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Mental Health Attitudes and Knowledge Among Shia Muslims in America

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MENTAL HEALTH ATTITUDES AND KNOWLEDGE AMONG SHIA MUSLIMS IN AMERICA

by

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ABSTRACT

Mental health has received more attention and stigma associated with it has decreased over time in the United States. However, subpopulations have differing views on mental illness since cultural factors can shape perceptions of and influence access to mental health information. Previous studies have investigated such cultural factors among Sunni Muslims (the majority sect of Islam) and less so among Shia Muslims (the minority sect). To address this gap, two research questions were investigated in this project: (1) What are the mental health attitudes among Shia Muslim adults in the United States, and (2) How much mental health knowledge or literacy do Shia Muslim adults in the United States have? A survey was created to assess Shia Muslim mental health attitudes (including stigma) and knowledge. Using snowball sampling, 256 responses were collected. Analysis showed Shia Muslims believe biological, sinful, spiritual, and external factors contribute to mental illness and have low social stigma towards the mentally ill. They also have high mental health knowledge/literacy. Barriers to care reported include cost, time, mistrust of the mental healthcare system, social/self-stigma, and lack of culturally competent care.

TABLE OF CONTENTS

LIST OF FIGURES/TABLES

CHAPTER 1: INTRODUCTION

According to the World Health Organization (WHO, 2019), approximately 264 million people around the world are affected by depression. Another 45 million are affected by bipolar disorder. Schizophrenia affects another 20 million people. These are just a few of the mental health issues that affect people worldwide. In 2001, the WHO indicated that 1 in 4 people around the world will be affected by a mental or neurological condition during their lifetime. Although this was estimated over twenty years ago, this points to a global problem that impacts both young and old.

Muslim Population and Mental Health Problems Globally

One of the biggest and fastest growing religious groups in the world are Muslims. As of 2015, there were approximately 1.8 billion Muslims in the world, about 24% of the world population, according to the Pew Research Center (Lipka, 2017). There are two highly concentrated areas of Muslims. About 20% of the Muslim population is in the Middle East and North Africa region and about 62% are in the Asia-Pacific region. There are about 3.45 million Muslims in the United States.

There are two main subgroups of Muslims: Sunnis and Shias. This divide between the groups dates back 1,400 years and is related to the succession of leadership after the death of Prophet Muhammad. The two groups have differences in beliefs and practices and some Sunnis do not even consider Shias to be Muslims (Lipka, 2017). An important religious difference between the two groups is that Shia Muslims believe in more centralized present day religious leadership in the form of Ayatollahs (translating to “Sign of God”), whose role is to interpret the Quran and hadith (religious teachings/saying from Prophets and Imams/spiritual leaders), to address modern day issues (Tasch, 2015). Most countries, except Iran, Iraq, and Lebanon, have

more Sunnis than Shias. Globally, approximately 85% of Muslims are Sunni and 20% are Shia (Sherwood, 2016). In the United States, about 55% are Sunni and 16% are Shia, other Muslims do not identify with either sect (Lipka, 2017).

Although there are no available statistics on the number of Muslims globally who experience mental health problems, there have been studies conducted in individual countries indicating that mental health issues are a major concern for Muslims in general. For example, one survey with responses from over 1,000 Muslims conducted by the Muslim Youth Hotline in the United Kingdom in 2019 found that 52% of individuals experienced depression, 63% suffered from anxiety, and 32% had suicidal thoughts (Muslim Youth Hotline, 2019). These rates are much greater than the 16% of people in the United Kingdom that report experiencing mental health problems such as anxiety or depression in a given week (Warsame, 2020). In another study that focused on Muslim nursing students in Thailand, 26% of the participants reported anxiety and 47% had at least a mild level of depression (Ratanasiripong, 2012). The results of this study could be influenced by high levels of stress among nursing students in general, however, the aforementioned studies point out that Muslims are experiencing mental health problems worldwide.

Mental Health in the United States

According to the National Institute of Mental Health, about 1 in 5 Americans live with a mental illness (2019). However, this number varies widely based on demographics. According to this national survey, adult females (24.5%) had a higher prevalence of mental illness than males (16.1%). Those between the ages of 18-25 (29.4%) were also more likely to have a mental illness compared to older age groups. Additionally, individuals identifying with multiple races (31.7%) were most likely to have a mental health problem, followed by White adults (22.2%). Compared

to other racial groups, Asian adults (14.4%) were the least likely to report having a mental health problem.

Muslim Mental Health in the United States

Muslim Americans face general and unique mental health issues. Similar to global rates, there is limited research on the prevalence on mental health issues among the Muslim community in the United States. Among studies that have examined this problem, Basit and Hamid (2010) found that intake diagnoses of Muslim clients revealed that 43% of adults experienced adjustment disorder, 15% anxiety disorder, 14% obsessive compulsive disorder (OCD), 10% post-traumatic stress disorder (PTSD), 9% mood disorder, 5% schizophrenia and other psychotic disorders, and 4% substance abuse disorder. However, these findings only report a sample of Muslim Americans who sought mental health care. Another study of 30 Arab Muslim women living in the United States found that 40% reported clinically significant depressive symptoms and 67% reported mild to severe anxiety (Hassouneh & Kulwicki, 2007). This study also reported that these participants experienced higher depression and anxiety symptoms than those in the general population. Both of these studies show that mental health issues exist amongst the Muslim American population, but prevalence of these concerns remain unknown.

Muslims face unique mental health issues due to being minorities and immigrants. According to a survey conducted by the Pew Research Center in 2017, about 48% of Muslim Americans say they have experienced at least one event of discrimination in the past 12 months (Lipka, 2017). Additionally, out of the 2.15 million Muslim adults in the United States, 58% are immigrants. Some of these immigrants faced hardships causing them to move and some may even be refugees who faced persecution in their original country, which could lead to mental health

problems like PTSD (Peconga & Høgh Thøgersen, 2020). Others face hardship adjusting to a new country and way of life which could contribute to adjustment disorder and anxiety.

Several studies have also examined Muslim perceptions about mental health in America and internationally; however, the research primarily studies the Sunni population or does not evaluate differences based on sect (Bagasra & Mackinem, 2014; Chaudhury, 2011; Parveen et al., 2014). One survey on the perceptions of mental illness was given to 75 Muslim participants, of unspecified sect, attending an educational seminar in the state of Michigan (Shebak et al., 2019). The survey found that 85.3% of respondents believed that depression is a medical illness, while 34.7% reported that black magic or the evil eye could cause depression. Approximately 37% believed that being close to God prevented depression. Another study conducted by Bagasra and Mackinem (2014), 255 Muslims were surveyed, out of which only 2% were from the Shia sect, the minority sect. Participants in this study had varying perceptions about mental illness. For example, the majority of the sample believed mental illness was a disease (61%) and caused by chemical imbalances in the brain (80%). About 24% of the sample also believed that sinful actions are the cause of mental illness, 42% believed that lack of will power contributes to mental illness, and 56% believed mental illness is a test from Allah (God). About 13% of the sample also believed that mental illness is often the result of possession by 'jinn', 27% believed mental illness is caused by the 'evil eye', and 28% believed mental illness is the result of the use of black magic.

Cultural Influences on Mental Health (CIMH) Model

For Muslim Americans, cultural beliefs can play a major role in whether mental health problems are identified and/or treated. The Cultural Influences on Mental Health model states that culture affects the prevalence of mental illness, etiology of disease, phenomenology of distress,

diagnostic and assessment issues, coping styles and help-seeking pathways, and treatment and intervention issues (see Hwang et al., 2008).

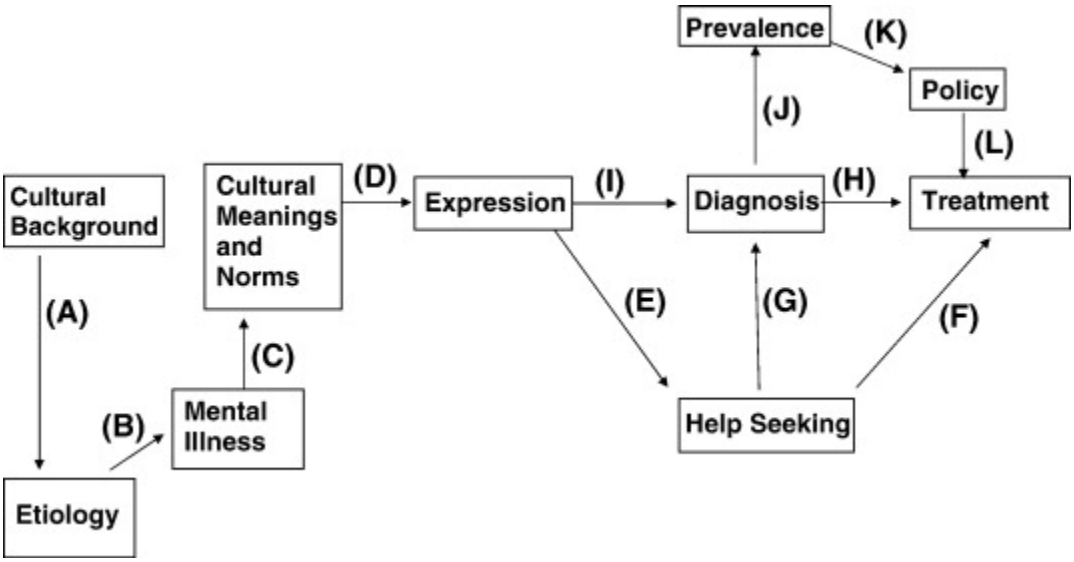

Fig. 1. The Cultural Influences on Mental Health (CIMH) Model.

Specifically, the model posits that cultural background can contribute to the cause of mental health issues. Cultural norms regarding mental health, mental illness and other emotions can also result in different expression of symptoms. In turn, the expression of these mental health issues leads to a diagnosis and determines the method of seeking help for the problem. The diagnosis and method of seeking help then determines the treatment plan. The diagnosis also adds to the prevalence of the mental illness which can lead to policies that affect treatment options (Hwang et al., 2008).

Muslim Concepts Related to Mental Health

There are several concepts in Islam that may affect the attitudes Muslims hold toward mental illness and treatment (Sabry & Vohra, 2013). The following cultural concepts are common among both Sunni and Shia Muslims.

- Divine will/test or punishment from Allah

    - Many Muslims may think their mental illness is a test or punishment from God. This can create shame related to identifying or treating the mental illness. Many also believe their mental health problems were meant to happen through divine will and nothing can be done about them as a result.

- Jinn
    - Muslims also believe in Jinn which are a type of creation of Allah that are not visible to humans. Some Muslims believe that possession by Jinn is the cause of mental illnesses, especially those involving hallucinations.
- Evil Eye
    - The evil eye is a concept found in Muslim culture where someone may bring bad luck or misfortune to someone due to bad intentions or jealousy towards them. Some Muslims may believe their mental health issues are a result of the evil eye.
- Black Magic
    - Black magic refers to using supernatural forces to cause harm. Some Muslims may believe their mental health issues are the results of someone practicing black magic towards them.
- Imams
    - Imams are religious leaders that lead prayers and are considered experts in Islamic teachings. Some Muslims may go to an Imam with their mental health concerns before going to mental health professionals. The Imam can then guide them with *duas* or refer them to a mental health professional. Thus, mental health awareness among Imams is very important. Shia Muslims also have another definition for Imam, using the term to describe divine leaders after Prophet Mohammad.

- Dua (Supplications)/Prayer
    - Muslims pray five times a day and some recite additional supplications along with the required five prayers. With the help of these prayers and dua, Muslims hope to receive help or guidance from Allah. Some Muslims believe that mental disorders can be prevented by closeness to Allah.

These cultural concepts can contribute to the attitudes regarding identification and treatment of mental health issues among Muslims.

Current Study

Mental health has been increasingly getting more attention and the stigma associated with it has decreased over time. For example, one survey conducted by the American Psychological Association (2019) found that 87% of adult Americans agreed that "having a mental health disorder is nothing to be ashamed of". However, the same study also found that 33% of American adults agreed that "people with mental health disorders scare me" (American Psychological Association, 2019), suggesting that stigma and negative attitudes and perceptions continue to exist. Subpopulations or groups in the United States may have differing views on mental illness since cultural factors can shape perceptions and attitudes about mental health and ways of managing mental health problems (Jimenez et al., 2012). There are several such cultural factors in the Muslim community. Specifically, compared to Sunni Muslims, Shia Muslims have more centralized religious leadership to guide their lives, and are a minority within a minority which may result in different mental health issues (Tasch, 2015). Thus, research is clearly needed to study how such factors influence perceptions and knowledge among the Shia Muslim population, as research looking at sect has focused mainly on the majority sect of Islam—Sunni Muslims. This is important to research so it can be determined if and in what regard mental health providers need

to be culturally aware, and whether the population needs to be educated regarding mental health. This research can also be used to determine if and what differences there are in mental health attitudes between Shia and Sunni Muslims in America.

Therefore, this research study contributes to the limited body of existing research. The following research questions were explored in this study:

(1) What are the mental health attitudes among Shia Muslim adults in the United States?

(2) How much mental health knowledge or literacy do Shia Muslim adults in the United States have?

CHAPTER 2: METHODS

Participants

The sample included Shia Muslim adults (18+) in the United States. The sample was recruited through a non-probability purposive and snowball sampling approach. Specifically, the sample was recruited through Muslim-affiliated community organizations, social media sites frequented by the Shia community (e.g., Instagram, Facebook, WhatsApp), and word of mouth (referrals through Shia communities). The sample size was 256. Participants were located throughout the United States including the states on Florida, Texas, New York, Illinois, Wisconsin, California, and Michigan. Participants ranged in age from 18 to 80, with a mean age of 38.52 (*SD* = 13.28). The majority of participants (67.2%) were female, with 32% male participants. One percent of the sample elected to not disclose their gender. Participants predominantly identified their cultural identity as South Asian (73%), with the second largest identifying as Middle Eastern (14%). About 57% of participants were not born in the United States, the average age at immigration was of 20.56 (*SD* = 10.48). Most of the participants held at least a 4-year college degree (70.7%), with 5.8% having a high school degree or less. The most common work/social roles included: homemaker (19.9%), student (16%), physical healthcare professional (15.6%), management/business professional (12.5%), and computer/engineering/information technology professional (10.2%).

Participants had varying degrees of religious behavior/engagement; however, for a large majority of respondents, religion was an important part of their lives. In particular, about 87% of participants indicated they try “hard to carry their religion into all other aspects of life”. In terms of religious attendance, 40.6% of the participants attended religious services at mosques only for major events/holidays, 31.3% attended weekly, and 26.2% monthly. About 70.4% of respondents

reported praying alone five or more times a day, 11.7% prayed alone between once or twice a day, 15,6% prayed when they felt the need or desire to, and 2.3% reported not praying alone at all.

Research Design

This was a cross-sectional quantitative study. The research question was answered by distributing an online survey through Qualtrics. Survey designs are used to determine a group's attitudes, opinions, behaviors, or characteristics. Surveys are beneficial because they can reach a large number of people, are easy to distribute to diverse people at various locations and are cost effective. The survey utilized in this study was designed based on existing surveys and using concepts specific to the study population.

Measures. The researcher developed a 28-item, quantitative survey primarily using a Likert response format to assess attitudes (including social stigma) and mental health knowledge among Shia Muslims.

Mental health attitudes were defined as perceptions or beliefs about mental health problems and/or treatment. This construct was assessed using several existing scales and a few additional questions created by the student researcher (see Table 1). Eight items were used from the Conceptions of Mental Illness scale, a 15-item survey created for a 2014 study conducted by Bagasra and Mackinem. Items in this scale assess views on culturally specific causes and beliefs about mental illness that are found in Islam cultures. An additional three items were created by this author based on Shia Muslim culture. Within this domain, attitudes/beliefs were defined as being shaped by *biological causes* (defined as beliefs that biological factors, including chemical imbalances and genetics cause mental illness, aligning with the scientific model of mental illness), *sinful causes* (defined as beliefs that the act of sinning, including general sinful actions and use of drugs/alcohol, cause mental illness), *spiritual influences* (defined as believing faith is a

preventative factor and a treatment for mental illness), *higher power influences* (defined as the belief that becoming mentally ill is the will of Allah or a test from Allah), and *external/outside causes* (defined as belief that mental illness is caused by jinn, the evil eye, or black magic).

Social Stigma was defined as beliefs about the mentally ill in the community. There were seven social stigma questions in the survey. One item was adapted from a 2018 survey conducted by the American Psychological Association. Six items were used from the Community Attitudes Toward Mentally Ill (CAMI), which is a 40-item survey created by Taylor and Dear (1981). Social stigma includes beliefs that individuals with mentally ill are dangerous, a burden, should be avoided, lack self-discipline or will power, and cannot get better with treatment (see Table 1).

Table 1. Mental Health Attitudes and Social Stigma

Sub-categories	Items	Source
Biological Causes (Cronbach's α=0.53)		
	Mental illness is a disease	CMI Scale
	Mental illness is usually inherited	CMI Scale
	Mental illness is caused by chemical imbalances in the brain	CMI Scale
Sinful Causes (Cronbach's α=0.74)		
	Sinful actions are often the cause of mental illness	CMI Scale
	Frequent drug use can lead to mental illness	CMI Scale
	Drinking alcohol will lead to mental illness	CMI Scale
Spiritual Influences (Cronbach's α=0.84)		
	The best treatment for mental illness is strong faith	Author created
	Being close to Allah prevents mental illness	Author created
Higher Power Influences (Cronbach's α=0.73)		
	If a person becomes mentally ill, it is often the will of Allah	CMI Scale
	Mental illness is a test from Allah	CMI Scale
External/Outside Causes (Cronbach's α=0.82)		
	Mental illness is often a result of possession by jinn	CMI Scale
	Mental illness can be caused by the evil eye	CMI Scale
	Mental illness can be caused by the use of black magic	CMI Scale
Social Stigma (Cronbach's α=0.67)		
	Those with mental illness can get better with treatment	APA Survey
	One of the main causes of mental illness is lack of self-discipline and willpower	CAMI Scale
	The mentally ill should be isolated from the rest of the community	CAMI Scale
	The mentally ill are a burden on society	CAMI Scale
	The mentally ill are less of a danger than most people think	CAMI Scale
	Less emphasis should be placed on protecting the public from the mentally ill	CAMI Scale
	It is best to avoid people with a mental illness	CAMI Scale
Individual Questions (not part of a summed construct)		
Environmental Causes	If the environment is bad anyone can become mentally ill	CMI Scale
Family Stress	Mental illness usually comes from tensions in family	CMI Scale
Discrimination Stress	Stress is often caused by religious persecution among Muslims	CMI Scale
Religious Treatment Preference	Muslims should go to a religious leader with mental health issues before a non-religious mental health professional	Author created

Mental health knowledge/literacy was defined as factual knowledge of mental illness. Two items were used from a 2018 study by Gryglewicz et al. that examined mental health literacy among individuals trained in a mental health training program. Two items were used from a 2018 study by Dias et al. that created a Mental Health Literacy questionnaire (MHLq). Table 2 includes the four items used in the mental health survey.

Table 2. Mental Health Knowledge/Literacy

Construct	Items	Source
Knowledge/Literacy		
	A person with schizophrenia may see and hear things that nobody else sees and hears	Gryglewicz et. al., 2018
	A balanced diet contributes to good mental health	MHLq Scale
	One of the symptoms of depression is the loss of interest or pleasure in most things	MHLq Scale
	If a person is threatening to harm themselves or others, it is best to approach them with an aggressive response	Gryglewicz et. al., 2018

Demographics were also collected from participants. In particular, participants were asked to provide their age, gender, level of education, cultural background, work role, origin of birth, and age of migration to the United States. Participants were also asked to indicate how often they pray alone, attend religious services, and rely on religion in all aspects of their life. These religiosity questions were taken from the Muslim Religiosity Scale (Koenig et al., 2014).

Data Analysis

The data was primarily analyzed using SPSS 28.0. Descriptive statistics (frequencies, mean, standard deviation) were used to examine demographic factors (i.e., age, gender, education) and each item in the survey. To create composite scores of key constructs (i.e., knowledge, social

stigma), Likert response items were re-coded if needed (i.e., reverse-coded) and then summed to create a total score. Items in each subscale were assessed for internal consistency using Cronbach's α values (0.7 or above meaning high internal consistency). Some items were kept together even with a lower Cronbach's α value if they measured the same concept. True/false questions were re-coded (1=correct; 0=incorrect) and then summed to create a total score for knowledge. Four items were used as stand-alone questions. The mean and standard deviation for each of the sub-scores and stand-alone items were analyzed. Pearson's correlation analysis was then conducted to examine the associations between the constructs. Pearson's r can range from -1 to 1, with a negative score showing a negative linear relationship and a positive score showing a positive linear relationship. A score of 0 indicates there is no linear relationship. A Pearson's r score ranging between 0.1-0.3 indicates a weak correlation, a score ranging 0.4 -0.6 indicates a moderate correlation, and a score ranging 0.7-0.9 indicates a strong correlation (Akoglu, 2018).

CHAPTER 3: RESULTS

The aim of this study was to explore mental health knowledge/literacy and attitudes (including stigma) among Shia Muslims in the United States. The following results include descriptive findings and correlations between these key variables of interest.

Mental Health Attitudes

Biological causes. The mean score for biological causes was 10.70 (*SD* = 2.22; range 3 to 15). This indicates that participants had a high level of belief that mental illness is caused by biological factors. For example, close to 76% of participants agreed that mental illness is caused by chemical imbalances in the brain (see Table 3). Biological causes also had a weak, but positive correlation with higher power influences (r=.135, p<.05) and a weak negative correlation with social stigma (r=-.255, p<.01) (see Table 11). This indicates those who believed biological factors cause mental illness were more likely to believe mental illness is the will of Allah or a test from Allah. More belief in biological causes was also associated with less social stigma.

Table 3. Attitudes: Biological Causes

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Mental illness is a disease	35.9%	34.4%	11.7%	8.3%	9.8%
Mental illness is usually inherited	5.1%	25.0%	41.0%	23.4%	5.5%
Mental illness is caused by chemical imbalances in the brain	21.9%	53.9%	18.8%	3.9%	1.6%

Sinful Causes. The mean score for sinful causes was 10.07 (*SD* = 2.54; range 3 to 15). Results indicate that participants had strong beliefs that mental illness is caused by substance abuse, as 76.2% and 57.1% of participants agreed that frequent drug use and drinking alcohol causes mental illness, respectively. Less than 25% of respondents agreed or strongly agreed that

general sinful actions (could be defined as substance use or differently by individuals) cause mental illness (see Table 4). Sinful causes had a moderate positive correlation with spiritual influences (r=.486, p<.01). This infers that participants who believed faith prevents or treats mental illness also believed that sins cause mental illness. Faith may prevent the sinful actions, particularly substance use, that participants agreed cause mental illness. There was also a weak, but positive correlation between sinful causes and higher power influences (r=.216, p<.01), external/outside causes (r=.289 p<.01), and social stigma (r=.177, p<.01) (see Table 11). Those who believed that sinful actions cause mental illness also had a higher belief that mental illness is the will of Allah and/or test from Allah. More belief that sinful actions cause mental illness was also associated with higher belief that jinn/evil eye/black magic cause mental illness and with higher social stigma.

Table 4. Attitudes: Sinful Causes

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Sinful actions are often the cause of mental illness	5.6%	15.5%	25.4%	38.5%	15.1%
Frequent drug use can lead to mental illness	27.0%	49.2%	14.3%	6.3%	3.2%
Drinking alcohol will lead to mental illness	20.6%	36.5%	27.4%	11.5%	4.0%

Spiritual Influences. The mean score for spiritual influences was 6.27 (SD = 2.30; range 2 to 10). This indicates a moderate belief that spirituality is related to mental illness, shown by 34.1% of participants agreeing that faith is the best treatment for mental illness and 49.3% agreeing that being close to Allah prevents mental illness (see Table 5). Spiritual influences had a moderate positive correlation with sinful causes (r=.486, p<.01), as mentioned above. Like sinful actions and higher power influences, an association was found between spiritual and higher power

influences. In particular, there was a weak positive correlation between spiritual influences and higher power influences (r=.155, p<.05), external/outside causes (r=.305, p<.01), and social stigma (r=.322, p<.01) (see Table 11).

Table 5. Attitudes: Spiritual Influences

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
The best treatment for mental illness is strong faith	13.5%	20.6%	27.0%	25.8%	13.1%
Being close to Allah prevents mental illness	18.7%	30.6%	23.8%	17.1%	9.9%

Higher Power Influences. The mean score for higher power influences was 5.63 (*SD* = 2.04; range 2 to 10), indicating that participants had a moderate belief that mental illness is caused by the will of Allah (22.7%) or a test from Allah (44%) (see Table 6). There was a weak positive correlation with biological causes (r=.135, p<.05), sinful causes (r=.216, p<.01), spiritual influences (r=.155, p<.05), and external/outside causes (r=.277, p<.05) (see Table 11). Aside from the associations mentioned above, belief that mental illness is the will of Allah and/or a test from Allah was also associated with an increased belief that jinn/evil eye/black magic causes mental illness.

Table 6. Attitudes: Higher Power Influences

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
If a person becomes mentally ill, it is often the will of Allah	2.5%	20.2%	29.6%	25.5%	22.2%
Mental illness is a test from Allah	7.8%	36.2%	25.9%	16.0%	14.0%

External/Outside Causes. The mean score for outside causes was 6.25 (*SD* = 2.64; range 3 to 15). As reported in Table 7, in general, the majority of participants did not believe that mental

illness is caused by jinn (82.6%), the evil eye (60.1%), or black magic (56.4%). External/outside causes had a weak positive correlation with sinful causes (r=.289, p<.01), spiritual influences (r=.305, p<.01), higher power influences (r=.277, p<.01), and social stigma (r=.274, p<.01) (see Table 11). In additions to the correlations described previously, higher belief that mental illness is caused by jinn/evil eye/black magic was also associated with higher social stigma.

Table 7. Attitudes: External/Outside Causes

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Mental illness is often a result of possession by jinn	0.0%	2.0%	15.3%	31.0%	51.6%
Mental illness can be caused by the evil eye	1.2%	14.5%	24.2%	25.4%	34.7%
Mental illness can be caused by the use of black magic	2.0%	18.1%	23.4%	25.4%	31.0%

Social Stigma

The social stigma construct had a mean score of 14.23 (*SD* = 3.88; range 7 to 35). This indicates that participants had low social stigma towards those with mental illness. For example, most participants (90.6%) agreed that those with mental illness can get better with treatment and the mentally ill are less of a danger than people think (59.8%). However, 26.3% of participants agreed that one of the main reasons for mental illness is lack of self-discipline and willpower, indicating some degree of social stigma (see Table 8). Social stigma had a weak negative correlation with biological causes (r=-.255, p<.01) and mental health knowledge/literacy (r=-.195, p<.01). Social stigma also had weak positive correlations with sinful causes (r=.177, p<.01), spiritual influences (r=.322, p<.01), and external/outside causes (r=.274, p<.01) (see Table 11).

Aside from the correlations described previously, those with more mental health knowledge/literacy had less social stigma towards the mentally ill.

Table 8. Social Stigma

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Those with mental illness can get better with treatment	41.2%	49.4%	7.8%	1.2%	0.4%
One of the main causes of mental illness is lack of self-discipline and willpower	3.7%	22.6%	21.4%	28.4%	23.9%
The mentally ill should be isolated from the rest of the community	1.7%	0.0%	6.6%	25.7%	66.0%
The mentally ill are a burden on society	0.8%	2.5%	8.7%	27.0%	61.0%
The mentally ill are less of a danger than most people think	18.7%	41.1%	19.9%	12.4%	7.9%
Less emphasis should be placed on protecting the public from the mentally ill	12.4%	34.4%	29.0%	16.2%	7.9%
It is best to avoid people with a mental illness	1.2%	4.1%	9.5%	40.7%	44.4%

Mental Health Knowledge/Literacy

The mean score for mental health knowledge literacy was 3.82 (*SD* = 0.40, range 1 to 4). This indicates that participants had very high mental health literacy, shown by 90.2% of participants correctly identifying loss of interest or pleasure in most things as a symptom of depression (see Table 9). Mental health knowledge/literacy had a weak negative correlation with social stigma, as described above (r=-.195, p<.01) (see Table 11).

Table 9. Mental Health Knowledge/Literacy

	True	False
A person with schizophrenia may see and hear things that nobody else sees and hears	78.9%	1.6%
A balanced diet contributes to good mental health.	75.4%	8.2%

One of the symptoms of depression is the loss of interest or pleasure in most things	90.2%	1.2%
If a person is threatening to harm themselves or others, it is best to approach them with an aggressive response	5.5%	84.8%

Individual Questions

Several items were also included in the survey to assess other perceived causes of mental health issues and treatment preferences. The mean score for environmental stressors/causes was 4.09 (*SD* = 0.92; range 1 to 5). This indicates that most participants (84.8%) agreed that anyone can become mentally ill in a bad environment. The score for family stress was moderately high, with a mean of 3.60 (*SD* = 0.94; range 1 to 5). Most participants (60.1%) had a moderately high belief that mental illness is caused by family tensions. The mean score for discrimination stress was 3.15 (*SD* = 1.15; range 1 to 5), this indicated that less than 50% of participants believed that stress is caused by religious persecution. Finally, the mean score for religious treatment preference was 2.12 (*SD* = 1.10; range 1 to 5). Only 12.3% of participants agreed that Muslims should go to a religious leader with mental health issues before a non-religious mental health professional, indicating a low preference for religious mental health treatment.

Table 10. Individual Questions

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
If the environment is really bad anyone can become mentally ill	34.4%	50.4%	8.6%	3.5%	3.1%
Mental illness usually comes from tensions in family	14.1%	46.0%	28.6%	8.1%	3.2%
Stress is often caused by religious persecution among Muslims	10.9%	30.5%	31.6%	16.4%	10.5%
Muslims should go to a religious leader with mental health issues before a non-religious mental health professional	4.1%	8.2%	16.9%	37.0%	33.7%

Table 11. Pearson's Correlations Between Key Constructs

	Mental Health Knowledge/ Literacy	Biological Causes	Sinful Causes	Spiritual Influences	Higher Power Influences	External/Outside Causes	Social Stigma
Mental Health Knowledge/ Literacy	1	.146	.146	-.065	.020	.039	**-.195****
Biological Causes		1	.080	-.085	**.135***	.023	**-.255****
Sinful Causes			1	**.486****	**.216****	**.289****	**.177****
Spiritual Influences				1	**.155***	**.305****	**.322****
Higher Power Influences					1	**.277****	.082
External/Outside Causes						1	**.274****
Social Stigma							1

**Correlation is significant at the 0.01 level (2-tailed)
*Correlation is significant at the 0.05 level (2-tailed)

Barriers to Treatment

Participants were also asked the following open-ended questions about barriers to treatment.

"What would stop you from seeking professional mental health care if you thought you needed it?"

There were several themes that emerged in the responses including cost, time, societal and self-stigma, mistrust of the mental healthcare system, and lack of culturally competent practitioners. The following responses were provided by participants.

Cost. Cost was frequently listed as a barrier, with some examples below.

- "*Cost (I don't have insurance)"*
- *"Money/co-pay"*
- *"Finances"*
- *"Access (affordable or culturally sufficient)"*
- *"If it's not covered by the insurance"*

Time. Some examples of responses related to this theme include:

- *"Time restraints"*
- *"Time constraints"*
- *"Lack of time"*
- *"Scheduling difficulties with my work schedule"*
- *"The fact [that] I have to go to the doctor. When you are [a] busy mom with kids, you don't have time to keep up with doc[tor] appointments"*

Societal and Self-Stigma. Some examples of responses that captured societal and self-stigma included:

- *"Self respect"*
- *"A sense of shame and weakness, and also being scared what people think about me for doing it"*
- *"What others think of me"*
- *"Acceptance of the fact that I am mentally ill."*
- *"Stigma and cultural taboo; concept of being perceived as weak; destruction of reputation within the community leading to stress within family and potential chance of not finding someone for marriage"*
- *"People gossiping about it"*
- *"Family pressures"*
- *"Parents and family judgement. They truly think anyone who gets mental health care is demented and should be ashamed of themselves"*

Mistrust of mental healthcare system. Several participants indicated lack of trust or fear of psychiatric medication and therapy, as shown below.

- *"Big Pharma"*
- *"Fear of being put on medication"*
- *"Psychiatry is pseudoscience"*
- *"Lack of trust in the medical system"*
- *"If they give me a treatment with alcohol based medicine or any other forbidden food by Islam"*
- *"If I think that the doctor would only prescribe medication instead of a holistic treatment plan"*
- *"Many therapists have secular/anti-religious agendas"*

- *"I don't know if it helps. Maybe the reason being that all references to mental healthcare I have seen are from pop culture. Haven't seen/heard about real life cases working."*

Lack of culturally competent providers. Many participants responded that they needed providers who understand their culture and religion. Examples included:

- *"Not finding an appropriate resource that would understand my identity"*
- *"A counselor who could take religious aspects into account. Who can understand the dynamics of being south Asian or expectations etc."*
- *"A therapist from another culture and religion"*
- *"Access to culturally/religiously competent care"*
- *"Finding a professional that understood my faith as well as guide me (faith base primary)"*
- *"Lack of relatable practitioners"*

CHAPTER 4: DISCUSSION

Overall, results indicate a mix of positive and negative mental health attitudes among Shia Muslim adults in the United States (RQ1). This study shows that Shia Muslims believe biological, sinful, spiritual, and external factors contribute to mental illness. Also, participants in this study had generally low stigma towards people with mental illness. Results are similar to findings reported in Bagasra and Mackinem's (2014) study of Sunni Muslims. Among this sect of Muslims, mental illness was believed to be caused by a mix of biological, spiritual, and environmental factors. It is not surprising that the two sects of Muslim have similar views on mental illness considering they have many similar core beliefs, practices, scriptures, and ethnic backgrounds (Pew Research Center, 2012).

In examining beliefs related to biological factors and mental illness, findings in this study indicated that mental health problems were viewed as a disease and a condition caused by chemical imbalances in the brain. Viewing mental health from a more medical standpoint may help to reduce shame and encourage treatment, shown by lower social stigma among participants with higher belief that mental illness is caused by biological factors. However, it is interesting to note that a large majority of the sample did not believe that family genes/genetics played a role in the development of mental illnesses. This may be due to possible underdiagnosis of mental illness in past generations due to lack of awareness and resources. Additionally, some participants reported mistrust of medication would prevent them from seeking professional mental healthcare if they though they needed it, despite believing mental illness is caused by biological factors. This is consistent with previous research showing minority mistrust of the healthcare system (Bazargan et al., 2021). Many participants also believed that the use of drugs and alcohol causes mental illness. Although there is a strong comorbidity between substance use and mental health problems,

determining the etiology of both problems can be difficult. For example, risk factors that contribute to the development of substance use disorders and mental illness are often similar (National Institute on Drug Abuse, 2021). Moreover, the effects of substance use can often mimic mental health symptoms, and substance use can contribute to the development of mental illness by changing brain structure and function (National Institute on Drug Abuse, 2021). This sample of participants had strong beliefs that substance use (which is viewed as a sin in Islam) causing mental illness. Considering this cultural belief, people who view substance abuse as a sinful act may possess negative views towards the mentally ill and/or those who seek treatment for additions. In this study, viewing sinful actions as a cause of mental illness was associated with the belief that lack of faith also leads to mental illness. Those who believed sinful actions cause mental illness also had higher social stigma.

Findings in this study also revealed that faith was viewed as a protective factor and treatment for mental illness, which in this case is considered a negative mental health attitude. While religion can be a protective factor to reduce mental health problems (Burshtein et al., 2016), attributing lack of faith to mental illness may create shame and stigma. Belief that faith is the best treatment for mental illness also discourages seeking counseling or medication. Those who had a high belief that faith prevents and treats mental illness also had higher social stigma levels. Moreover, some participants also believed that mental illness is due to the will of Allah or a test from Allah. Some Shia Muslims may find comfort in attributing their mental illness to Allah's overall plan. Alternatively, this belief may create turmoil for others who believe that mental illness is a punishment from Allah or feel they are failing their "test". Other external factors such as jinn, evil eye, and black magic had mixed findings. Some of the Shia Muslims is this sample may attribute mental illness to these religious forces as they are mentioned in the Quran and are widely

accepted by Muslims around the world (Pew Research Center, 2012).

Notably, for the most part, Shia Muslims reported favorable opinions about mental health treatment possibility and did not perceive individuals who have mental illness to be dangerous or a burden to society. Biological attribution and higher mental health literacy was associated with lower social stigma. However, sinful, spiritual, and jinn/evil eye/black magic attributions to mental illness were correlated with higher social stigma. Despite low measurable stigma in this sample, many individuals still reported that stigma would prevent them from seeking treatment (as indicated in qualitative findings).

In examining the degree of mental health knowledge about Shia Muslims (RQ2), mental health literacy scores were very high indicating that this sample was aware of general factual knowledge related to mental illness. This may be due to high education levels represented in the study sample and/or the simplicity of the questions. Additionally, it was noted that two of the items had high rates of missing responses, despite being listed before other questions with more responses. It may be speculated that these questions had low responses due to not being aware of symptoms of schizophrenia or how diet plays a role in mental health. Future research should incorporate more comprehensive ways of studying mental health literacy.

Other external forces/conditions appeared to influence perceptions about mental illness. For example, many Shia Muslims believed that anyone could become mentally ill in bad environments. This finding can be viewed as a positive or negative attitude, depending on attribution of blame for being in a "bad" environment. For instance, this can include being forced to live or work in a stressful environment or alternatively choosing a bad environment to socialize in, such as with unhealthy friends. A large majority of the sample also attributed mental illness to family tension. Attributing mental illness to family issues can reduce blame on the individual, but

it may also decrease the likelihood to seek social support for fear of bringing shame to the family or lack of autonomy to address mental health problems. Among some Shias, stress was viewed as the direct result of religious persecution. This finding may reflect islamophobia or trauma inflicted to individuals who immigrated from high conflict areas due to religious persecution. Over half of this sample was immigrants who moved to the United States, on average, as adults. They may have faced traumatic experiences while growing up in their home country or acculturation challenges upon moving to the United States.

There were many barriers to seeking treatment, including cost, time, social and self-stigma, mistrust of the mental healthcare system, and lack of culturally competent providers. Cost and time could be addressed as barriers by educating the Shia Muslim community about existing resources and services is needed. Mistrust/fear of the mental healthcare system could be addressed by showing cultural competence and creating a multidimensional treatment plan, including potentially medication, psychotherapy, and spirituality if faith is important to them. Explaining the treatment options in detail to these clients and involving them in creating a treatment plan may help reduce mistrust. This sample was highly educated and may be more likely to accept treatment if they are fully informed about the mechanisms, ingredients, benefits, and potential short term and long-term side effects of medication. They may also be more willing to engage in psychotherapy if they are informed about the efficacy of different types of therapy and given a long-term plan for sessions. Spirituality can also be incorporated into this population's treatment. Initially, Shia Muslims clients should be evaluated for religiosity and asked if they would like to include spirituality in their care. If they prefer this, psychoeducation of coping skills could include religious mindfulness techniques, such as practicing dua (supplication) and prayer. Religious Shia Muslims may also find comfort in discussing Quranic verses and hadith, which are saying from

the Prophet and important religious leaders (most often the 12 Imams for Shia Muslims). A psychotherapist could ask a Shia Muslim to find a motivational Quranic verse or hadith, or one that applies to their situation, and discuss it as a positive mantra or advice. If the client is inclined to attend religious services, encouraging this could be a way to increase social interaction as well.

In addition, lack of trusted providers and/or culturally competent professionals is a commonly cited barrier found in the literature (Johnson et. Al., 2004) and was frequently mentioned by this sample. To address this issue, this study highlights several issues that are important for practitioners to be aware of. For example, as stated above, some Shia Muslims may believe their mental health is affected by external forces such as Allah, jinn, the evil eye, and black magic. However, it is interesting to note that belief in jinn, the evil eye, and black magic was lower for this Shia sample than the primarily Sunni sample in the 2014 study (Bagasra & Mackinem, 2014). Clinicians should be aware of these concepts to avoid mistaking cultural beliefs as delusions, paranoia, or hallucinations. Shia Muslims may also carry shame due to societal attitudes and internal faith attributions related to mental health. In this case, traditional strategies of social support may not be as accessible and perhaps exploring possible faith related turmoil in psychotherapy would be helpful in reducing shame. Several Islamic concepts in the Quran such as Allah's mercy and compassion could be discussed to counter such issues. Additionally, the belief that Allah does not burden a soul beyond what it can bear, may be a source of hope to be discussed with Shia Muslims. Shia Muslims may also experience Islamophobia and deal with stress from discrimination, or even general acculturation struggles. Practitioners dealing with Shia Muslims should therefore be trained in trauma informed care. Additionally, clinicians should be aware of religious preferences in interactions to create a trusting and respectful environment. For example, some Shia Muslims may prefer not to shake hands or even maintain eye contact with the other

gender. Some may also prefer clinicians of the same gender to maintain modesty and respect gender boundaries in the religion (Atum et al., 2021).

It is also important to encourage dialogue and awareness about mental health in the community to address any negative perceptions and reduce overall socials stigma. Some participants also noted that the best treatment for mental illness is strong faith, and a limited number preferred to seek help from a religious leader. These findings indicate that religious leaders should be trained in mental health issues in to serve those who prefer seeking help from religious leaders.

Limitations

There are several limitations to this study. For one, the survey was distributed via social media, leaving out those in the population who do not use social media. Additionally, the sample was highly educated and comprised of primarily South Asian cultures and female gender. The survey was also in English, leaving out non-English speakers. A more diverse sample would allow more generalization to the overall population of Shia Muslims. Another important limitation is that the volunteer sample may have had a vested interest in the topic and be biased towards higher knowledge and positive attitudes on mental health. This was noticeable in the social stigma questions that indicated low social stigma, but participants still listed stigma as a barrier to care. The questions in this survey may not have measured more subtle forms of stigma or self-stigma or participants in this survey were skewed towards lower stigma since they volunteered to participate. This study overall captured a narrow view of mental health attitudes, stigma, and knowledge. Some constructs were measured using only a few items since this study aimed to assess multiple constructs in a limited amount of time to maintain participant interest.

Future Studies

For further research on this topic, a larger, more diverse sample is needed to examine differences between sections of the community to allow for greater generalizability to the overall community. Shia Muslims are a diverse group and there may be different findings with more representation from different cultural groups. The survey could also be translated into other languages for greater inclusion. It may be beneficial to visit mosques in person to reach those who are not on social media or otherwise inclined to volunteer to participate in a study. Focus groups and interviews could be conducted to collect qualitative data as well.

Other outcomes (or constructs) could be added to future studies including self-stigma and psychological openness, defined as willingness to acknowledge and discuss one's mental health. These concepts were seen briefly in the free response answers so further study of these variables could provide more insight on how to identify needs and better serve this community. Future studies could capture knowledge of mental health warning signs, risk factors, and protective factors.

Overall, this study had a good sample size, including adults who resided throughout the United States. This study adds to the limited research on Muslim mental health attitudes and knowledge. More specifically, this study provides insight on the views of Shia Muslims who have not been studied previously due to being the minority sect of Islam. Shia Muslims have a complex understanding of mental illness and healthcare providers need to be culturally aware to serve this population. Future research should consider ways to increase awareness and reduce taboo associated with mental health within the Shia Muslim community.

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