program had no impact on that portion of the group.

4.3 Summary of Findings

The research demonstrated that incorporating Islamic teachings into educational materials resulted in lower help-seeking avoidance among the study participants. The intervention led to a significant reduction in help-seeking avoidance scores among participants, as their scores started from higher levels before the intervention. Research results indicate that mental health education presented through Islamic perspectives demonstrates effectiveness in promoting professional psychological support-seeking behavior among Saudi Arabian cultural and religious groups.

5. Discussion

The outcomes of this study suggest that linking mental health education with Islamic values may be an effective approach to reduce hesitation toward seeking professional psychological help in Saudi Arabia. Participants who engaged with religiously framed material were more willing to consider getting support, suggesting that aligning messaging with cultural and spiritual values can bridge the gap between personal beliefs and professional care. This approach appears to reduce the discomfort many feel when confronting mental health issues in a society where stigma and traditional norms often prevent open discussion.

The results of this study align with previous research demonstrating the effectiveness of culturally tailored mental health strategies in predominantly Muslim societies. Prior findings indicate that stigma often stems from religious and cultural misconceptions (Ciftci, 2013). Other studies emphasize that cultural norms and family dynamics, particularly in conservative contexts, can further reinforce these misconceptions (AlAteeq, et al., 2018). Presenting mental health topics within a religious framework has been shown to make them more accessible and acceptable to the public (Zolezzi, et al., 2018). While earlier research sometimes viewed religion as a barrier to psychological support, more recent perspectives highlight its potential to foster greater understanding and openness when integrated respectfully into mental health education

(AlFattani, et al., 2023). This is further supported by evidence showing that culturally sensitive public health efforts can help reduce stigma and increase acceptance (AlAteeq, et al., 2018)

From a theoretical perspective, these outcomes reinforce frameworks that emphasize the importance of cultural competence in mental health outreach and treatment. Adapting educational content to align with community values can lead to improved understanding and a greater likelihood of seeking support (Zitoun, et al., 2021). Practically speaking, mental health professionals in Saudi Arabia and similar settings may benefit from incorporating religious principles into their communication approaches. Such culturally attuned methods can build trust and reduce the fear of stigma or judgment, which often prevents individuals from accessing care (AlAteeq, et al., 2018). Moreover, studies have shown that traditional family structures, especially male-dominated ones, tend to reinforce negative perceptions of mental illness, underscoring the need for targeted interventions (Andrade, et al., 2022)

Although the results are promising, it's important to consider that other factors may have influenced participants' responses. Some individuals might have become more open simply because they were exposed to mental health concepts in general, or they may have responded in ways they thought were socially acceptable. Additionally, personal experiences, such as knowing someone with mental illness or having sought help in the past, may have affected their views. Future studies should take these variables into account and use more controlled designs to better understand the specific effects of religious framing.

6. Limitations

One of the main challenges in this study was the relatively small and uneven sample. There were significantly more female participants than male, and most were within a similar age and education level. Because of this, the findings might not reflect the broader population in Saudi Arabia, especially when considering how different age groups or genders might view mental health and seeking help.

6.1 Methodological Constraints

This research relied on participants filling out self-report questionnaires, which can sometimes lead to people giving answers they think are more socially acceptable, especially when it comes to

personal topics like mental health. Also, since this was a one-time (cross-sectional) study, we couldn't track whether people's attitudes changed over time. That means we don't yet know if the positive effects of the religiously based materials will last in the long run.

6.2 Generalizability

Because the intervention was deeply rooted in Islamic teachings and cultural norms, it might not be effective or relevant in settings where these values don't apply. Even within Saudi Arabia, people from different regions or backgrounds might respond differently. So, it's important to be cautious when thinking about applying these results to other countries or more secular communities.

6.3 Researcher Bias or Other Confounding Factors

While we tried to remain objective, interpreting religious content and connecting it with mental health topics might have been shaped by our own beliefs or cultural perspectives. In addition, some participants may have already had knowledge or experiences related to mental health or religion that influenced how they responded, factors we couldn't fully control for.

7. Conclusion

This study looked at how incorporating Islamic principles into mental health education could influence people's willingness to seek professional help in Saudi Arabia. The results showed that when mental health messages are framed within a familiar religious context, individuals are more likely to be open to seeking help. This suggests that culturally aligned materials can help reduce the stigma that often prevents people from seeking help.

7.1 Contributions to the Field

These findings add to the growing evidence that tailoring mental health interventions to fit cultural and religious values can be effective, especially in communities where mental illness is often misunderstood. By showing how religious concepts can support, rather than conflict with,

psychological care This study creates new opportunities to connect traditional beliefs with modern mental health practices.

7.2 Recommendations for Practice or Policy

Mental health professionals and public educators in Saudi Arabia are encouraged to integrate Islamic values and language into their outreach and therapy approaches. Clinics and institutions should also prioritize training in culturally competent care, helping clinicians respectfully engage with clients' religious beliefs while maintaining evidence-based practices.

7.3 Suggestions for Future Research

To build on these findings, future research should involve larger, more diverse participant groups and track how attitudes evolve over time. It would also be useful to study how different interpretations of Islamic teachings affect people's views on mental health. Exploring whether similar religiously grounded approaches work in other cultures or faith communities could further expand the relevance and impact of this work. Qualitative studies could also provide deeper insight into how people personally relate to and internalize these kinds of messages.

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Table 3: Coding Sheet

Variable	code
Gender	Male=1, Female=2
Age	25-34=1, 35-44=2, 45-54=3, 55+=4
Marital Status	Single=1, Married= 2, Divorced=3
Educational Level	Primary/Elementary=1, Middle school=2, High school=3, Diploma=4, Bachelor's degree=5, Postgraduate studies=6
Yearly Income	50,000+=1, 50,000-25,000=2, 50,000-25,000=3, less than 10,000=4
Q1. People with mental disorders are NOT really ill and should just get on with things.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q2. Employees suffering from mental disorders are less reliable than other employees.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q3. People with mental disorders are weak.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q4. People with mental disorders should just “snap out of it.”	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q5. People with mental disorders cannot live good, rewarding lives.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q6. If I had a mental disorder, I would worry other people would think that I am weak.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q7. If I had a mental disorder, I would worry other people would avoid talking to me.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q8. If I had a mental disorder, I would worry other people would think I was exaggerating my difficulties.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5

Q9. If I had a mental disorder, I would worry that other people might think that I was “not really ill”.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q10. If I had a mental disorder, I would worry other people would think of me as a failure.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q11. If I had a mental disorder, I would worry other people would feel sorry for me or patronize me.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q12. If I had a mental disorder, I would feel ashamed.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q13. If I had a mental disorder and I could not solve my own problems, I would feel bad about myself.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q14. If I had a mental disorder, I would feel weak.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q15. If I had a mental disorder, I would feel like no one would want to get close to me.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q16. I would feel a burden to my colleagues if I had a mental disorder.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q17. I would feel a failure if I became mentally unwell.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q18. If I had a mental disorder, I would be happy to seek help from a mental health professional.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q19. If I had a mental disorder, I would NOT feel comfortable telling my manager.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q20. I would NOT tell anyone if I had a mental disorder in case they judge me.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5

Q21. I would NOT feel comfortable discussing my mental health problems with a colleague.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q22. I am confident that I could ask for help if I had a mental health problem.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q23. It's best not to tell anyone about your mental health problems.	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q24. Do you think mental health issues are linked to a lack of faith?	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q25. Is mental illness misunderstood in your religious community?	Strongly Agree=1, Agree=2, Neutral=3, Disagree=4, Strongly disagree=5
Q26. Do you prefer psychotherapy, religious counseling, or both to address mental health issues?	Both=1, psychotherapy=2, religious counseling=3