Mental Health Attitude Assessment Survey in the Canadian Muslim Community

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Abstract

The aim of this paper was to examine the attitudes of Muslims residing in Canada, towards mental illness. The study involved an online survey derived from “Stop Stigma Survey”, developed by Cornwall Counsel of the UK. The questionnaire included statements on a range of attitudes to mental illnesses such as; awareness and tolerance, fear and exclusion, stereotype and label avoidance and help seeking. A total number of 191individuals participated in the study. In order to obtain appropriate representation of both young and adult segment of the community, the participants were categorized into two age groups of 18-24 and 25-65 years. The participation of the survey was voluntary and consent was obtained prior to the survey. The majority of the participants appeared to be engaged more in self-stigma than public-stigma. Although, most of the participants disagreed with the statements representing negative attitudes such as, stereotyping, fear and exclusion and name calling, 72% of the respondents equally shared “neither agree nor disagree” and “agree” options, when asked if they would feel embarrassed to share their own experience of mental illness with others. Family physicians were the most common resource for mental help seeking. The research found that Canadian Muslim community is sensitive to mental illness with mixed attitudes. More efforts are needed in the community to increase awareness of mental illnesses and currently present resources in the country.

Introduction

The stigma concept has been applied to an enormous array of circumstances. Each one of these is unique, and each one is likely to lead experimenters to conceptualize stigma in a somewhat different way. Stafford and Scott propose that “Stigma is a characteristic of persons that is contrary to a norm of a social unit" where a "norm" is defined as a "shared belief that a person ought to behave in a certain way at a certain time"[1]. Crocker indicated, "Stigmatized individuals possess some attribute, or characteristics, that convey a social identity that is devalued in a particular social context"[2].

Allport suggests in his book that ‘‘Ethnic prejudice is an antipathy based upon a faulty and inflexible generalization. It may be felt or expressed. It may be directed toward a group as a whole or toward an individual because he is a member of that group’’ [3]. Goffman states that ‘‘Stigma…is the situation of the individual who is disqualified from full social acceptance” [4].

Jones et al (1984) writes, “stigma is the relationship between an attribute and stereotype; a mark (attribute) that links a person to undesirable characteristics (stereotypes)” [5]. One of the most encompassing definitions of stigma is by Link and Phlean; “When elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” [6].

Stigma processes unfold over a period of time. Dominant cultural beliefs link labeled person to negative stereotypes, which are mental images or generalized beliefs and opinions, about characteristics, attributes or behaviors of most members of a particular group [7]. These stereotypes serve to psychologically distance people from that group, and make them treat someone unfairly for being a member of that group. This is categorized as Interpersonal discrimination. Other forms of discrimination could be organizational and cultural [8]. Since it is hard to discriminate against people we feel empathy for, it becomes easier when the psychological distance is created [9].

People with mental illness face more stigmatized attitude than any other social group, due to the perception that they are the reason of their illness and are restrained by it [10, 11]. These misconceptions are based on media portrayal and family and peers experiences and impressions about mental illnesses [11, 12]. Almost 77% respondents of a survey indicated that media portrayal of psychiatric disorder seemed insulting and derogatory to them [13]. Another study analyzed the media content and found that danger, violence and criminality are direct themes in 40% of Canadian newspaper articles on mental illness. The study also found that a cure was only discussed 19% of the times which could lead people to believe that mental illnesses are permanent and incurable [14].

According to Corrigan and Watson, there are two dimensions of mental illness stigma; Public stigma, which is the negative attitudes of general public towards people with mental illness, whereas, self-stigma is an internalized stigma, where a person with mental illness agrees with the stereotypes and labeling described by others and applies them to one’s self[11]. (Corrigan 2002).

Results of a study conducted in UK, with 1737 participants, indicated that vast majority of the interviewees’ perceived individuals with different mental illnesses as dangerous, unpredictable and hard to talk with [15].

Research shows that stigma affects self-esteem of people with psychiatric illness. A study with 72 participants of a mental illness club house program, discussed that fear of being perceived as less trustworthy, less competent and less intelligent by their friends, family, neighbors and employers, makes people with psychiatric illness, less confident and defensive, and fear of rejection makes them avoid social contacts[12]. Living in a society where stigmatized notions are so prevalent and act as a barrier to good jobs, diverse social contacts, safe housing and quality health services for individuals with mental illness, make these individuals agree with these negative ideas and believe that they are less efficient and less valued than others [16].

About 80% respondents of a survey with 100 participants, reported to face hurtful remarks about mental illnesses and 70% indicated

avoiding disclosure of their diagnosis outside of their immediate family, to their friends, neighbors and while applying for jobs, licenses or housing. [13].

Peter Byrne 2000 writes, “The adaptive response to private and public shame is secrecy. Secrecy acts as an obstacle to the presentation and treatment of mental illness at all stages. So unlike physical illness, when social resources are mobilized, people with mental disorders are removed from potential supports” [17]. In an attempt to stay away from the labels and stereotypes, people with mental illness tend not to associate themselves with mental health personals, thereby avoid diagnosis by avoiding mental health care. A study shows that although, almost half of the respondents stated that at sometimes they felt that they needed to seek help for their mental health issue, they did not so ,the most frequent reason being embarrassment followed by not knowing who to seek help from[18].

According to Canada's 2011 National Household Survey, slightly over 1 million individuals identified themselves as Muslim, representing 3.2% of the nation's total population (Statistics Canada) [19].

Ayse Ciftci and Corrigan refer;

“Although Muslim beliefs and ethnic sub-cultures are heterogeneous, they are often perceived as a monolithic group, negatively stereotyped and subjected to significant interpersonal and structural discrimination. There are contextual differences among practices and beliefs about health and illness and important commonalities across Muslim groups” [20].

Despite significant variations in national and cultural associations, Muslims share some basic beliefs, such as; believing in one God who’s the Creator and who controls everything, life after death being a reward, or punishment based on the actions in this world, messenger of God as guides to mankind, the angels, the divine books and the fate. According to Amber Haque, for Muslims, soul becomes more important to be cared for as body is just a temporary vessel for the ever-living soul. Spirit, Aql (intellect) and qalb (heart) are different attributes in Islamic beliefs that describe different aspects of human psyche [21].

Various studies indicate that mental help seeking is not very encouraging among various Muslim groups and is influenced by their cultural beliefs and perceptions about mental illness, awareness of available resources and stigmatized behaviors [22-24].

A study conducted in Sydney, Australia indicated that Arab Muslim exhibit restricted mental help seeking. Embarrassment, traditional practices that discourage discussing family matters in outer circles especially because of their impact on marriages appeared to be the main causes [24].

Another study showed that Muslims are more likely to contact a family physician to seek help for their mental health issues followed by religious leaders [25].

Studies also found out that religious and cultural mistrust on western mental health system appeared to be an obstacle in treatment seeking [21, 22, 24]. Haque and Kenwari and Aloud suggested cultural and religious sensitive psychiatric practice for Western Muslims as religion play an important role in their lives. [21, 22, 24]

An important question to ask is, whether all the psychiatric illnesses are associated with same level of stigma and discrimination or they vary with the type and extent of mental illness. Studies show different views on this. A

qualitative research which was conducted to identify feelings and experiences of 46 people with mental illnesses shows that people diagnosed with psychotic illnesses reported to experience physical violence, verbal abuse and loss of contact with people because of their illness; whereas, people with depression, anxiety and personality disorders did not express very strong views about the general public and did not appear to have undergone the same degree of discrimination, yet they seemed to face many of the same challenges. Similarly, individuals dealing with drug dependency seemed to experience more frequents acts of overt discrimination and stigma as compared to people with non-psychotic illnesses [26]. On the contrary, Corrigan refers to some research that suggests that people labeled mentally ill, regardless of the specific psychiatric diagnosis or level of disability, are stigmatized more severely than those with other health conditions and there is no specific label effect [16].

Studies also discuss ways of reducing stigma. Laws that target the purpose of stigma and reduce chances of stigma are one effective way of reducing it. Power plays a big role in stigmatization and once that is taken away, through creating equal playing field, the stigma reduces [27].

Intergroup contact theory is a general social psychological theory which suggests that intergroup contact typically reduces intergroup prejudice in presence of four conditions; equal status, common goals, intergroup cooperation and the support of authorities and law or custom. A Meta-analysis on contact hypothesis shows samples with no claims to these conditions still demonstrate significant relationships between contact and prejudice but the structured contact predicts stronger contact- prejudice effects [28]. Whereas Contact under favorable conditions decreases prejudice. On contrary, contact under unfavorable conditions increases prejudice and intergroup tension [29].

Previous literature shows research conducted on the mainstream societal groups, but very little research has been conducted on minority groups such as Muslims. Canadian literature is also very limited when it comes to research on Muslims despite them being the second largest religious minority in Canada. Since Muslims constitute a significant part of Canadian population, we therefore set out to explore attitude of this important ethnic group toward mental illness, in terms of awareness and tolerance, fear and exclusion, stereotyping and label avoidance and help seeking. Our study leads the way for future researchers in conducting research on minority communities and designing ways to help Canadian Muslims against Mental illness.

Method

The questionnaire was derived from an online “Stop stigma survey”, which was developed by Cornwall Council of UK and was based on “Stigma attitude assessment scale” this survey is included in the appendix [1]. The survey included statements on a range of attitudes towards mental illness. Respondents were asked to give their opinion on each attitude statement, using a5-point scale from ‘Agree strongly’ to

'Disagree strongly'. A number of qualitative questions were added to get a broader sense of community attitude (survey copy is included as appendix). The questionnaire was kept short on recommendation from previous researchers in the community, who experienced high attrition rates due to long surveys. The participants of the survey represented the population of Canada who identify themselves as Muslims and belonged to the age groups between 18 to 65 years. The survey had 191 participants, 49.7% of the participants were 18-24 years old, 48.3% of the respondents were aged 25-64 and 2.1% were over the age of 64. The survey was conducted as an internal study under the organization of Think for Actions and it was posted on the organization's website and various Facebook pages. Think for Actions' website, community organization mail groups and individual emails were used to advertise the study and recruit subjects.. The survey was left open for several days for participants to fill out at their own convenience. Participation of the respondents was voluntary and an informed consent was obtained from all respondents after having been informed about the aims of the study. Survey was created using Google Docs and Google Forms, and statistical analysis of the results was conducted using Microsoft Excel. Bias was limited in analyzing the results since the data was categorical. The percentages for responses in each category were plotted in charts, and these charts were used to interpret the findings of this study. Using SPSS would give researchers an opportunity to analyze the results and compare the results between the two different age groups adults and youth. SPSS would also give researchers an opportunity to contrast different questions and report the relationship between survey questionnaires. This study is limited in that capacity. In the future researchers are recommended to use a combination of SPSS and Nvivo software to analyze the results. Researchers opted for the simple data evaluation method in this study, a more intricate method would be better option in future studies.

[2]

Results

The survey questionnaire measured participants' knowledge about mental health. Of all the participants, approximately 64.4% showed an awareness of the fact that it is not easy to spot someone with a mental health disorder. 65.4% of the participants disagreed with the statement that mental health disorders are permanent. 73.8% of participants did not believe in immediate hospitalization of people with mental illness. When participants were asked if anyone could have a mental illness, 65% agreed and 35% disagreed (Figure1.1). The survey also assessed people's attitudes towards mental illness.

Findings of the study showed that people engaged in self-stigma more than in stigma against other people. 36 % of the respondents said that they would be embarrassed to tell anyone that they had a mental health illness, whereas 28% disagreed with this statement and 36 % chose to neither agree nor disagree with the statement. Hence, more people agreed that they would be embarrassed to tell anyone that they had a mental illness compared to those who disagreed. 61% of the participants disagreed with the statement that they would not want to live next door to a person with mental illness, thus more participants did not show negative attitude in terms of living next door to an

[2] http://www.thinkforactions.com/

individual with mental illness (Figure 5). An overwhelming majority of survey respondents at 71% agreed with the statement that using words such as “Nutter” “Psycho” or “loony” is hurtful to people with mental illness (Figure 7). 49.8% of the survey population disagreed with the statement that people with mental illnesses are violent, whereas only 17.8% agreed with that statement, and 32.1 % choose to neither agree nor disagree with the statement (Figure 2). Only 51% of the population believed that people with mental illness should have an equal opportunity to jobs. The survey also aimed to measure participants’ help seeking strategies. The qualitative answers could be summarized in 4 major categories; doctors, counselors, family /friends and self-help. Doctors were the most common response from the participants followed by family and friends and then counselors, whereas the category of self-help came last with participants indicating they would get self-help through educating themselves

Knowledge of Mental Health Illness

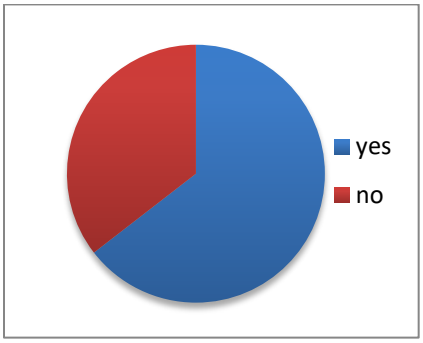

Figure 1: 65 % of the participants believed anyone can have a mental health illness and 35 % believed only certain people get mental health illness.

Violence and mental health illness

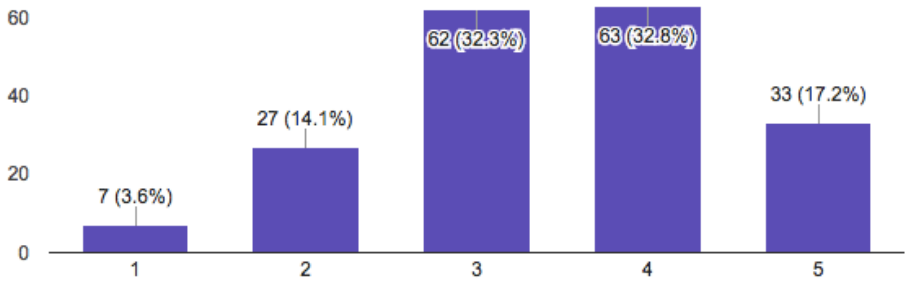

Figure 2: Participants response when they were asked if they people with mental health illness are likely to be violent.

Signs of mental health illness

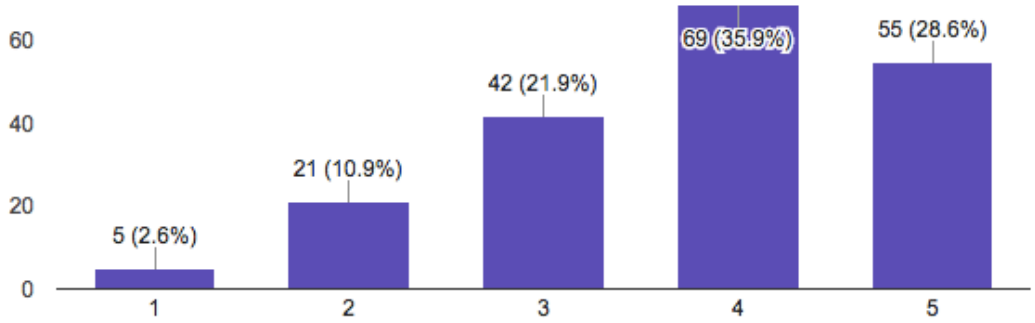

Figure 3: Participants response when they were asked if it is easy to spot someone with a mental health illness.

Treatment for mental health illness

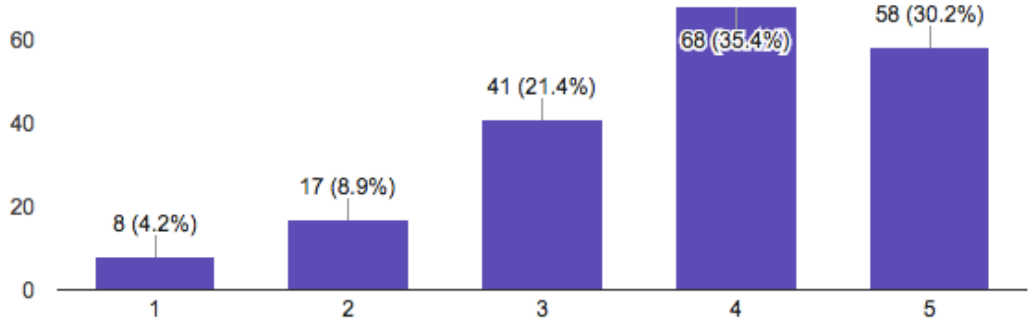

Figure 4: Participants attitude on the permanence of mental health was measured and most participants disagreed with statement, conveying their belief in treatment.

Stigma against mental health illness

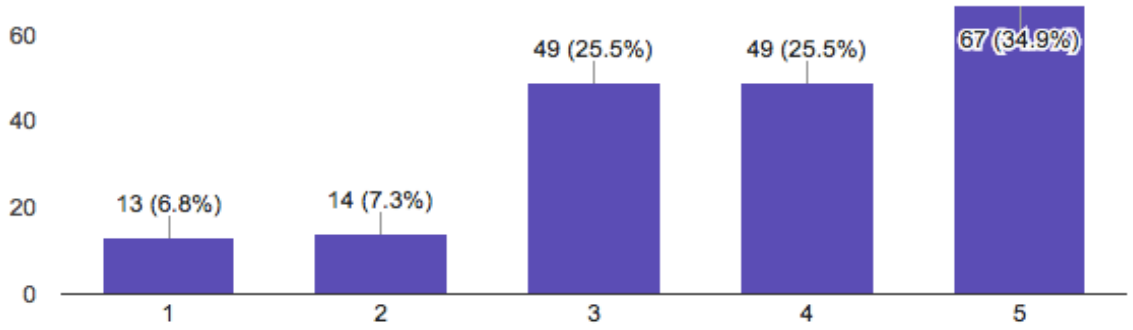

Figure 5: Participants were asked if they would want to live next door to someone with a mental health problem and most participants responded that they would not mind.

Knowledge of mental health illness

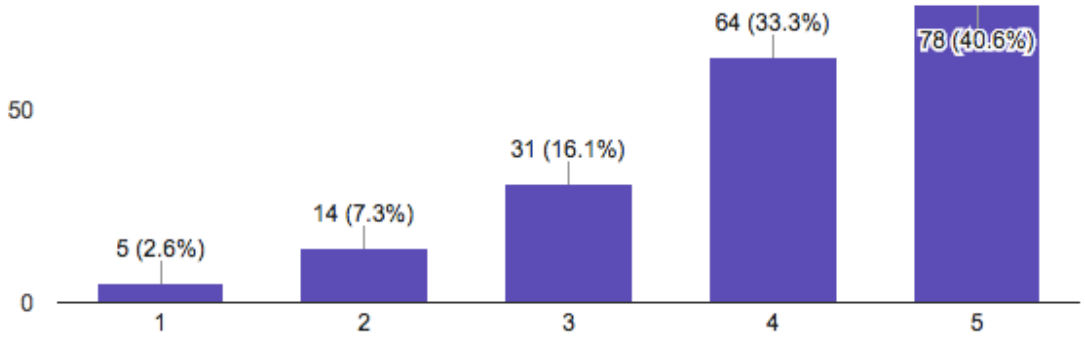

Figure 6: Most participants disagreed with the statement that as soon as a person shows signs of a mental health problem they should be transferred to a hospital.

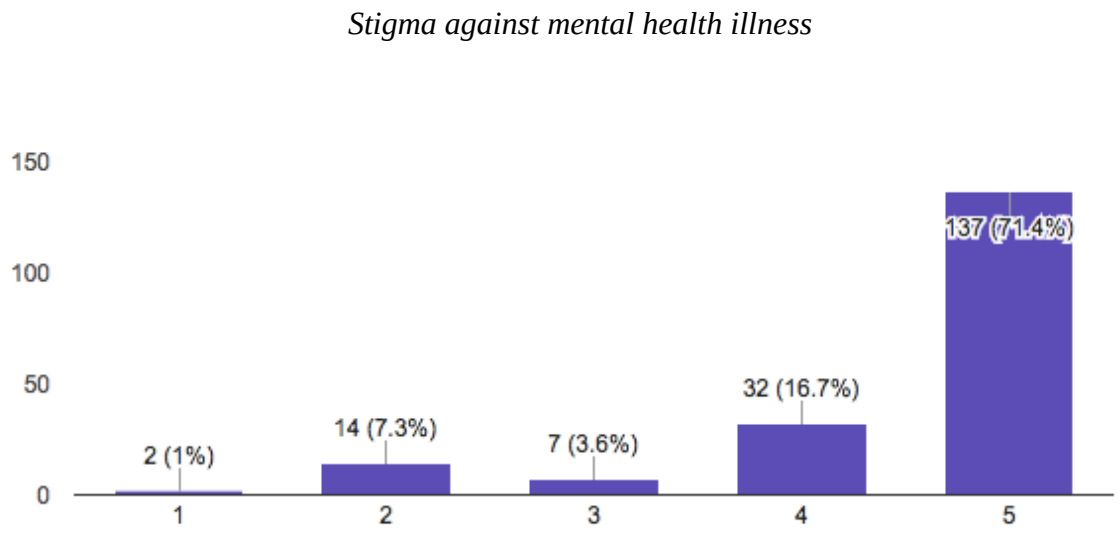

Figure 7: Overwhelming majority of participants disagreed with the statement that Using words like 'nutter', 'psycho', 'loony' is just a bit of fun. No-one gets hurt.

Discussion

The primary aim of our study was to examine general attitude of Canadian Muslim community towards mental illness. Our study is significant because very limited data is available related to mental health issues among Canadian Muslims. The survey questions measured the attitude, in terms of awareness and tolerance of mental illness, fear and exclusion of psychiatric patients, stereotyping and label avoidance and help seeking. Our Literature review discussed that misconceptions and negative mental images provide basis for discriminatory behaviors towards people with mental illness and act as a barrier to seeking help. Based on previous research [22-24,30], our hypothesis was that Canadian Muslims, in general, lack knowledge about mental illness and exhibit negative attitudes towards it. It is interesting to note that some results of our study are contradictory to our hypothesis and contrary to previous research, as most participants exhibited an awareness of the facts that anyone can have mental illness; mental illnesses are not permanent, all psychiatric patients are not necessarily violent and immediate hospitalization is not essential for everyone with a mental health illness. Furthermore, most respondents did not show a negative bias against individuals with mental illness. However, another interesting finding was that although, participants in the study did not engage in stigma against other people but feared that they would be stigmatized if they ever had a mental health illness. Results demonstrate that self-experience of mental illness still remains in the realm of silence and shame when it comes to

public discussion. Research shows that individuals who engage in self-stigma are less likely to get help for their mental illness. This, when combined with other hindrances in health care system, structural and institutional, financial, personal and cultural barriers [31](Riedel 1998) could prevent individuals from accessing appropriate treatment. The survey also aimed to measure participants' help seeking strategies from the qualitative answers that could be summarized in 4 major categories; doctors, counselors, family or friends and self-help. Family Doctors were the most common response from the participants. The reason for this can either be the fear of stigma from close family and friends and the tight knit culture of the community or the understanding that mental illness also has biological basis and therefore, should be treated as other medical diseases. In interpreting the results of the survey, its limitations should be taken into account. Even though, our study aimed to be inclusive of all groups within Muslim community, it can't be ascertained if it actually represents all the groups within the community, since questions regarding the sect or cultural background of the participants were not included in the survey. Socioeconomic status of the participants was also not inquired in the survey. Our literature review found that education is a major factor in stigma; which could have affected our results as most of our participants were able to access the online survey and receive it through their work or school email. Moreover, we asked about mental illness in general without mentioning specific Psychiatric illnesses, because we wanted to assess a general viewpoint of the community about mental health issues. Survey respondents might have different knowledge of and attitude to different psychotic and neurotic illnesses. In future, more studies should be conducted to explore further, focusing some aspects of our study, such as awareness in terms of causation and treatment of mental illnesses, knowledge of specific psychiatric disorders and barriers to seeking help. Contact with people with mental illness is fundamental to public stigma change, [28, 29] which is another information absent in the study. Future surveys should discover this from the participants if they or someone they know has mental health illness.

Conclusion

The research found that a significant amount of Muslim community that participated in the survey is sensitive towards mental health issues but feel embarrassed if they have a mental illness themselves. The results of the study did not prove our hypothesis that Muslims in Canada would reach out to get help from spiritual leaders for their mental illness and hold very strong negative bias against people with mental illness. Future research is needed around the factors that impact individual attitude towards mental health. Muslim Community showed to have some knowledge of mental illness and believed in its treatment, but it is not clear if people were aware of different available resources, as most individuals considered a Family Physician to be the first go-to resource. Holding educational sessions in mosques could be one way to reach the Muslim community in order to spread awareness of mental health and available resources in the country.

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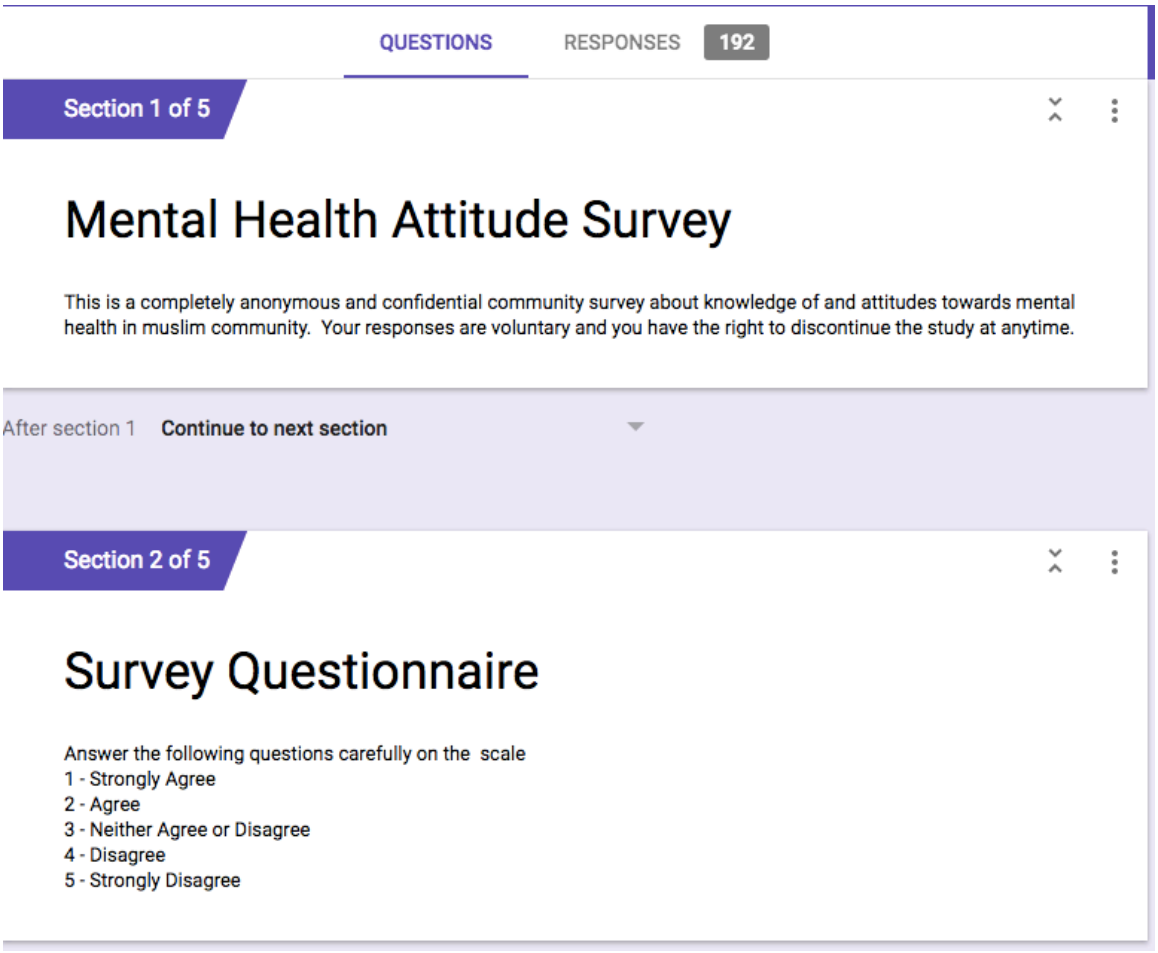
Appendix


QUESTIONS
RESPONSES 192
Section 1 of 5
Mental Health Attitude Survey
This is a completely anonymous and confidential community survey about knowledge of and attitudes towards mental health in muslim community. Your responses are voluntary and you have the right to discontinue the study at anytime.
After section 1
Continue to next section
Section 2 of 5
Survey Questionnaire
Answer the following questions carefully on the scale
1 - Strongly Agree
2 - Agree
3 - Neither Agree or Disagree
4 - Disagree
5 - Strongly Disagree

How old are you ? *

- 18- 24
- 25 - 64
- 64 +

I would be too embarrassed to tell anyone that I had a mental health problem. *

	1	2	3	4	5	
Strongly Agree						Strongly Disagree

People with mental health problems are likely to be violent. *

	1	2	3	4	5	
Strongly Agree						Strongly Disagree

It's easy to spot someone with a mental health problem. *

	1	2	3	4	5	
Strongly Agree						Strongly Disagree

Once you have a mental health problem you have it for life. *

	1	2	3	4	5	
Strongly Agree						Strongly Disagree

I would not want to live next door to someone with a mental health problem. *

	1	2	3	4	5	
Strongly Agree						Strongly Disagree

As soon as a person shows signs of a mental health problem they should be transferred to a hospital. *

	1	2	3	4	5	
Strongly Agree	○	○	○	○	○	Strongly Disagree

Using words like 'nutter', 'psycho', 'loony' is just abit of fun. No-one gets hurt. *

	1	2	3	4	5	
Strongly Agree	○	○	○	○	○	Strongly Disagree

Should someone with a mental health problem have the same rights to a job as someone without a mental illness. Why or why not? *

Should someone with a mental health problem have the same rights to a job as someone without a mental illness. Why or why not? *

Short answer text

Can anyone have a mental health illness? If not, who is more prone to having a mental health illness? *

Short answer text

If you thought that you had a mental health problem, how would you get help? *

Short answer text

I would not want to live next door to someone with a mental health problem. *

	1	2	3	4	5	
Strongly Agree	○	○	○	○	○	Strongly Disagree

As soon as a person shows signs of a mental health problem they should be transferred to a hospital. *

	1	2	3	4	5	
Strongly Agree	○	○	○	○	○	Strongly Disagree

Using words like 'nutter', 'psycho', 'loony' is just abit of fun. No-one gets hurt. *

	1	2	3	4	5	
Strongly Agree	○	○	○	○	○	Strongly Disagree