

## A Qualitative Study of the Perceptions of Mental Health Care in Kuwait

Nicholas C. Scull  
American University of Kuwait and Fawzia Sultan  
Rehabilitation Institute

Neha Khullar, Nasser Al-Awadhi,  
and Resha Erheim  
Fawzia Sultan Rehabilitation Institute

Ten adult Kuwaitis (5 men and 5 women) participated in in-depth semistructured interviews regarding their perceptions of mental health care in Kuwait. The interviews were analyzed using grounded theory and the emergent theory identified stigma as being the overarching theme, supported by cultural factors, Islamic beliefs, and therapist characteristics. More specifically, participants described a relationship between the stigma of mental health care and prominent Kuwaiti cultural factors such as familialism, gossip, and the importance of reputation. Participants also discussed how Islam informs their perceptions of mental health care and ideal therapist characteristics that would possibly help reduce stigma. Implications for mental health care in Kuwait in light of the World Health Organization's Mental Health Action Plan (WHO, 2013) and directions for future research are also discussed.

*Keywords:* mental health care, Kuwait, stigma, qualitative research

The perceptions of mental health care are broad and multifaceted, especially in the Middle East, where mental health care is still relatively new and not widely accepted. The practice of mental health care is especially challenging in the Middle East because it is stigmatizing to both the help-seeker and their families (Hamid & Furnham, 2012; Aloud, 2004; Al-Krenawi, 2002; Al-Krenawi & Graham, 1998, 1999a, 2000). Unfortunately, there is a lack of published research conducted in the Arab world, particularly in Kuwait, on how individuals view mental health care. To better understand this

phenomenon and help improve access to services, we conducted a qualitative study on Kuwaitis' attitudes toward mental health care. The results of this study are a step in supporting the World Health Organization's (WHO) mental health initiative (of which, Kuwait is a member state) to advance mental health research and advocacy, and guide policy-making processes in Kuwait (WHO, 2011a, 2011b, 2013, 2014).

### Kuwait

Kuwait is a relatively small country (about the size of New Jersey at 11,072 sq. miles) bordered by the Persian Gulf, Iraq, and Saudi Arabia. According to the CIA World Factbook (2014), the population of Kuwait is 2,742,711, where only 31% are registered as Kuwaiti nationals, while the remainder are either Asian (38%), other Arab (28%), African (2%), or other (1%, including those of North and South American, Australian, and European origin). The vast majority of individuals in Kuwait identify as Muslim (77%), representing both Sunnis (70%) and Shi'as (30%), while the remainder are either Christian (17%) or other and unspecified (6%). The urban population of Kuwait is 98% of the total population. Although Arabic is the national language, English is widely spoken.

---

Nicholas C. Scull, Department of Social and Behavioral Sciences, American University of Kuwait, and Psychological Services Department, Fawzia Sultan Rehabilitation Institute; Neha Khullar, Nasser Al-Awadhi, and Resha Erheim, Psychological Services Department, Fawzia Sultan Rehabilitation Institute.

We thank all the participants for sharing their experiences. We would also like to thank Dr. Khadeja Mousa who served as an auditor and Aisha Al-Qimlass for her assistance. We are also incredibly grateful to the Kuwait Foundations for the Advancement of the Sciences for generously funding this study.

Correspondence concerning this article should be addressed to Nicholas C. Scull, Department of Social and Behavioral Sciences, American University of Kuwait, P.O. Box 3323, Safat 13034, Kuwait. E-mail: [nscull@gmail.com](mailto:nscull@gmail.com)

Kuwait has a gross domestic product of approximately US\$ 180 billion (50% accounted for by crude oil reserves) and a per capita income of approximately US\$ 182,000, making it rank 5th among the world's wealthiest countries (CIA World Factbook, 2014).

### Stigma, Shame, and Secrecy

Despite a robust body of literature demonstrating the effectiveness of mental health care across diverse groups of people, many avoid seeking mental health care due to stigma. Corrigan et al. (2001) described stigma as being an affective and cognitive process that consists of both public-stigma (e.g., society imposing prejudicial beliefs onto a particular group) and self-stigma (e.g., individuals internalizing societal prejudices often resulting in shame). Mental health treatment is especially stigmatizing among Arab populations (Aloud, 2004). For instance, in a sample of 325 parents in the United Arab Emirates (UAE), only 38% reported that they would seek services for their children, even when presented with obvious mental health issues (Eapen & Ghubash, 2004). In another study, Arab-Muslims reported that psychological disorders are stigmatizing, and very few said they would turn to formal therapy for a psychological issue (Aloud, 2004).

Shame has been found to be a significant barrier to seeking mental health care (Sirey et al., 2001), and this is especially true among Arabs and Muslims in general. For example, Muslims in the United Kingdom were significantly more likely than non-Muslims to report that shame prevented them from seeking services (Pilkington, Msetfi, & Watson, 2011). Similar results were found in the United States, where almost 70% of Arab Women also felt that seeking mental health services would be a major source of shame for them (Abu-Ras, 2003). Because Arab cultures are ruled by the integration of family and society rather than autonomy, Arab-Muslims tend to prioritize relationships more than individual achievement (Okasha, 1999). Therefore, how one is perceived by society is a primary influence on their behavior. Because shame reflects on not only oneself but on one's entire family, it becomes a more significant barrier to seeking mental health treatment for Arab populations.

Because of the stigma and shame associated with mental illness, being secretive in seeking treatment is of the utmost importance to Arabs. Hamid and Furnham (2012) found that, although shame and stigma are predictive of Arabs' negative perceptions of mental health care, concerns about confidentiality played a significantly larger role in their attitudes toward mental health care. Similarly, Erickson and Al-Timimi (2001) found that Arabs living in the United States underutilize these services due to a fear of confidentiality breaches, and reassuring them that the client-therapist relationship is confidential would increase their likelihood to engage in therapy.

The underutilization of mental health services due to stigma is a global phenomenon (Saxena, Thornicroft, Knapp, & Whiteford, 2007), and mental health care advocates have recently sent a worldwide call to action to "improve the quality and human rights conditions in mental health and social care facilities and empower organizations to advocate for the rights of people with mental and psychosocial disabilities" (WHO, 2014, p. 4). Currently, however, there is no empirical research on the stigmatization of mental health care in Kuwait, though anecdotal evidence suggests that it is severe and on par with the aforementioned research on other Arab populations. Therefore, significant changes need to occur in Kuwait's health care system to mitigate stigma and reduce barriers to seeking treatment (see Almazeedi & Alsuwaidan, 2014).

### The Role of Family

Arab-Muslim populations, including Kuwait, tend to be collectivistic in that individuals are bound by mutual obligation (Oyserman, Coon, & Kemmelmeier, 2002). Meeting familial expectations is common, and in most cases, highly enforced; therefore, behaviors that deviate from social norms are highly disapproved of (Erickson & Timimi, 2001). Thus, the stigma associated with mental health care can cause significant interpersonal problems including limiting marital prospects or causing divorce (Al-Krenawi & Graham, 1998, 1999a, 2000; Hamid & Furnham, 2012). For this reason, individuals may rely on family when they have mental health problems and in effect, the family be-

comes a substitute for professional mental health care (Fakhr El-Islam, 2008).

Arab-Muslims tend to consider alternative sources of support before seeking mental health treatment. For example, Aloud (2004) examined who Arab-Muslims turn to in times of a mental health crisis and found that they are more likely to turn to their family practitioners (33%), family members (22%), and Sheiks (i.e., elders; 19%) for mental health issues than to professional therapists (11%). In fact, in Arab cultures, important health care decisions generally tend to be made collectively by the family (typically the father), rather than the individual (Padela, Guntner, & Killawi, 2011; Al-Krenawi & Graham, 2000; Meleis, 1984). In some cases, a patient's family member might seek health services on their behalf and withhold potentially embarrassing information from the patient's practitioner, further complicating their treatment (Al-Krenawi & Graham, 2000).

### The Role of Religion

Mental health professionals in Kuwait need to be aware of Kuwait's complex cultural background, as well as of the role that Islam plays in beliefs about mental health care (Kapborga & Berterö, 2002; Ypinazar & Margolis, 2006). Islam is a monotheistic and Abrahamic religion that, through the Qur'an and its teachings, provides a framework for most aspects of life including guiding relationships, finances, family life, charity, and health care. Because Muslims tend to believe that God is omnipotent and has absolute power, their lives are based entirely on God's will (Insha'Allah). Thus, physical and mental health problems tend to be attributed to the will of God (Ypinazar & Margolis, 2006). For example, in a qualitative study of American Muslims, most participants believed that God had the primary role in health and that their illness was a test of faith or a punishment of sort for not following the tenets of Islam more closely (Padela, Guntner, & Killawi, 2011). Although Muslims tend to believe that their fates are predetermined, Islam does encourage adherents to be proactive in their own care and, to this end, mental health care is necessary (Ypinazar & Margolis, 2006).

Arabs and Muslims often have alternative explanations for mental illness (Fakhr El-Islam, 2008). For example, some Muslims believe in

supernatural forces or spirits called jinn. Some believe that jinn may cause people to hear voices, speak unusually, or behave abnormally or aggressively. These forces may then be treated or exorcised by traditional religious healers (el-Islam & Abu-Dagga, 1992; Okasha, 1999). Some Muslims may also attribute mental health problems to mystical forces such as the "evil eye"; that people may cause bad luck or misfortune as a result of envy or jealousy. Individuals may protect themselves from such forces by making certain statements such as Masha'Allah ("God has willed it."), reciting particular prayers from the Qur'an, or by carrying talismans designed to ward off the evil eye.

Some research on mental health and illness in Kuwait showed that it is not uncommon for Kuwaitis to believe that their thoughts, feelings, and actions can be provoked by the devil, and that temptations are due to demonic manipulation (al-Ansari, Emara, Mirza, & El-Islam, 1989). Additionally, satanic temptations are often considered the cause of obsessive and compulsive patterns of thought and behavior. Therefore, some Muslims may believe that their mental health problems are caused by the devil and/or supernatural spirits and consequently turn to religious help rather than professional mental health care (Al-Adawi et al., 2002; al-Ansari et al., 1989; el-Islam & Abu-Dagga, 1992; Okasha, 1999). To provide culturally competent mental health care, clinicians must consider the indigenous beliefs, values, and traditions of their clients (Al-Krenawi & Graham, 2000).

### Service Delivery in Kuwait

All health care, including mental health care, is free for all Kuwaitis and anyone holding a current work visa. There is one public mental health center that offers a range of inpatient and outpatient services, including an acute ward for emergencies, psychological assessments, and outpatient psychotherapy. Unfortunately, many people are reluctant to receive services there because of the perception of poor quality of care, fear of confidentiality breaches, and stigma (Almazeedi & Alsuwaidan, 2014). Consequently, many people will seek care from their family practitioners, who are ill-trained and unequipped to provide adequate mental health care.

The lack of faith in the public mental health sector has given rise to the opening of several private mental health clinics. However, the credentials, clinical training, and quality of care can vary greatly in private clinics because there are no laws regulating the practice of mental health care. Many clinicians are providing mental health care with only professional certificates, questionable online degrees from unrecognized and unaccredited institutions, or bachelor's degrees. There is currently no way of verifying that practitioners have actually earned the degrees or professional credentialing they claim. There are currently five U.S.-licensed doctoral-level psychologists practicing in Kuwait, two of whom are Kuwaiti, and only two are able to practice therapy in Arabic.

More private psychiatric clinics are also beginning to open in Kuwait. Currently, there are approximately six psychiatrists who prescribe psychotropic medications in an independent practice setting. Most medicines that are available in the United States are also available in Kuwait. Some health insurance providers will reimburse for counseling and psychiatric visits in private clinics, but most clients tend to pay for services out-of-pocket. Because psychiatry is a medical practice, it is more closely regulated by the Kuwait government.

Although "mental [health] resources continue to be insufficient, inequitably distributed, and inefficiently utilized" throughout the world (WHO, 2011a, p. 10), this appears to be especially true in Kuwait. Recent data from the WHO's Mental Health Atlas for Kuwait (WHO, 2011b) indicate that the number of psychiatrists (2.62), psychologists (2.29), and social workers (0.66) per 100,000 is exceedingly low. Al-Krenawi (2005) also found that the number of psychiatrists (both licensed and unlicensed) are inadequate to meet the demands for those services in countries such as Lebanon, Egypt, Jordan, Bahrain, Palestine, and UAE. Additionally, most social workers in those countries have insufficient educational backgrounds and training. Alqashan and Alzubi (2009) examined the qualifications of 75 social workers in the public sector in Kuwait, and determined that most of them practiced with only a bachelor's degree (53%), and there were more clinicians with high-school diplomas (27%) than those practicing with graduate degrees (20%). It is likely that the lack of access to qualified mental health care

providers further exacerbates stigma and increases barriers to seeking treatment in Kuwait.

Unfortunately, unlike many other WHO member states, mental health legislation is not considered under legal provision in Kuwait (WHO, 2011b). For example, individuals seeking mental health care in North America have legal rights to confidentiality which prevent disclosure or acknowledgment of their case without the patient's consent. However, there is currently no confidentiality act in Kuwait that protects the privacy of individuals seeking mental health care. The lack of licensing regulations, mental health laws, and a professional ethics code increases the likelihood of professional maltreatment.

### Statement of Purpose

As Western forms of mental health treatment (e.g., psychotherapy and psychotropic medication) become more internationalized, we wished to understand how Kuwaitis perceive mental health treatment and the cultural factors that shape Kuwaitis views of mental health care. In particular, we wished to understand the perceptions of individuals who seek mental health care; identify possible barriers to seeking mental health care; views about different forms of mental health treatment (e.g., group therapy vs. individual therapy); and beliefs about the intersection of Islam and mental health care.

### Method

#### Rationale for the Social Constructionist Version of Grounded Theory

Charmaz's (2000) social constructionist version of Grounded Theory (Strauss & Corbin, 1998) was used, not as an alternative to traditional Grounded Theory, but because it acknowledges the researcher's role in shaping the interviews, and encourages researchers to interrogate and question their own influence on the study. Thus, it promotes and protects the integrity of social-scientific work by acknowledging that the researchers' interpretations are subjective, yet auditable and credible readings of the data (Charmaz, 2000; Strauss & Corbin, 1998; Willig, 2008).

## Participants

Participants were recruited until themes became repetitive and saturation was met. Among the 10 participants, five participants were male and five were female. Participants ranged in age from 25 to 72 years, with a mean age of 42. Four of them had a history of seeking mental health services, either for themselves (Participants 1 and 3) or for a family member (Participants 7 and 8). Eight of the participants reported having a college degree or higher. Five participants had no professional work history, two had mid-level management positions in private businesses, and two were self-employed and starting their own businesses. Nine of the participants identified being Muslim (all nine were Sunni, which is the majority group in Kuwait) and one identified as “agnostic.”

## Researchers

The study was conducted by a team of four diverse researchers, and most were involved in every stage of the research process. Acknowledging the researcher as a tool in the process of collection and analysis (Charmaz, 2000; Hesse-Biber & Leavy, 2011; Strauss & Corbin, 1998; Willig, 2008), the researchers remained reflexive during the data collection phase and kept memos during the analysis stage to uncover any biases for the duration of the study. At the time of the study, two of the researchers were also mental health professionals practicing in Kuwait. Additionally, each researcher was from a different cultural and ethnic background; therefore, the impact of their cultural affiliation on the discourse was considered. Lastly, every researcher had varying levels of experience with qualitative research.

The first author is a U.S.-born licensed psychologist (United States). The second author is of Indian descent and nationality but was born and raised in the Middle East. The third author is bicultural, British-Kuwaiti, and had lived in the United Kingdom, Kuwait, and the United States. The fourth author was born in the Middle East and is of Arabic background but spent much of her life living in Canada. The auditor was born in the United States and is bicultural (Kuwaiti and American).

## Procedure

**Data Collection.** Given the high value placed on interpersonal relationships in Kuwait, participants were recruited through word-of-mouth and a snowball technique, whereby participants helped connect the researchers to other potential participants. The first participant was recruited through a personal contact of one of the research assistants. The first participant then suggested we interview someone they knew and facilitated a connection with the second participant. This process continued until we developed a working model of the data. All prospective participants were screened to ensure they met the inclusion criteria of being Kuwaiti and of legal adult age. All prospective participants met the inclusion criteria and were interviewed in their homes or a nonprofit health clinic, depending on their preference.

Thirteen interviews were conducted; however, three were discarded due to technical problems, resulting in 10 interviews for analysis. All of the participants were offered the option of conducting the interview in English or Arabic. Nine of the 10 interviews used in the analysis were conducted in English. It is important to note that English is widely spoken in Kuwait and all of the participants who chose to conduct the interview in English reported that English was their preferred language. The interviews were ~45 min long, open-ended, and semistructured, allowing the participants to freely discuss their personal thoughts and feelings. All interviews were transcribed by members of the research team. The Arabic interview was transcribed and translated by an Arabic and English speaking researcher and then back-translated to further ensure accuracy.

**Interview protocol.** The interview protocol (Table 1) included four core areas: (a) Participants' general views on mental health care; (b) Beliefs about Islam and mental health care; (c) Beliefs about mental health treatment in Kuwait; and (d) Therapy modalities and confidentiality. The questions and probes were modified with the development of new data. Three of the researchers conducted the interviews and had experience conducting interviews for qualitative research. A U.S.-licensed psychologist supervised all the interviewees and completed “face sheets” to summarize the field notes and initial impressions of the interview.

Table 1

*Interview Protocol Used to Understand Kuwaitis' Perceptions of Mental Health Care in Kuwait*

1. What are your views about mental health care in Kuwait?
2. How do you think Kuwaitis typically view mental health care?
3. What do you personally think of people who seek mental health treatment?
4. Under what circumstances would you encourage a friend or family member to seek mental health care?
5. What do you think your family would think if you were in therapy?
6. Is there a difference between your views of mental health treatment and those of your parents or older relatives? And if so, please explain.
7. Who/what has influenced you the most regarding your views of mental health care?
8. How could mental health care become more widely accepted in Kuwait?
9. What do you think keeps people from seeking mental health treatment in Kuwait?
10. What kind of therapists/counselors do you think would be best suited for Kuwait?
11. What kind of therapeutic environment do you think would be best suited for Kuwait?
12. Religion is important to many Kuwaitis. How do you think Islam and psychology/mental health care relate?
13. What do you think is the biggest concern people may have regarding seeking mental health treatment?
14. How do you understand "confidentiality"?
15. Is confidentiality something that concerns you?
16. How could people be better informed about what confidentiality is?
17. How do you understand the use of "groups" in mental health treatment?

*Note.* These were the questions that were modified with further interviews.

**Data Analysis.** The primary goal of Grounded Theory is to use an iterative process of coding to build up to an explanatory model of the social processes that drive the phenomenon in question using an inductive or bottom-up approach (Charmaz, 2000; Starks & Trinidad, 2007; Strauss & Corbin, 1998). The purpose of the current study was to develop a theory that explains the social and cultural processes that influence the perceptions of mental health care in Kuwait. Themes and categories were developed until they approached saturation, or the point at which themes and categories became repetitive.

Three stages of coding were employed: open coding (data exploration and literal coding with text appearing within the transcripts); axial coding (reassembling codes into higher order categories based on researchers' interpretations); and selective coding (modifying themes to develop central "core categories"; Hesse-Biber & Leavy, 2011; Starks & Trinidad, 2007; Strauss & Corbin, 1998). Each transcript was coded one by one and involved a constant comparison method. Open, axial, and selective coding overlapped one another in order to modify the final core categories (Strauss & Corbin, 1998). Additionally, differences within some of the core categories were explored by breaking them down again to identify additional subcategories, in an attempt to counteract the impulse to ho-

mogenize the developing themes (Willig, 2008).

Negative case analysis (exploring unique instances that could not be categorized into any of the higher-order categories), as outlined by Willig (2008), was also an integral part of this study, as it allowed for the exploration of contingencies within the data, which actually enhanced the concreteness of the exploratory model. Acknowledging Charmaz's (2000) social constructionist version of grounded theory, the researchers engaged in a process of "bracketing," whereby they remained reflexive throughout the data analysis stage by memoing their ideas with the goal of reserving their a priori perceptions about mental health care, without abandoning them (Gearing, 2004).

After a working model of the data was developed, several data checks were used to reveal in-group biases and to enhance the credibility of the explanatory model (Van Vliet, 2008). First, each transcript was individually coded by four members of the research team, who met on a weekly basis to discuss any discrepancies and ensure consistency between the codes and categories. Second, a researcher who was not involved in the coding stages was consulted to audit the data. The auditor reviewed the interview protocol, transcripts, codes, core categories, and the generated theory, and concurred with the findings of the research team. Third,

the audit trail was also used to make sure that the interpretations captured the participants' meanings and perceptions.

**Results**

The results yielded a complex intersection of themes (see Figure 1). The direction of the arrows indicates the inductive, bottom-up approach in the analysis, and how broader categories were constructed. Lower order themes (i.e., salient axial codes) such as "importance of privacy" are in rectangles, while selective, higher order categories such as "negative personal experiences" are in circles. All themes presented in the model were heavily saturated with the exception of "social pressure to appear religious." Although this theme did not reach saturation in the analysis, it was included in the model, as it alludes to an important aspect of Kuwaiti culture, especially among some younger adults. Although Islam is an important cultural factor in Kuwait, it was not directly related to the stigma associated with seeking mental health care, hence the dotted circle in Figure 1. As indicated by the wider arrows, the overall model demonstrates how participants' negative personal experiences with mental

health professionals increased psychological distress and the stigma of mental health care, which then decreased their willingness to seek services.

The most salient theme that emerged across all of the interviews pertained to how heavily stigmatized mental health care is. All participants reported that there is limited understanding and awareness of mental health care in Kuwait. This lack of public knowledge of mental health care therefore led people to base their perceptions on experiences they had learned through second-hand information (e.g., a friend having a negative experience). Such second-hand information often reinforced misperceptions and led to increased stigma.

A second theme that emerged highlighted the major cultural factors that often negatively impacted Kuwaitis' perceptions of mental health care. Cultural factors such as the importance of one's reputation and social standing, and a culture of "gossip" all pose barriers to seeking treatment. These cultural factors also informed people's perceptions about mental health care more specifically. Themes related to the role of Islam in mental health care as well as those related to privacy, family dynamics, and the stigmatization of mental health care were the

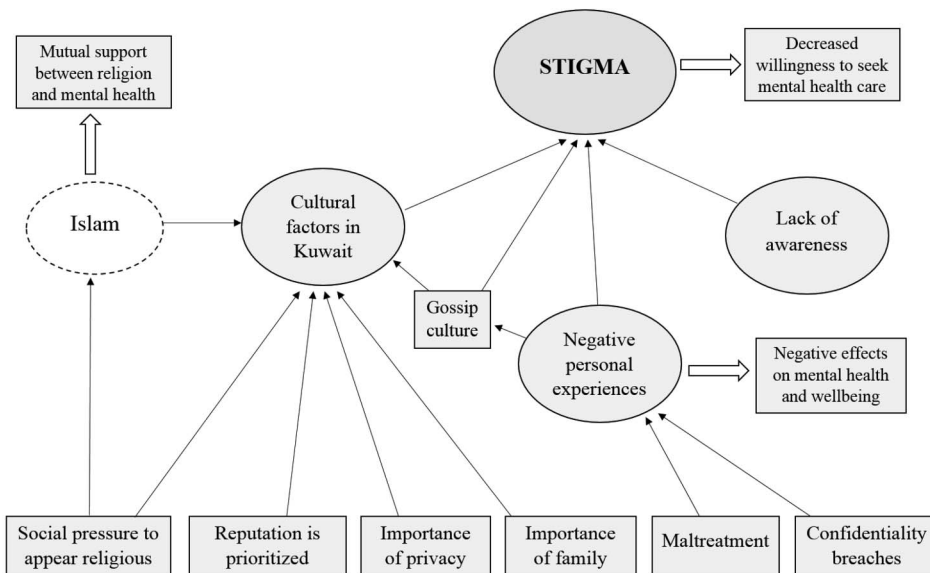


Figure 1. Explanatory model summarizing the perceptions of mental health and the effects of seeking mental health care within Kuwait's cultural context. The rectangles indicate axial codes, while the circles represent selective, higher order categories.

most saturated; however, individuals generally had mixed perceptions of ideal therapist characteristics; therefore, these themes were not included in the model.

## Stigma

There was a very strong consensus among all the participants that mental health care is stigmatized in Kuwait, and that seeking mental health treatment is highly stigmatizing to the individual and his or her family. Misconceptions about mental health care, a general lack of awareness, and negative personal experiences with the mental health sector in Kuwait were key themes that gave rise to stigma as the central and core theme of this study.

**“Mental health [care] is only for crazy people.”—Participant 10.** All participants noted that it is commonly believed in Kuwait that an individual must be “crazy” or “insane” to seek mental health services. Participants who reported no history of seeking mental health care generally demonstrated a lack of understanding of mental health care, and associated it exclusively with psychiatry. About half of the participants had trouble defining what mental health care is, as seen in the following quote by Participant 5—

*Um mental health- what does it include? See when I heard mental health, I automatically thought disability . . . that's how much it shows you about Kuwait, how we talk about it here.*

Another participant highlighted that many people in Kuwait believe hospitals and clinics can exacerbate mental illness—

*It's for crazy people . . . There is a [high] percentage I mean—they think that this place [hospitals and clinics] in Kuwait you cannot trust. You cannot. . . . If you go there you will become more crazy.*

**Lack of awareness.** Participants generally agreed that there is a severe lack of awareness of mental health care in Kuwait, which likely perpetuates the stigma associated with it. As Participant 3 stated—

*[People avoid seeking mental health care because of] stigma and lack of awareness . . . It's something that the government does not fund as much as they should, because they don't believe in it as much as they should.*

There are two possible explanations for this lack of awareness. First, about half of the participants proposed that psychoeducation is lim-

ited in schools; therefore, school-age children are unaware of what mental health care is, or the types of services that are available to them. Participant 9 alluded to this during his explanation of how mental health care can be destigmatized in Kuwait by raising awareness in schools—

*Children and teenagers develop their opinions at this age. So we have to tackle that at this age. So maybe if we talk to them, raise awareness in this group. In the future, we will see people understanding [mental health care].*

Second, most participants felt that older and more traditional Kuwaitis generally foster a negative attitude toward mental health care. Therefore, these negative perceptions and lack of awareness of mental health are either explicitly or inadvertently conveyed to younger Kuwaitis—

*I don't think they really believe in the concept of counseling . . . They believe that it doesn't apply to them . . . They can't realize that it applies to them . . . It's what we were raised to, quote-unquote, “believe” about mental health [care] in Kuwait—it's because this is what the generation that preceded us believed.—Participant 6*

Owing to this lack of public outreach, and poor understanding and awareness of mental health care within families, individuals are more likely to believe hearsay information that has been passed on to them from less informed individuals. Additionally, information that has been conveyed through word of mouth from those who have had negative experiences with some services in Kuwait further contributes to the stigma associated with mental health care.

## Negative Personal Experiences

Individuals who were exposed to the mental health sector in Kuwait, or were currently in treatment typically reported negative personal experiences with mental health professionals (mainly psychiatrists and the government hospitals)—

*The problem is the hospital . . . They [just] test for how smart you are, but when you need to talk, they talk before you and they don't listen [to you]. It's not right what's going on in Kuwait . . . Actually they lost my file as well . . . They don't want to communicate with you . . . It's all bullshit, they're not helping.—Participant 1*

*[My psychiatrist] called one of his patients . . . I think she was deeply manic or she was having an episode of*

some sort. She [interrupted] our session [and] he told me, “don’t worry, that’s one of my patients, but you’re not like her, she’s crazy.” Quote . . . That is exactly what he said: “you’re not like her, she’s crazy.” This is also the same man who also initially tried to push the *Qur’an* on me.—Participant 3

Experience with the mental health sector was a factor in how the participants formulated their opinions and perceptions about mental health care. Individuals who had seen clinicians in Kuwait reported breaches of confidentiality, judgmental attitudes from their therapists, authoritative and oppressive language, unnecessary hospitalization, and general misconduct. These individuals spoke about their experiences with more conviction and were more informed about mental health services, but were highly critical of the current system in Kuwait—

*I’ve just seen mental health [practiced] on an authoritative level . . . I know that for instance you can get admitted into the mental hospital here for being gay . . . They’ll call it a psychological disorder . . . and that’s because of a lack of awareness and because of the stigma that surrounds it.*—Participant 3

*When [my brother] was little, he had issues with learning disabilities . . . there was absolutely no facility in Kuwait to help him. And it was so obvious that he had [an issue] . . . When we went to register him within the government, we got a paper back [where] they called him a “mutant” . . . Seeing my little brother being called that for a simple learning disability like dyslexia; you’re calling him a “mutant.” It took my breath away . . . That’s when I started seeing there was a problem in this country.*—Participant 7

### Cultural Factors in Kuwait

All participants described major cultural factors that significantly shape the perceptions of mental health care in Kuwait, and felt that individuals must protect their entire family’s reputation. For example, Participant 3 stated, “In Kuwait, it’s almost like it could hurt your family . . . They don’t want for it to be known that so and so’s daughter or someone from this family is a manic-depressive.” This participant highlights how an individual’s mental health problem could potentially affect how others view the entire family. Moreover, owing to the cultural factor of collectivism, individuals feel obligated to share their problems with their family members before seeking help from someone outside of the family. For instance, Participant 7 stated—

*My parents and grandparents were big on “problems stay within the family.” They don’t understand the idea of confidentiality; “that’s still another person . . . this is Kuwait; keep the problems within the family.”*

Part of the rationale for keeping problems within the family was to preserve the reputation of the individual and the family. As Participant 10 stated—

*We have this reputation part; it’s very big especially with big family names. And the families know each other most of the times. And they won’t accept you . . . They judge a lot. Because here, Kuwait, it’s built on reputation.*

If one’s reputation is damaged, it can have significant social consequences including limiting marriage prospects. This point was highlighted by Participant 11—

*If you see most people who [seek mental health care], they won’t tell anyone. It’s like a secret . . . For example, young girls [and] marriages . . . If their husband goes and [finds out] that she seeks mental health care, [his attitude will be] “I won’t get married [to her].”*—Participant 11

Compounding the fear of damaging one’s reputation, all participants noted that there is a culture of gossip in Kuwait. For example, Participant 10 stated, “the Kuwaitis, they have this kind of personality they want to hide . . . they are afraid that they will be known. Because the Kuwaitis, they talk a lot.” This point is further elucidated by Participant 9 who stated, “what-ever two people know in Kuwait, then everyone knows in Kuwait; we have this gossip culture and everybody knows everything about other people.” Participants described a pervasive fear of losing privacy and people learning that they were accessing mental health care. Given the gossip culture in Kuwait, this would most surely mean that much of Kuwaiti society would talk and share this information with others, which would then damage one’s reputation.

### The Role of Islam in Mental Health Care

**Mutual support.** As Kuwaitis are predominantly Muslim, much of daily life is viewed through the lens of Islam. Therefore, the role of Islam in mental health care became a pervasive theme in the interviews. Generally participants believed that Islam and mental health care do not conflict and in some ways may be mutually supportive. For example, as two participants reasoned—

*They're not against each other. They wouldn't create a conflict because our religion, it's always looks for the best for the human being. If they're having any mental problem or anything that might lead them to suicide, that's against our religion. So I think it's for the best if someone goes to a doctor to help him solve his problems or just talk.—Participant 2*

*The way I understand Islam, is you fall and break your leg, you have to go get a cast. If you have a psychological issue, you have to go and seek help. There's nothing in Islam or Hadith (Islamic teachings) that tell you not to go and seek help.—Participant 8*

**Relying on Islam before seeking mental health care.** Participants often noted that people would tend to rely on Islam to cope with mental health problems before seeking traditional mental health care. Participant 10 noted in her interview, “*Islam is the solution for me . . . The first thing you think is God . . . This is what makes you calm down; just reading the Qur'an.*” Participant 1 also reflected on how he relied on religion to cope with his own struggles with mental health problems and substance use: “*If I don't believe in God, I will do bad [things] . . . I will steal . . . So I had two choices: only go to drugs and die . . . or pick a religion.*” The following quote highlights how Participant 8 sees that Islam helps him cope—

*Faith is kind of like an antibiotic. It helps the person realize that the period we're living is only a transition period . . . There are beliefs that with faith and Islam, this is how life is. To accept it the way it is, with all its good and bad . . . I have simple problems in my life, but when I pass away, I will be in a better state. So I think this reduces the issues. My understanding of religion, the saying goes, “Do in your life as you're living forever, and do for your afterlife like you will die tomorrow.”*

Although most participants felt that religious faith acted as a protective factor against mental illness or that mental health care and Islam do not conflict with each other, bringing religion into a session may be counterproductive for some individuals who do not conform to the cultural ideal of being “*compliant with God*” (Participant 3), or struggle between “*temptations*” and Islam (Participant 1). This was clearly demonstrated by Participant 3, who stated that “[*my psychiatrist*] tried to push the Qur'an on me.” Participant 3 also noted personal experiences of coping with obsessive-compulsive disorder and substance abuse, and eloquently described the complex interaction of Islam and mental health care—

*[Destigmatizing mental health care] would absolutely require, first of all, a separation of education and Mosque . . . Because never will they ever classify [mental illness] as normal . . . So there's the people obstacle. There's a cultural obstacle that ties into the legal. The legal is tied into the religion. It's all interwoven. And it's kinda like getting a bunch of necklaces intertwined and trying to one by one undo the whole knot that it's created. And it's going to take us a very, very long time.—Participant 3*

## Ideal Therapist Characteristics

Throughout all of the interviews, participants spoke at length about characteristics and qualities therapists working in Kuwait should possess. When considering important characteristics of a mental health provider, the single most frequently discussed factor was the issue of which therapist characteristics would assure confidentiality and privacy. As a result, almost all participants noted a belief that a Kuwaiti clinician would be less trustworthy and more likely to break confidentiality. Participant 10 stated, “*with a Kuwaiti [therapist] . . . there is no [security]. They are afraid that [they] will talk about them to someone they know.*” Participant 11 also noted a belief that Kuwaitis would feel a greater sense of privacy if they met with a foreign-born therapist, “*the patients would be more confident; he can tell whatever he wants to say so he feels more secure than [with] the Kuwaiti.*” Participant 6 also described their rationale for why she perceived foreign-born therapists to be more confidential—

*So you know, I think it goes back to the confidentiality thing. If it's an American, or like a foreigner, you don't have that fear because you have this perception of them being . . . not within the community, so you might feel more open talking to them.*

Although participants tended to feel that meeting with a foreign therapist offered an added amount of confidentiality and privacy in comparison with a Kuwaiti therapist, many participants noted that therapists should be multi-culturally competent and have an understanding of Kuwaiti culture and societal norms. For example, shortly after Participant 6 spoke about the perception that a foreigner would be more likely to maintain confidentiality than a Kuwaiti therapist, she described an importance of the therapist having an understanding of Kuwaiti culture—

*But again, you do want someone with a similar [cultural] background . . . I think the pros of someone with a similar background is that they can be more understanding or empathic to your situation.*

Participant 11 also described her perception that a therapist needs to have an understanding of Kuwaiti cultural norms, and in some cases it might be beneficial to see a Kuwaiti therapist: “it would be better for Kuwaitis to see Kuwaitis . . . [a Kuwaiti therapist] knows the culture, he knows the society so he knows the thoughts of the people.” Moreover, Participant 8 stated—

*[A therapist] doesn't necessarily have to be Kuwaiti by birth but he lived in Kuwait or studied in Kuwait . . . That's necessary [an understanding of Kuwaiti society] because the problems did not come from [just] anywhere; it's due to society.*

### Discussion and Implications

The primary purpose of this study was to obtain an in-depth understanding of how Kuwaitis perceive mental health care in Kuwait. Ten semistructured interviews with adult Kuwaitis were analyzed using grounded theory and elucidated a complex intersection of issues pertaining to stigma, cultural and societal pressures, the influence of Islam, and beliefs about therapists' backgrounds. Taken together, these themes formulate a model of how Kuwaitis view mental health care in Kuwait.

Owing to the lack of public health information about mental health care, participants described a pattern of having to rely on word-of-mouth information. The importance of privacy and reputation in Kuwait, along with the inclination toward gossip, and a general lack of awareness of mental health care collectively increase the stigma surrounding mental health care. Individuals' negative personal experiences of unethical, authoritative, and oppressive treatment from professionals in the public mental health sector are translated through word-of-mouth, further perpetuating the stigma associated with mental health treatment.

Consistent with previous literature (Abu-Ras, 2003; Al-Krenawi, 2002, 2005; Aloud, 2004; Eapen & Ghubash, 2004; Fakhri El-Islam, 2008; Erickson & Al-Timimi, 2001; Takriti, El-Sayeh, & Adams, 2005), all of the participants spoke in depth about how highly stigmatizing mental health care is in Kuwait. As a result, stigma became the most central and prominent theme.

Participants commonly believed that Kuwaitis tend to believe that one needs to be “crazy” in order to seek mental health care. Therefore, stigma seemed to be promulgated by a pronounced misunderstanding and lack of awareness of the purpose of mental health care. A final factor that perpetuated stigma of mental health care was negative personal experiences with mental health providers.

Consistent with Al-Krenawi and Graham (2000), participants generally described mistrust of mental health services. All of the participants who had personal experience with mental health care in Kuwait reported unethical treatment, breeches of confidentiality, and general incompetence and maltreatment. Some participants noted that the language used by mental health care providers was pejorative and degrading. This was clearly highlighted by Participant 3, whose psychiatrist referred to one of his patients as “crazy,” and then again by Participant 7, whose family received a report from her brother's physician, labeling him as a “mutant” for suffering from a learning disability. Participant 1 also complained about the fact that his psychiatrists “never listened” and merely tested for how “smart” he was. These negative experiences seemed to cause participants to lose confidence in mental health providers and perpetuated stigma.

Participants also described specific cultural factors that informed their perceptions of mental health care. Al-Krenawi and Graham (1998, 1999a, 2000), Hamid and Furnham (2012), and Moradi and Hasan (2004) have noted how Arab cultural values of collectivism and the primacy of the family inform perceptions of mental health care among Arab populations. This body of literature has also noted how mental health problems can be a source of shame for Arab families (Abu-Ras, 2003; Okasha, 1999). The participants in this study reflected similar beliefs. Participants commonly noted that the problems of the family superseded the problems of an individual family member. Reputation was also described as being highly important in Kuwaiti culture. Due to the stigma of mental health care, participants noted that having a mental health problem would therefore assuredly pose a risk to the individual's reputation.

A second cultural factor that emerged from the data was the role of gossip in Kuwaiti society. Due to the centrality of individuals' and

families' reputations, participants expressed concern that others would discover that they sought mental health care and share this information with other people. Participants noted that because of stigma, such gossip would have profound consequences including limiting job opportunities and marriage prospects (marriage and the joining of families in Kuwait is considered highly important). Taken together, participants described cultural values of collectivism, preservation of reputation, and gossip as coalescing to create a significant barrier to treatment.

As Kuwaitis are predominantly Muslim, everything in life tends to be viewed through the lens of Islam. Participants described how Islam shaped their perceptions of mental health care and noted a belief that Islam supported seeking mental health care and that there was no conflict in this sense. However, consistent with [Al-Krenawi and Graham \(1999b\)](#), most participants also noted that they tended to rely on Islam before seeking mental health care. Participants explained that prayer and faith were effective ways of coping with mental health problems and difficult life circumstances. However, some participants explained that incorporating Islam into clinical practice can be challenging. These participants reflected on their personal experiences of feeling pressured to accept their clinician's own personal religious beliefs. One participant also highlighted how the social pressure to appear religious can be a source of conflict for nonreligious Arabs in Kuwait.

A fourth primary theme that emerged pertained to ideal therapist characteristics. Consistent with research indicating that the therapist's ethnic match with a client is unrelated to clinical outcomes ([Cabral & Smith, 2011](#)), participants typically noted that there was benefit to seeing a foreign-born therapist. Participants explained that due to stigma and the fear that their reputation would be damaged if they sought mental health care, they generally perceived foreign-born therapists to be more trustworthy in maintaining confidences than Arab clinicians. This finding is consistent with research conducted with Arabs in the United Kingdom ([Hamid & Furnham, 2012](#)) and Australia ([Youssef & Deane, 2006](#)), who believed that Arab clinicians are unable to

preserve confidentiality, and felt fear and shame in expressing themselves to clinicians from their own ethnic community. However, consistent with [Sue & Sue \(2013\)](#) and [Sue, Arredondo, and McDavis \(1992\)](#), participants emphasized the importance that clinicians be multiculturally competent and that having an understanding of Kuwaiti culture would be essential to effective clinical practice.

### Implications for Mental Health Care

This study has important implications for public health and mental health practice. Research suggests that having confidence in mental health care helps reduce stigma and encourages treatment-seeking behavior ([Meltzer et al., 2003](#)). Unfortunately, however, all participants who had first-hand experience with mental health care in Kuwait reported maltreatment. These negative personal experiences with mental health professionals have negative effects on mental health and well-being. Additionally, these experiences exacerbate the stigma of seeking mental health care, and result in a decreased willingness to seek mental health services. Therefore, it stands to reason that steps should be taken to regulate mental health practice. For one, Kuwait would do well to create formal laws and policies regulating mental health practice. Such laws and policies would ideally set guidelines for legal and ethical standards, and educate the public on basic human rights and their violations. Second, given that many clinicians in Kuwait are practicing with little formal education and training ([Alqashan & Alzubi, 2009](#)), Kuwait should ensure that clinicians have a standard level of credentials including training and education.

Because Kuwait is a WHO member state ([WHO, 2011b](#), p. 79), it has recognized that mental health is a national priority. Therefore, it would do well to adhere to objectives and targets of the WHO's Mental Health Action Plan 2013 - 2020 ([WHO, 2013](#)) to "value, promote, and protect mental health" and "to access the full range of human rights and to access high quality, culturally appropriate health and social care" (p. 9). Considering Kuwait is one of the most socioeconomically powerful states under the [WHO \(2011b, p. 79\)](#), the lack of quality care should be a

significant cause of concern among public health administrators. It is likely that more tightly regulating mental health practice in Kuwait will ultimately lead to greater public confidence and less mistrust of mental health care providers, and destigmatize mental health care. Additionally, by legally reinforcing dedicated mental health policies, Kuwait can more adequately meet the standards of international human rights and mental health practice.

Participants provided a great deal of insight into what type of therapist would be most helpful. In particular, foreign-born therapists working in Kuwait should receive additional training and exposure in Arab mental health and have specific understanding of Kuwaiti religious and cultural values. Therapists would do well to consider how/if Western conceptualizations of mental health problems and clinical practice fit with their clients' understanding of their problems, cultural values, and worldviews. Moreover, consistent with previous studies (Youssef, & Deane, 2006), results elucidated the point that many prospective clients may be skeptical of Kuwaiti therapists' ability to maintain confidentiality. Therefore, clinicians in Kuwait may consider spending additional time discussing with clients the limits of confidentiality and the ways in which their privacy is protected.

Lastly, results indicated that more public health information is needed. Participants generally described little access to sound information about mental health care, resulting in reliance on second-hand information (which was often negative). Research has demonstrated that education is effective in reducing stigma of mental illness and seeking mental health care (Corrigan, 2004; Corrigan et al., 2001). Therefore, governmental and nongovernmental organizations should develop public health campaigns including ads on radio, printed material, posters in public areas, and online resources. There is also some evidence supporting the efficacy of public health campaigns being delivered through imams (Islamic leaders) and mosques (Rifat et al., 2008). Campaigns could focus on informing people about how to identify mental health concerns, how best to support loved ones with mental health concerns, where to go for help, destigmatization messages, and grounding advocacy of mental health treatment

in Islamic tenets. Because Kuwaitis tend to consult with primary doctors for mental health concerns, it would also be important to provide additional training to physicians, nurses, and other medical care providers in the identification of mental health problems, treatment, and how best to facilitate referrals to mental health specialists. Finally, mental health care could be further destigmatized by developing culturally sensitive advocacy groups for consumers of mental health care and support/educational groups for their family members/caregivers.

### Limitations and Directions for Future Research

The results of the study should be considered in the context of some caveats. For one, as with all qualitative studies, due to the small sample the generalizability of the results is limited. Moreover, the fact that nine of the 10 participants chose to conduct the interview in English rather than Arabic, could enter some bias. Although English is widely spoken in Kuwait, a participant's preference for English could suggest somewhat greater exposure to the West, which might influence perceptions of mental health care. Further research would do well to quantitatively examine the themes and concepts that were salient in the data across a broader cross-section of the Kuwaiti population. Moreover, given that Kuwait is a relatively culturally diverse country, future studies should consider sampling from other specific populations living in Kuwait including Bedouins and foreign workers. Different populations in Kuwait will likely have different views of mental health treatment in Kuwait.

The results of the study present a number of compelling areas for follow-up. In particular, because this study focused on Kuwaitis' perceptions of mental health care, it would also be useful to conduct research with mental health professionals working in Kuwait to understand how/if mental health care and diagnosis differs in Kuwait from other parts of the world. Additionally, follow-up studies with clinicians should evaluate how the lack of mental health legislature in Kuwait impacts clinical practice. In so doing, we will gain a more holistic understanding of how current policies and practice can be modified to improve the quality of mental health care in Kuwait.

## Conclusion

Mental health care is progressively becoming more internationalized and more widely adopted in non-Western contexts. Mental health care is relatively new to Kuwait and in order to help it become more culturally relevant and effective in general, it is critical to understand peoples' perceptions of it. In Kuwait, it appears that cultural factors (e.g., collectivism, gossip, and reputation), Islam, and ideal therapist characteristics all intersect and coalesce to contribute to a more general theme of stigma of mental health care. Culturally congruent practices, mental health regulations, and laws would help improve service delivery and likely reduce stigma. Stigma and mental health care in Kuwait are closely intertwined so as more Kuwaitis have better experiences with mental health care, word will spread, and stigma will be eventually be reduced. As Participant 3 quite eloquently stated, "nobody wants to be stigmatized, nobody wants to hurt their families, and no one wants to be put in that vulnerable position".

## References

- Abu-Ras, W. (2003). Barriers to services for Arab immigrant battered women in a Detroit suburb [Abstract]. *Journal of Social Work Research and Evaluation, 1*, 49–65. Retrieved from <http://connection.ebscohost.com/c/articles/27689757/barriers-services-arabimmigrant-battered-women-detroit-suburb>
- Al-Adawi, S., Dorvlo, A. S., Al-Ismaïly, S. S., Al-Ghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., & Chand, S. P. (2002). Perception of and attitude towards mental illness in Oman. *International Journal of Social Psychiatry, 48*, 305–317. doi:10.1177/002076402128783334
- al-Ansari, E. A., Emara, M. M., Mirza, I. A., & El-Islam, M. F. (1989). Schizophrenia in ICD-10: A field trial of suggested diagnostic guidelines. *Comprehensive Psychiatry, 30*, 416–419. doi:10.1016/0010-440X(89)90007-2
- Al-Krenawi, A. (2002). Mental health service utilization among the Arabs in Israel. *Social Work in Health Care, 35*, 577–589. doi:10.1300/J010v35n01\_12
- Al-Krenawi, A. (2005). Mental health practice in Arab countries. *Current Opinion in Psychiatry, 18*, 560–564. doi:10.1097/01.yco.0000179498.46182.8b
- Al-Krenawi, A., & Graham, J. R. (1998). Divorce among Muslim Arab women in Israel. *Journal of Divorce and Remarriage, 29*, 103–119. doi:10.1300/J087v29n03\_07
- Al-Krenawi, A., & Graham, J. R. (1999a). Gender and biomedical/traditional mental health utilization among the Bedouin-Arabs of the Negev. *Culture, Medicine and Psychiatry, 23*, 219–243. doi:10.1023/A:1005455809283
- Al-Krenawi, A., & Graham, J. R. (1999b). Social work and Koranic mental health healers. *International Social Work, 42*, 53–65. doi:10.1016/0010-440X(89)90007-2
- Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work, 25*, 9–22. doi:10.1093/hs/w/25.1.9
- Almazeedi, H., & Alsuwaidan, M. T. (2014). Integrating Kuwait's mental health system to end stigma: A call to action. *Journal of Mental Health, 23*, 1–3. doi:10.3109/09638237.2013.775407
- Aloud, N. (2004). *Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab-Muslims population* (PhD dissertation). Ohio State University, Columbus, OH. Retrieved from [https://etd.ohiolink.edu/!etd.send\\_file?accession=osu1078935499&disposition=inline](https://etd.ohiolink.edu/!etd.send_file?accession=osu1078935499&disposition=inline)
- Alqashan, H. F., & Alzubi, A. (2009). Job satisfaction among counselors working at Stress Center—social development office—in Kuwait. *Traumatology, 15*, 29–39. doi:10.1177/1534765608330052
- Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*, 537–554. doi:10.1037/a0025266
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509–535). Thousand Oaks, CA: Sage.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625. doi:10.1037/0003-066X.59.7.614
- Corrigan, P. W., River, L., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., . . . Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*, 187–195. doi:10.1093/oxfordjournals.schbul.a006865
- Eapen, V., & Ghubash, R. (2004). Help-seeking for mental health problems of children: Preferences and attitudes in the United Arab Emirates. *Psychological Reports, 94*, 663–667. doi:10.2466/pr0.94.2.663-667
- el-Islam, M. F., & Abu-Dagga, S. I. (1992). Lay explanations of symptoms of mental ill-health in Kuwait. *International Journal of Social Psychia-*

- try, 38, 150–156. doi:10.1177/002076409203800208
- Erickson, C. D., & Al-Timimi, N. R. (2001). Providing mental health services to Arab Americans: Recommendations and considerations. *Cultural Diversity and Ethnic Minority Psychology, 7*, 308–327. doi:10.1037/1099-9809.7.4.308
- Fakhr El-Islam, M. (2008). Arab culture and mental health care. *Transcultural Psychiatry, 45*, 671–682. doi:10.1177/1363461508100788
- Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research, 14*, 1429–1452. doi:10.1177/1049732304270394
- Hamid, A., & Furnham, A. (2012). Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion and Culture, 16*, 1–18. doi:10.1080/13674676.2012.718753
- Hesse-Biber, S. N., & Leavy, P. (2011). *The practice of qualitative research* (2nd ed.). Thousand Oaks: Sage.
- Kapborga, I., & Berterö, C. (2002). Using an interpreter in qualitative interviews: Does it threaten validity? *Nursing Inquiry, 9*, 52–56. doi:10.1046/j.1440-1800.2002.00127.x
- Meleis, A. I. (1984). The Arab American and psychiatric care. *Perspectives in Psychiatric Care, 22*, 72–76. doi:10.1111/j.1744-6163.1984.tb00208.x
- Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., Jenkins, R., & Lewis, G. (2003). The reluctance to seek treatment for neurotic disorders. *International Review of Psychiatry, 15*, 123–128. doi:10.1080/0954026021000046038
- Moradi, B., & Hasan, N. T. (2004). Arab American persons' reported experiences of discrimination and mental health: The mediating role of personal control. *Journal of Counseling Psychology, 51*, 418–428. doi:10.1037/0022-0167.51.4.418
- Okasha, A. (1999). Mental health in the Middle East: An Egyptian perspective. *Clinical Psychology Review, 19*, 917–933. doi:10.1016/S0272-7358(99)00003-3
- Oyserman, D., Coon, H. M., & Kimmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*, 3–72. doi:10.1037/0033-2909.128.1.3
- Padela, A., Gunter, K., & Killawi, A. (2011). Meeting the healthcare needs of American Muslims: Challenges and Strategies for Healthcare Settings. *Institute for Social Policy and Understanding*. Retrieved from [http://www.ispu.org/pdfs/620\\_ispu\\_report\\_aasim%20padela\\_final.pdf](http://www.ispu.org/pdfs/620_ispu_report_aasim%20padela_final.pdf)
- Pilkington, A., Msetfi, R., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion and Culture, 15*, 1–22. doi:10.1080/13674676.2010.545947
- Rifat, M., Rusen, I. D., Mahmud, M. H., Nayer, I., Islam, A., & Ahmed, F. (2008). From Mosques to classrooms: Mobilizing the community to enhance case detection of tuberculosis. *American Journal of Public Health, 98*, 1550–1552. doi:10.2105/AJPH.2007.117333
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *The Lancet, 370*, 878–889. doi:10.1016/S0140-6736(07)61239-2
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *The American Journal of Psychiatry, 158*, 479–481. doi:10.1176/appi.ajp.158.3.479
- Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*, 1372–1380. doi:10.1177/1049732307307031
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Oaks: Sage.
- Sue, D. W., Arredondo, P., & McDavis, R. D. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477–486. doi:10.1002/j.1556-6676.1992.tb01642.x
- Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken: Wiley.
- Takriti, Y., El-Sayeh, H. G., & Adams, C. E. (2005). Internet-based search of randomised trials relevant to mental health originating in the Arab world. *BMC Psychiatry, 5*, 30. doi:10.1186/1471-244X-5-30
- The CIA World Factbook. (2014, June 9th). Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/geos/ku.html>
- Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology, 55*, 233–245. doi:10.1037/0022-0167.55.2.233
- Willig, C. (2008). *Introducing qualitative research in psychology*. London: Open University Press.
- World Health Organization. (2011a). Mental Health Atlas. Retrieved from [http://www.who.int/mental\\_health/publications/mental\\_health\\_atlas\\_2011/en/](http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/)
- World Health Organization. (2011b). Mental Health Atlas: Kuwait. Retrieved from [http://www.who.int/mental\\_health/evidence/atlas/profiles/kwt\\_mh\\_profile.pdf?ua=1](http://www.who.int/mental_health/evidence/atlas/profiles/kwt_mh_profile.pdf?ua=1)
- World Health Organization. (2013). Mental Health Action Plan 2013 - 2020. Retrieved from [http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf)

- World Health Organization. (2014). QualityRights Project. Retrieved from [http://www.who.int/mental\\_health/policy/quality\\_rights/QRs\\_flyer\\_2012.pdf?ua=1](http://www.who.int/mental_health/policy/quality_rights/QRs_flyer_2012.pdf?ua=1)
- Youssef, J., & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic speaking communities in Sydney, Australia. *Mental Health, Religion and Culture*, 9, 43–66. doi:10.1080/13674670512331335686
- Ypinazar, V. A., & Margolis, S. A. (2006). Delivering culturally sensitive care: The perceptions of older Arabian Gulf Arabs concerning religion, health, and disease. *Qualitative Health Research*, 16, 773–787. doi:10.1177/1049732306288469

Received September 19, 2013

Revision received July 18, 2014

Accepted August 5, 2014 ■