Social Science Review - 2795-3785
No, 1, Vol 2 July-December, 2021 / 247-255

The Role of Religiosity and Religious Affiliation on Attitude towards Mentally Challenged Persons

Tamuno-opubo Addah TEMPLE
Department of Psychology, Obafemi Awolowo University,
Osun State, Ile-Ife, Nigeria
Email: addahson5@gmail.com; +2348030773809

Abstract

The study examined the influence of religiosity on attitude towards mentally challenged persons and assessed the influence of religious affiliations on attitude toward mentally challenged persons. It also examined the joint influence of religiosity and religious affiliation on attitude towards mentally challenged persons in Ile-Ife, Nigeria. This study was a descriptive survey design, which necessitated the data collection from a sample of 250 residents of a local community in Southwest Nigeria. These samples were selected through a two-stage sampling procedure which is purposive and stratified sampling techniques. The result showed religious affiliation has no significant influence on attitude towards mental illness, $F(2, 247) = 0.63$, $p>.05$. The result showed religiosity has no influence on attitude towards mental illness, $F(2, 247) = 0.64$, $p>.05$. The results also indicate that statistically there is no joint influence of religious affiliation and religiosity on attitude towards mental illness ($F\{2,249\} = 0.79$, $p >.05$).The study concluded that the participants' religious affiliation and degree of religiosity does not significantly influence their attitude towards the mentally ill.

Keywords: Religiosity, Religious affiliation, Mental Health, Mentally Challenged.

Introduction

Persons who are mentally challenged can be susceptible to some level of difficulties or vulnerabilities (Rettie & Daniel, 2021 Irrespective, the mentally ill need to be rehabilitated and their illnesses should also be effectively managed rather than neglected or making them roam about the streets due to some diverse cultural misconceptions. In Africa, the majority of persons with mental health challenges are found by the roadside begging for alms, are usually unsheltered, and are sometimes abandoned by their family members because of their health status. Moreso, the mentally challenged are often subjected to stigmatisation by members of the community where they reside as a result of misconceptions (Rayan & Fawaz, 2018). Many of these societal misconceptions suggest that they are irresponsible and hence incapable of making their own decisions, or that they are dangerous, and should be avoided (Corrigan & Watson, 2002; Rossler, 2016). Negative preconceptions of sufferers of mental disorders are rife. Irrespective, these prejudices place the mentally challenged at a disadvantage and their prospects of generating an income and finding work are severely limited. In addition, their health condition exacerbates environmental stress and reduces their ability to cope. Findings from Okpalauwaekwe, Mela and Oji (2017), showed that stigma, misinformation, misunderstandings, and social prejudice may be responsible for developing unfavourable opinions towards persons who are mentally ill in society. In some societies, studies revealed negative attitudes toward mentally ill people (Zhang, Sun, Jatchavala et. al., 2019). Individuals in diverse groups have unfavourable views, according to Zhang, Sun, Jatchavala et al. (2019). There have been some assumptions made regarding the stigmatisation of persons with mental illnesses. The majority of these implicit assumptions propagate the impression that individuals affected with such illnesses are labelled risky, unstable, hideous and unlikely to be effective in these communities (Corrigan, 2005; Brown, Johnstone, & Ross, 2021). Furthermore, despite advances in scientific knowledge and efforts to improve public awareness of the illness, these negative assumption structures have remained remarkably persistent (Link et al., 1999; Pescosolido et al., 2010). Consequently, such negative attitudes and misconceptions are unlikely to occur alone during adulthood, instead of evolving during childhood and advancing in the development sequence of the person.Despite the cultural differences, Nigerians have nearly the same belief system when it comes to mental illness and its victims as other African countries (Udoka et. al., 2017). Intuitive findings also suggest that the mentally ill are seen negatively in Nigerian culture. The consensus is that anyone suffering from a mental illness is abnormal

and should be kept to a bare minimum (Armiyau, 2015). This is because many people are unaware of the risk factors for mental illness, and the prognosis is bleak (Mental Health Foundation, 2016). Popular beliefs reinforce the belief that mental illness is caused by God, and malevolent supernatural forces (Abasiubong, Ekott & Bassey, 2007; Adewuya & Makanjuola, 2008; Okpalauwaekwe, Mela & Oji, 2017). In short, mental illnesses are perceived to be a result of punishment for the supposed sins or bad behaviour of the individual and should thus be treated as incurable. These socio-religious perceptions have impacted Nigerians' attitudes toward the mentally deprived to the extent that the prevailing societal belief is that the mentally ill are invalids. Stigmatization is based on perceived flaws in an individual's character and is linked to views that people with mental illnesses are dangerous and should be held culpable for their health condition (Goffman, 1963; Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). People with mental illnesses have fewer chances for work, housing, health treatment, and social contact as a result of discrimination (Bathje & Pryor, 2011; Sickel, Seacat & Nabors, 2014). Any attempt to understand the construct of a social stigma would require the exploration of several paradigms. Stigma, according to Goffman's (1963) social identity writings, is any long-term individual or group feature that is deemed abnormal and may elicit negative or punitive responses from others. The dichotomy between public stigma and self-stigma. Self-stigma has been described as an internalised negative perception of the self that finds expression as self-doubt and decreased self-esteem (Corrigan, 2003; Corrigan, 2004).Globally, religion is seen as a part of everyone's life, including youngsters and adults with mental disorders (Abuhammad et al., 2020). Religiosity is conceptualised in terms of the degree of individual regard and commitment to a supernatural entity (Ketola & Stein, 2013). Religion, according to Testoni et al. (2018), promotes psychological well-being and enhances emotional stability in the face of mental illness. Hence, all talks of religiosity must take the treatment process for mental health disorders into consideration (Moleiro & Rosmarin, 2016). According to research, religion has a major impact on people's views and attitudes toward sufferers of mental illnesses (Bushong, 2018). This sort of stigma exists in all religions, including Christianity, Islam, and Judaism, to name a few. Furthermore, Lyons et al. (2015) discovered that religious views exert a significant impact on how persons with mental disorders are treated.

Literature

Recent studies have equally indicated the existence of a strong positive association between mental health and religiosity (Koenig & Al Shohaib, 2019; Astrachan, et al., 2020; Koenig, et al., 2020; Malinakova, et al., 2020). These associations have extended across various human populations, strata, the young, adults, older people, general community residents, immigrants and refugees, college students, the sick, addicts, homosexuals, persons of parenthood, individuals with mental health problems and personality disorders (Braam, et al., 2017; Miller et al., 1997; Levin & Chatters, 1998; Braam et al., 2004; Koenig et al., 2004). Research pointed out that, there is a probability for most people who were not religiously inclined at the onset of their lives to resort to religion for comfort (Koenig, 2015; Koenig & Larson, 2001). Beliefs in a loving and caring God, private religious activities, reading the scriptures for direction and encouragement, or the desire for support from pastors or members of the faith community all contribute to this indulgence in religious practice and rituals. There is a growing consensus in literature about religiosity as serving as a potent resource for hope, meaning, comfort, solace and meaning. People with diseases and impairments benefit the most from these protective and helpful benefits (Koenig et al., 1998; Mueller et al., 2001; Koenig et al., 2004). Studies from sub-Saharan Africa have suggested a special preference for traditional and spiritual healers (Adewüya & Makanjuola, 2008). For instance, a study on the role of religion and mental health in Nigeria revealed that religion plays a significant role in the life of the average Nigerian especially, as it relates to psychosocial, economic and health-related matters (Kitause & Achunike, 2013). The average Nigerian still believes in supernatural and preternatural causes in the aetiology of mental illness irrespective of their educational status (Udoka et al., 2017). In Nigeria, religious affiliation is inextricably tied to ethnicity, with most ethnic groupings having significant regional divides. The Hausa and Fulani ethnic groups dominate the primarily Islamic northern regions, whereas the southern ethnic groupings have a substantial Christian population. However, there is no predominant religion in the Southwestern states of Nigeria. The Yoruba tribe,

which makes up the majority of the population in the southwest, subscribe to Christianity, Islam, or traditional Yoruba religion; which is based on the belief in one supreme God and numerous deities (Agara et al., 2008). In a nutshell, available figures show that around 46% of the population is Muslim, with the Sunni branch of the faith being practised by the majority. About 46.3% are Christians. In addition, 7.4 per cent follow traditional African faiths, while 0.3 per cent follow other religions or none at all. In the same vein, many individuals incorporate elements of tradition into their religious practices (Brian et al., 2017).The review provided the requisite and relevant knowledge of approaches and results in mental health care across the world. More so, information on the existing relationship between culture, religion and attitude of people concerning mental health issues among a sample population including youths and adults was made available. The information obtained was very salient to the understanding of the kind of data required for this study. It was based on the information that socio-demographic variables such as gender, age, income, tribe and religion were found useful to the study. Other variables generated for this study include mental health attitude, behaviour and patterns.

Methods

The study adopted a descriptive survey design, which necessitated the use of primary data sourced through the administration of questionnaires. The study population comprises residents of Ile-Ife, Osun State, Nigeria, and a representative sample was selected through a two-stage sampling procedure. At the first stage, a purposive sampling technique was employed in selecting two hundred and fifty (250) participants for the study. Demographic characteristics showed: 154 (62%) males and 96 (38%) females. The age range for participants was between 17 to 54 years with a mean age of 26.24 and a standard deviation (SD) of 7.03. Single (not yet married) respondents constituted 188 (75.2%) of the sampled population, married respondents constituted 47 (18.8%) and divorced respondents constituted the remaining 15(6%) of the sampled participants for this study. The religious affiliations of respondents are as follows: Christianity with the frequency of 189 participants (75.6%), Islam with the frequency of 46 participants (18.4%), traditional religion with the frequency of 11 participants (4.4%), others with the frequency of 4 participants (1.6%). In the second stage, stratified sampling was used in grouping participants into the four major ethnic groups, Hausa, Igbo, Yoruba and other minor ethnic groups. The analysis thus indicated that Hausas were 21(8.4%), Igbos were 48 participants (19.2%), Yorubas were 159 participants (63.6%) and other ethnic groups were 22 participants (8.8%). Participant's level of education is as follows: degree holders were 74 (29.6%), HND holders were 26 (10.4%), institution holders were 86 (34.4%), NCE holders were 12 (4.8%), OND holders were 27 (10.8%) and SSCE holders were 25 (10.0%).

Instruments

A standardized structured questionnaire with three sections was utilized to collect information from participants in this study. Section A tapped information on the personal data of the participant, while Section B tested the participants' level of religiosity which is in three levels of Christianity, Islam and traditional. Section C focused on attitude towards mental illness.

Personal Data Questionnaire:

This was a self-developed questionnaire designed to measure such items as age, sex, marital status, occupation, religion, ethnicity, and level of education. Respondents were asked to fill in the gaps where necessary or indicate by ticking the suitable option, as well as the extent to which the items best describe them.

Religious Orientation Test:

The test was designed to measure the level of religiosity and was developed by Idehen (2001). It has a nine (9) item scale with a 5 Likert-type format of scoring, which is directly formatted and could be administered individually. It has such items as: 'How religious do you consider yourself to be' and 'How satisfied are you with your religious beliefs. The scale was categorized into three namely low, moderate and high. A score below the

mean was regarded as low religiosity; a score to the mean was regarded as moderate religiosity while a score above the mean was regarded as high religiosity. The reliability coefficient from this study is Cronbach's Alpha = 0.84 and Guttman split-half Coefficient = 0.80.

Attitude towards Mental Illness Scale (ATMIS):

This scale was developed by Ng and Chan (2000) to measure the attitude of people towards mental illnesses. It also has a direct scoring format with a 5- point Likert-type and a 40 - item scale. It could either be administered individually or to a group. It has such items as: 'It is possible to deduce that an individual is suffering from mental illness by simply observing their attitudes' and 'People with mental illness have unpredictable behaviour'. This instrument includes measures of Benevolence – an expression of kind gestures towards mental health sufferers (with 8 - items); Separatism - emphasizes the uniqueness of mental health sufferers and the need to honour their privacy (with 10 - items); Stereotyping - a preconceived notion that persons with mental illnesses exhibit certain patterns of behaviour and patterns (with 4 - items); Restrictiveness - believes that sufferers of mental illnesses are a menace to society and their participation in social activities should be limited. (with 4 - items); Pessimistic prediction – posits that mentally sick persons are unlikely to improve (with 4 - items); and Stigmatization – suggests that mentally sick persons are stigmatized, and sufferers should be isolated from others. (with 4 - items). The reliability coefficient from this study is: Cronbach's Alpha = 0.70 and Guttman split-half Coefficient = 0.53

Procedure

At the beginning of the exercise, participants were provided information on the purpose of the study. Assurances were proffered based on the confidentiality of information provided and due appreciations were offered to the respondents. Concerning the administration of the questionnaire, the researcher personally went around the town of Ile-Ife to carry out the distribution of the questionnaire and also, got permission where necessary from the head of any religious group.

Data analysis

The data obtained were analysed using both descriptive and inferential statistics. The descriptive statistics used comprised the frequencies and percentages, means and standard deviations with their results presented in tabular format. Due to the formation of hypotheses for the study, the inferential statistics involved was the Analysis of Variance (ANOVA). The results are also presented in tabular format.

Results

Attitudes of residents of Ile -Ife to mental illness

The determination of attitudes of respondents toward mental illnesses was done in two stages. In the first stage, the norms for the ATMIS were calculated using measures of central tendency (mean and standard deviation). These values were found to be mean 116.05 and standard deviation = 16.43. Then the cut-off point for positive and negative attitudes was determined using the extreme scores of one standard deviation above and below the mean were calculated. The result of this analysis is presented in Table 1. The results indicate that the lower cut-off is a score of 99.62 while the upper is a score of 132.48

Table 2: Overall Attitude of Participation towards Mental Illness

Group	Frequency	Percentage
Positive	84	34
Moderate	125	50
Negative	41	16
Total	250	100

The results indicated that a vast majority (50%) of the participants had only a moderate attitude towards mental illness, 34% had a positive attitude and the remaining minority of 16% had a negative attitude towards mental illness. In brief, the residents of Ile-Ife have a positive attitude towards mental illness.

Hypothesis Testing

Hypothesis 1: This hypothesis states that religious affiliation will have a significant influence on attitude towards Mental Illness. The hypothesis was tested using an analysis of variance (0ne-way ANOVA). The results of the analysis are presented in Table 3. The result showed religious affiliation has no significant influence on attitude towards mental illness, $F(2, 247) = 0.63$, $P>.05$. This finding suggests that the participants' religious affiliation did not trend significantly in the predicted direction of influence towards the mentally ill. The hypothesis is, therefore, rejected. Hypothesis 2: This hypothesis states that religiosity (low, moderate and high) will have a significantly more positive attitude towards the mentally ill. The hypothesis was tested using ANOVA and it is summarised in Table 3. The result showed religiosity has no significant influence on attitude towards mental illness, $F(2, 247) = 0.64$, $P>.05$. This result is suggesting that the variables were marginally trending in the predicted direction, that is, participants' degree of religiosity does not have a statistically significant influence on attitude towards the mentally ill among the study population. The hypothesis is, therefore, rejected.

Hypothesis 3: This hypothesis states that there will be a significant joint influence of religious affiliation and religiosity on attitude towards the mentally ill. The hypothesis was also tested using multiple regression and the results are presented in Table 3. The results indicate that there is no statistically significant joint influence of religious affiliation and religiosity on attitude towards mental illness ($F\{2,249\} = 0.042$, $P>.05$). This finding suggests that both variables do not jointly influence the attitude of a participant towards the mentally ill.

Table 4.2.3: Summary of Multiple Regression table showing the joint role of religiosity and religious affiliation on attitude toward mentally ill

Variables	B	t	P	R	R^2	F	P
Christianity	-.18	.08	>.05				
Islam	-.01	.9	>.05	.204	.042	1.931	>.05
Traditional	.163	.04	<.05				
Deep Religiosity	-.057	.48	>.05				
Superficial Religiosity	.171	.12	>.05				

Discussion of findings

This study examined religiosity and attitude towards the mentally challenged among residents of Ile-Ife. Two hundred and fifty (250) questionnaires were administered to selected residents of Ile-Ife. The first hypothesis stated that: religious affiliation will have a significantly more positive attitude towards the mentally ill. This hypothesis was rejected. This implies that the participants' religious affiliation did not influence their attitude to the mentally ill. This study shows that despite the high percentage of Christianity as compared to other religious groups, the attitude of participants towards the mentally ill is not a result of their attachments to various religious groups.

The second hypothesis stated that: the deeply religious have a significantly more positive attitude towards the mentally ill. This hypothesis was rejected. This from the findings indicates that a participants' degree of religiousness does not influence his/her attitude towards the mentally ill. This finding is in sharp contrast to the findings of Donahue (1984) and Aydemir et al. (2009). These researchers identified a link between innate religiosity and ethical views. People who are intrinsically driven have more favourable ethical views than those who are motivated by external factors. Put differently, the higher a respondent's feeling of intrinsic religiosity, the more likely he or she was to consider certain dubious environmental or societal actions to be bad (Vitell & Nuncy, 2005). The following represents one of the most fundamental explanations for the favourable link between intrinsic religion and ethical attitudes: a person who is extrinsically driven by his religion will utilize it, but someone who is intrinsically motivated will probably not use it (Allport & Ross, 1967). The findings, however, are consistent with those of Saat et al. (2009), who discovered that the influence of religion on people's ethical attitudes is situational. In other words, the fact that an individual is high in religiosity does not imply that he or she possesses high ethical values.

The third hypothesis which stated that: there will be a significant joint influence of religious affiliation and religiosity on attitude towards the mentally was rejected. This suggests that both variables do not either individually or jointly influence the attitude of a participant towards the mentally ill This finding is in sharp contrast with those of Koenig and Al Shohaib (2019); Astrachan, et al., (2020); Koenig, et al., (2020); Malinakova, et al., (2020). These studies found that there is a strong positive association between mental health and religiosity. Although, the sub-domain of religious affiliation (Traditional) showed an influence on attitude towards mental illness further buttress the notion that the influence of religion on people's ethical attitudes is situational.

Conclusion

This study examined religious affiliation, religiosity and attitude towards the mentally challenged among residents of Ile-Ife. Religion has performed a telling role in determining the type of mental health care that can be termed "moral". The relationship between religion and mental health has been debated for centuries. This study, therefore, illustrated that:

- Religious affiliation did not have any role on attitude towards the mentally ill
- Religiosity did not have any significant role on attitude towards the mentally ill
- There is no significant joint influence of religious affiliation and religiosity on attitude towards the mentally ill.

Given the above, this study has been able to lend more insight to this area of research. The study's findings have significant ramifications for both mental health professionals and the general population. This will include Psychiatrists, Psychologists, Physicians, Public health workers, Sociologists, Epidemiologists, Social workers, religious groups, Scholars, Biologists and the public. The study reveals the impact of religiosity and attitude towards the mentally challenged among residents of Ile-Ife. Members of the mental health team, and other personal/individuals discipline/department can use this to make referrals to services that assist

caregivers and should look beyond religiosity and focus on the mentally challenged persons in the course of treatment of patient/clients, and this, when properly done, will enhance positive well-being and more reliable society. The different institutions should also contribute to eliminating the stigma associated with mental illness by altering people's views about sufferers of mental illnesses. Also, educate the public more on the possible causes, origin and possible solutions to mental illness especially here in Nigeria. For this singular reason, there is a need to galvanise more research interest to consolidate existing knowledge in this area.

References

Abasiubong, F., Ekott, J. U., & Bassey, E. A. (2007). A comparative study of attitude to mental illness between journalists and nurses in Uyo, Nigeria. African journal of medicine and medical sciences, 36(4), 345-351.

Abuhammad, S., Alzoubi, K., & Mukattash, T. L. (2020). Religiosity and perceptions about research misconduct among graduate nursing students. Nursing Open, 7(6), 1774-1778.

Adewuya A.O, & Makanjuola R.O., (2008). Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. Social psychiatry and psychiatric epidemiology 43:336-341.

Adewuya, A. O., & Makanjuola, R. O. (2008). Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. Social psychiatry and psychiatric epidemiology, 43(4), 336-341.

Armiyau, A. Y. (2015). A review of stigma and mental illness in Nigeria. Journal of Clinical Case Report, 5(1), 1-3.

Astrachan, J. H., Astrachan, C. B., Campopiano, G., & Baù, M. (2020). Values, spirituality and religion: Family business and the roots of sustainable ethical behavior. Journal of Business Ethics, 163(4), 637-645.

Aydemir, M., Göksu, A., & Obralic, M. (2009). The Impacts of Religiosity on the Ethical Attitudes of the Prospective Managers", 1. International Symposium on Sustainable Development - ISSD "09, June 9-10, 2009, Sarajevo, Bosnia and Herzegovina, Volume 1, pp.100-104.

Bathje, G., & Pryor, J. (2011). The relationships of public and self-stigma to seeking mental health services. Journal of Mental Health Counseling, 33(2), 161-176.

Braam A.W., Beekman, A.T.F., Deeg D.J.H., Smith J.H., & Van T. W., (2004). Religiosity as a protective or prognostic factor of depression in later life; results from the community survey in the Netherlands. Acta Psychiatrica Scandinavia, 96, 199–205.

Braam J. G., Todd M. J., Vegard S., & Gina A. Z., (2017). Yearbook of International Religious Demography 2017 (Leiden: Brill, 2017). 2 New Corrigan P.W. (2005). On the Stigma of Mental Illness: Practical Strategies for Research and Social Change. Washington, DC, American Psychological Association, 2005

Brown, C., Johnstone, M., & Ross, N. (2021). Repositioning social work practice in mental health in Nova Scotia.

Bushong, E. C. (2018). The Relationship Between Religiosity and Mental Illness Stigma in the Abrahamic Religions.

Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., & Kubiak, M. A. (2000). Stigmatizing attributions about mental illness. Journal of Community Psychology, 28(1), 91-102.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. World psychiatry: official journal of the World Psychiatric Association (WPA), 1(1), 16–20.

Corrigan P (2003). Beat the stigma: come out of the closet. Psychiatr Serv 2003; 54:13. doi: 10.1176/appi.ps.54.10.1313

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. Journal of health and Social Behavior, 162-179.

Corrigan, P. (2004). How stigma interferes with mental health care. American psychologist, 59(7), 614.

Corrigan P. W., Markowitz F. E., & Watson A. C., (2004). Structural levels of mental illness stigma and discrimination. Schizophr Bull 30 (3): 481–491.

Corrigan P.W., (2005). On the Stigma of Mental Illness: Practical Strategies for Research and Social Change. Washington, DC, American Psychological Association, 2005

Donahue, M. J. & Benson, P. L. (1995). Religion and the well-being of adolescents. Journal of Social Issues, 51, 145-160.

Idehen, E. E. (2001). The development and evaluation of a religiosity scale. IFE Psychologia: An International Journal, 9(2), 58-69.

Ketola, J., & Stein, J. V. (2013). Psychiatric clinical course strengthens the student–patient relationships of baccalaureate nursing students. Journal of Psychiatric and Mental Health Nursing, 20(1), 23-34.

Koenig H. G., & Larson D. B., (2001). Religion and mental health: evidence for an association. International Review of Psychiatry (2001), 13, 67–78

Koenig H. G., (2015). Religion, spirituality, and health: A review and update. Advances in Mind-Body Medicine 29: 19–26.

Koenig H. G., George L. K., & Titus P., (2004). Religion, spirituality, and health in medically ill hospitalized older patients. Journal of the American Geriatrics Society, 52, 554-562.

Koenig, H. G., & Al Shohaib, S. S. (2019). Religiosity and mental health in Islam. Islamophobia and psychiatry, 55-65.

Koenig, H., McCullough, M. & Larson, D. (1998) Handbook of Religion and Health. New York: Oxford.

Levin, J. S., & Chatters, L. M. (1998). Research on religion and mental health: An overview of empirical findings and theoretical issues. Handbook of religion and mental health, 33-50.

Link B.G., Phelan J., & Bresnahan M., et al (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. American Journal of Public Health 89:1328– 1333, 1999.

Lyons, Z., Laugharne, J., Laugharne, R., & Appiah-Poku, J. (2015). Stigma towards mental illness among medical students in Australia and Ghana. Academic Psychiatry, 39(3), 305-308.

Malinakova, K., Tavel, P., Meier, Z., van Dijk, J. P., & Reijneveld, S. A. (2020). Religiosity and mental health: A contribution to understanding the heterogeneity of research findings. International journal of environmental research and public health, 17(2), 494.

Mental Health Foundation (2016). Fundamental Facts About Mental Health 2016. Mental Health Foundation: London.

Miller J.J., Fletcher K., & Kabat-Zinn J., (1997). Three- year follow-up and clinical implications of mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. General Hospital Psychiatry, 17, 192–200.

Moleiro, C., & Rosmarin, D. H. (2016). Calling for awareness and knowledge: perspectives on religiosity, spirituality and mental health in a religious sample from Portugal (a mixed-methods study). Open Theology, 2(1).

Mueller P., Plevak D., & Rummans T., (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. Mayo Clinic Proceedings, 76(12), 1225-1235. http://dx.doi.org/10.4065/76.12.1225

Ng, P., & Chan, K. F. (2000). Sex differences in opinion towards mental illness of secondary school students in Hong Kong. International Journal of Social Psychiatry, 46(2), 79-88.

Okpalauwaekwe, U., Mela, M., & Oji, C. (2017). Knowledge of and attitude to mental illnesses in Nigeria: a scoping review. Integrative Journal of Global Health, 1(5), 1-14.

Pescosolido B.A., Martin J.K., & Long J., et al (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. American Journal of Psychiatry 167:1321–1330, 2010

Rayan, A., & Fawaz, M. (2018). Cultural misconceptions and public stigma against mental illness among Lebanese university students. Perspectives in psychiatric care, 54(2), 258-265.

Rettie, H., & Daniels, J. (2021). Coping and tolerance of uncertainty: Predictors and mediators of mental health during the COVID-19 pandemic. American Psychologist, 76(3), 427.

Saat M. M., Porter S., & Weedbine G., (2009). "Does Religiosity Influence Ethical Sensitivity? An Investigation on Malaysian Future Accountants," Malaysian Accounting Review, Vol. 8, No. 2, 17-41.

Sickel, A. E., Seacat, J. D., & Nabors, N. A. (2014). Mental health stigma update: A review of consequences. Advances in Mental Health, 12(3), 202-215.

Udoka O., Mansfield M., & Chioma O., (2017). Knowledge of and Attitude to Mental Illness in Nigeria: A Scoping Review. Integr J Glob Health. 2017, 1:1.

Zhang Z., Sun K., Jatchavala C., Koh J., Chia Y., Bose J., Li Z., Tan W., Wang S., Chu W., Wang J., Tran B., & Ho R., (2019). Overview of Stigma against Psychiatric Illnesses and Advancements of Anti-Stigma Activities in Six Asian Societies. International journal of environmental research and public health, 17(1), 280. https://doi.org/10.3390/ijerph17010280