

RESEARCH ARTICLE

Cultural norms and religious coping: Barriers to mental health help-seeking among Egyptians in domestic and western contexts

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Abstract

Background: Mental health stigma and religious coping heavily influence professional help-seeking, but their collective cross-cultural impact on Egyptians remains underexplored.

Objective: The aim of this mixed-methods study was to explore mental health help-seeking attitudes among Egyptians in cross-cultural settings, with a focus on the roles of cultural norms and religious coping.

Methods: This mixed-methods study surveyed 115 Muslim Egyptians in domestic and Western contexts. Quantitative data were analyzed using analysis of covariance (ANCOVA) and general linear model (GLM) mediation, alongside rigorous thematic analysis of qualitative responses.

Results: Quantitative analysis ($n = 115$), employing ANCOVA and a GLM for mediation, revealed that cultural masculinity norms significantly contributed to less positive attitudes toward seeking professional psychological help among Egyptian men, regardless of age or residence (Egypt versus Western countries). Positive religious coping significantly mediated the relationship between Western residence and help-seeking attitudes (indirect effect: $\beta = 0.076$, $z = 2.22$, $p = 0.027$, 95% confidence interval [0.312–2.052]). Specifically, Western residence predicted lower reliance on positive religious coping ($\beta = -0.276$, $z = -3.08$, $p = 0.002$), which in turn was associated with more favorable help-seeking attitudes ($\beta = -0.277$, $z = -3.20$, $p = 0.001$).

Conclusion: Qualitative thematic and comparative analyses expanded on these findings, identifying key barriers such as cultural stigma, associating mental health problems with “madness,” rejection of help-seeking by older generations, and the influence of “toxic masculinity” in suppressing men’s willingness to seek professional support. Religion emerged as a complex barrier, with participants often prioritizing religious practices over therapy despite acknowledging no religious prohibition against seeking professional help. Additional barriers included mistrust of providers, financial challenges, and misconceptions about mental health services. Practical implications emphasize the importance of targeted educational programs in schools and universities to reduce stigma, challenge cultural stereotypes, and encourage open discussions about mental health, particularly among younger populations. These efforts could foster societal change and improve acceptance of mental health support.

Keywords: Mental health help-seeking; Masculinity norms; Religious coping; Cultural stigma; Mental health attitudes

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1. Introduction

Mental health care is stigmatized in many cultures and religions, which constrains individuals' willingness to seek professional psychological help.¹⁻³ This is particularly evident in faith-based societies whose cultural and religious norms regulate various aspects of behavior. Existing research has shown the role of religious coping—defined as the use of spiritual practices to manage life's challenges^{4,5}—in shaping mental health help-seeking decisions.

Although religious coping has been widely studied, its role in cross-cultural comparisons within the Middle Eastern population remains underexplored. This study investigates how religious coping and cultural context collectively influence attitudes to seeking mental health services in Egyptians residing in both Egypt and Western contexts. We define help-seeking behavior in the context of mental health as the act of seeking professional assistance for mental health issues by accessing professional mental health services.

Focusing on Egyptian Muslims in a cross-cultural setting, this study offers insights into the population with persistent stigma surrounding mental health. Additionally, a mixed-methods research design incorporated in the study allows for a more nuanced investigation of mental help-seeking behaviors and attitudes in understudied populations, while also allowing for broader generalization of the findings.

1.1. Theoretical framework

This study is grounded in the theory of planned behavior (TPB), widely used for predicting social behavior and developing health help-seeking interventions.^{6,7} According to TPB in the context of mental health help-seeking, three core factors—attitudes, subjective norms, and perceived behavioral control—impact individuals' intentions and thus actions. TPB defines attitudes as the personal evaluation of help-seeking (e.g., its perception as beneficial or stigmatized). Subjective norms reflect the social expectations or pressure to seek professional help (influenced by societal, family, cultural, or religious beliefs). Finally, perceived behavioral control refers to people's beliefs in their ability to access professional help.⁸ This framework is relevant to our study's aim to explore attitudes of Egyptians residing in Egypt and in Western countries towards mental health help-seeking, as it integrates the influence of gender norms, cultural stigma, and religious coping strategies.

1.2. Background

1.2.1. Cultural influences on mental health help-seeking attitudes

Culture plays a significant role in influencing people's

willingness to seek professional psychological help. Some cultural beliefs act as barriers to seeking professional help if struggling with a psychological issue. These beliefs stem from the fear of being misunderstood and labeled. For instance, in the Asian context, mental disorders are often seen as a sign of failure of self-control or weakness, and thus perceived as shameful for individuals.^{1,9,10} In various parts of Africa, mental disorders are commonly attributed to spiritual causes.¹¹

Culture plays a significant role in shaping people's willingness to seek professional psychological help. In Egypt, mental health problems are commonly labeled as "madness."¹² Within this cultural context, "madness" is rarely viewed as a manageable medical condition; rather, it is heavily stigmatized as a complete loss of reason, a supernatural affliction, or an unacceptable deviation from normal societal functioning, which deeply embeds feelings of shame and forces individuals to prioritize family reputation over seeking care.^{12,13} Similarly, adolescents and young adults in Palestine and New Zealand perceive seeking mental health support as a sign of weakness. In Palestine, this "weakness" is contextualized against a backdrop of prolonged conflict and traditional gender roles, where seeking help is perceived as a character flaw, a lack of faith, or a failure to demonstrate the resilience expected for survival.^{14,15} In New Zealand, acknowledging mental health struggles directly contradicts cultural expectations of self-reliance and stoicism, framing the need for external psychological support as a fundamental personal vulnerability or an inability to independently manage life's challenges.¹⁶ In the West, stigma often arises from misconceptions about mental disorders, such as the belief that individuals with mental illnesses are dangerous or unpredictable.¹

1.2.2. Religious coping and mental health help-seeking

Religion often shapes mental health attitudes and help-seeking behaviors across various religious contexts. For instance, Muslims may attribute mental disorders to supernatural causes, such as the evil eye or magic, while others view them as a test of faith or punishment from Allah.^{13,17} This often results in reliance on spiritual practices rather than professional psychological support.

Some studies found that higher levels of religiosity in Muslim communities were associated with lower use of mental health services, as individuals relied on prayer instead of seeking professional help.^{18,19} It was also reported that high levels of positive religious coping (PRC) were paradoxically related to low readiness to take up professional help.⁵ In faith-based communities, praying and spiritual healing are often preferred to address

emotional problems, which can delay help from other clinical support services.²⁰

1.2.3. Gender and mental health help-seeking

Studies reported gender differences in openness to mental health help-seeking among populations in the Middle East. It was shown that Egyptian, Kuwaiti, and Palestinian men were less likely to seek professional psychological help compared to women, largely due to traditional gender roles and perceptions of masculinity.^{21,22} These norms often discourage men from expressing vulnerability or seeking external support, as doing so may be perceived as a sign of weakness. Similar findings were reported in the population in the United Kingdom, Canada, Australia, and the United States of America,²³ which suggests that lingering stigma surrounding mental health disproportionately affects men.

Despite growing evidence that gender, age, religiosity, cultural stigma, and social norms individually impact mental health help-seeking, their interactive effects within cross-cultural Egyptian communities are not well understood. Building on these insights, our study aims to explore how the compound influences of gender, age, cultural context (residing in Egypt versus Western countries), and religious coping (positive and negative) shape attitudes toward professional psychological help among Egyptians. The novel aspect of this study lies in its mixed-methods comparative design, which contrasts Egyptians residing domestically with those in Western contexts. By isolating the influences of geographic residence, gender norms, and religious coping, this approach bridges the existing gap in the literature. This novel framework clarifies how demographic and socio-cultural shifts shape persistent barriers to professional mental health care across borders.

2. Methodology

2.1. Sample description

The sample consisted of self-identified Muslim Egyptians aged 24–45 years ($n = 115$). The study sample inclusion criteria were English-language proficiency at an intermediate level (initially self-reported by participants), self-identification as Egyptian and Muslim, and being at least 24 years of age. This specific age constraint was deliberately selected to capture individuals who are typically financially and legally independent, meaning their mental health help-seeking behaviors are driven by personal attitudes rather than parental gatekeeping. Furthermore, this cohort allows capturing a generation that is navigating the tension between deeply rooted traditional cultural norms and increasing exposure to modern, globalized mental health awareness.

The initial sample consisted of 121 participants. To ensure the language proficiency criterion was met, participants' open-ended qualitative survey responses served as an additional language assessment. These responses were independently evaluated by two English language instructors at the university. Four participants whose written responses indicated a proficiency level below intermediate were excluded from the data analysis, which resulted in a sample of $n = 117$. Additionally, two participants self-identified their gender as "fluid" and "do not want to say"; they were excluded from the analysis due to an insufficient number for statistical comparison. This rigorous screening process resulted in a final sample of 115 self-identified Muslim Egyptians aged 24–45 years (Table 1).

Participants were divided into two groups based on residence: Egyptian-born individuals who had lived in Egypt their entire lives ($n = 66$; 57.4%), and Egyptian-born individuals who had resided in a Western country for more than six years ($n = 49$; 42.6%).

2.2. Study design and data collection procedure

This study employed a mixed-methods design comprising quantitative and qualitative components. Both components were conducted on the same sample of participants. To accommodate the mixed-methods design, the study utilized a purposive criterion sampling strategy to ensure participants possessed the specific cultural and religious experiences required to answer the research questions. After establishing these strict inclusion criteria, initial recruitment was facilitated through convenience sampling by sharing a survey link in targeted online communities of Egyptian expatriates and through direct outreach. Subsequently, snowball sampling was employed, in which eligible participants were encouraged to disseminate the survey to their networks.

Potential participants were invited via a standardized digital message that briefly described the study's aim, the voluntary nature of participation, the anonymity of the data collection process, and the approximate time needed to complete the survey. The recruitment message stated:

You are invited to participate in a research study exploring cultural influences on your mental health attitudes. This survey is anonymous, takes approximately 20 minutes, and is for academic research purposes only. By participating, you will help ensure that the unique cultural and religious perspectives of your community are accurately represented in psychological research. Your insights can help researchers and practitioners better serve diverse populations. No financial

or other material incentives were offered for participation to minimize self-selection bias.

Table 1. Study sample ($n = 115$)

Demographic	<i>n</i>	%
Women	69	60.0
Men	46	40.0
24–34 years	79	68.7
35–45 years	36	31.3
Egyptians living in Egypt	66	57.4
Egyptians residing in the Western states (Canada, United States of America, Germany, Spain, France, and United Kingdom)	49	42.6

In the survey, the demographic screening section and all quantitative scale items (brief religious coping scale [RCOPE] and attitudes toward seeking professional psychological help [ATSPPH]) were set as mandatory fields. However, the six open-ended qualitative questions were optional, allowing participants to share as much or as little detail as they felt comfortable with. To prevent duplicate entries and ensure unique responses, each user was limited to one response on Google Forms.

2.3. Ethical considerations

The study was approved by the FOAH Ethics Committee of the British University in Egypt (Approval #24-0201). Informed consent was obtained from all participants included in the study. Consent was obtained through an anonymous online survey. Participants were informed about the nature of the study, the anonymous data collection process, data protection measures, and the voluntary nature of participation. The principal investigator's contact email was included so participants could seek assistance if needed.

2.4. Quantitative study instruments

Because an intermediate level of English proficiency was a verified inclusion criterion for all participants, all quantitative scales were administered in English. This ensured standardization across both the domestic and Western-residing cohorts.

2.4.1. The brief religious coping scale

The brief RCOPE was used to assess religious coping behaviors. Its items were developed based on empirical research and Pargament's theory of religious coping.²⁴ The

brief RCOPE's items evaluate both positive (adaptive) and negative (maladaptive) religious coping strategies. The questionnaire has 14 items in total and two subscales (seven items for PRC and seven items for negative religious coping [NRC]) and is scored on a 4-point Likert scale from 0 "not at all" to 3 "a great deal."²⁵ In our sample, the RCOPE's reliability, measured with Cronbach's alpha (α), was $\alpha = 0.870$ for the NRC and $\alpha = 0.819$ for the PRC.

2.4.2. Attitudes toward seeking professional psychological help

The scale used to assess help-seeking behaviors was the shortened version of the ATSPPH.²⁶ The questionnaire consists of 10 items and is scored on a 4-point Likert scale from 0 "disagree" to 4 "strongly agree." Items 2, 4, 8, 9, and 10 are reversely scored. Scores are added, and higher total scores demonstrate more positive attitudes toward seeking professional help.²⁶ Its construct validity was reported to be 0.87.²⁷ In our sample, the internal consistency of the scale was assessed using Cronbach's alpha. The analysis yielded a Cronbach's alpha of 0.653, indicating moderate reliability.

Quantitative data were analyzed using both analysis of covariance (ANCOVA) and generalized linear model (GLM) mediation analysis, using the statistical software Jamovi (version 2.6.19).

2.5. Qualitative study

This study employed a qualitative descriptive design using open-ended survey questions to explore participants' perspectives on mental health help-seeking behaviors. The qualitative data were analyzed using thematic analysis.^{28,29} This process involved a six-phase recursive process: (i) familiarization with the data, (ii) generating initial codes, (iii) searching for themes, (iv) reviewing potential themes, (v) defining and naming themes, and (vi) producing the final report. This approach enabled the identification of latent meanings underlying cultural norms and religious coping strategies. The qualitative data were collected simultaneously with the quantitative study data via the same open-ended Google Form. The participants ($n = 115$) were invited to answer six questions to share their perspectives on mental health help-seeking. The qualitative approach aimed to conduct a more nuanced exploration of participants' lived experiences and perspectives regarding: (a) how religious beliefs impact willingness to seek mental health support, (b) cultural acceptability of men seeking mental health help compared to women, (c) which age groups are culturally more accepted when seeking mental health support, (d) how cultural attitudes shape perceptions of therapy, (e) experiences that have affected views on mental health help-seeking, and (f) major barriers preventing individuals from seeking professional mental

health help. The five questions (1, 2, 4, 5, and 6) were open-ended. In question 3, we asked participants to select one or more age groups from 18–25, 26–35, 36–45, 46–55, and 56+. The qualitative data were then analyzed in two stages: thematic analysis and comparative analysis.

2.5.1. Thematic analysis and coding procedure

Thematic analysis was conducted using the open-source qualitative data analysis software (Taguette³⁰) by two independent coders. Each coder independently tagged and coded the participants' responses and generated two codebooks. Initially, the first codebook had six codes, and the second had eight, reflecting some variations in thematic interpretations.

To ensure consistency, the coding process followed an iterative approach. At first, the two coders independently reviewed and manually refined the codes by identifying recurring themes, merging overlapping codes, and branching broad codes to ensure accuracy and clarity. Then, the initial codes were compared and aligned into one codebook.

Second, the two coders conducted standardization of the codebook through developing code definitions and inclusion/exclusion criteria. As a result, 13 codes were included in the codebook (Table 2).

Using the standardized codebook, both coders independently re-tagged the participant responses within Taguette to ensure coding reliability. To confirm thematic analysis consistency, inter-rater reliability was measured using Cohen's kappa ($n = 115$). The number of responses coded by both raters varied by question because not all participants answered every question. Cohen's kappa was calculated based on the number of responses coded by the coders for each question out of 5 (Table 3).

Questions 1, 2, 4, and 6 showed substantial agreement (κ in the range of 0.77–0.80), while question 5 showed moderate agreement ($\kappa = 0.51$). Further, the responses for question 5 were excluded from the thematic analysis to minimize subjectivity in data interpretation.

2.5.2. Comparative qualitative analysis

To address the study's aim of understanding the compound influences of demographics on mental health attitudes, the next step was a comparative analysis of the qualitative results. The scientific merit of this comparative approach lies in its ability to investigate, through an intersectional lens, how specific demographic variables that collectively influence the core components of the TPB interact to create unique profiles of barriers. This approach also serves as a natural experiment in cultural exposure.^{31,32} By comparing

distinct Muslim minority contexts, the study can isolate whether geographical location (environmental facilitator/barrier) or shared religious identity (subjective norm) is the more dominant predictor of help-seeking attitudes.

The coded unique responses of the participants were categorized by three intersecting demographic criteria: gender, age, and residence (Egypt or a Western country). As a result, eight distinct subgroups were analyzed: (i) women 24–34 years old residing in Egypt ($n = 35$; 30.4%), (ii) women 24–34 years old residing in the West ($n = 17$; 14.8%), (iii) women 35–45 years old residing in Egypt ($n = 7$; 6.1%), (iv) women 35–45 years old residing in the West ($n = 10$; 8.7%), (v) men 24–34 years old residing in Egypt ($n = 16$; 13.9%), (vi) men 24–34 years old, residing in the West ($n = 11$; 9.6%), (vii) men 35–45 years old residing in Egypt ($n = 8$; 7.0%), and (viii) men 35–45 years old residing in the West ($n = 11$; 9.6%).

A manual comparative analysis was conducted using Google Sheets. We applied a structured approach to the comparative data organization and processing. The demographic groups were organized into columns, while the relevant codes from the codebook were organized into rows. The unique responses were entered into thematically relevant cells. Next, we conducted pattern identification by eliciting trends for each demographic group.

Finally, we performed cross-group comparisons to identify commonalities and differences in attitudes toward mental health help across all groups of our study participants. The manual, structured approach was justified because our sample was moderate in size and because this method allowed direct control over tagging accuracy and process flexibility.

3. Quantitative study results

3.1. Analysis of covariance

A three-way ANCOVA was conducted to examine the main and interaction effects of the categorical independent variables (age, gender, and residence) on the single continuous dependent variable (ATSPPH), while controlling for PRC and NRC as continuous covariates (Table 4).

The overall model was significant ($F[9, 105] = 4.02$, $p < 0.001$). The results showed that the main effect of age on ATSPPH was non-significant. However, a significant main effect of gender on the former was found ($F[1, 105] = 11.82$, $p < 0.001$, $\eta^2 p = 0.101$), indicating a medium-to-large effect size, with men having less positive ATSPPH than women. In practical terms, this effect size implies that gender accounts for approximately 10.1% of the variance in help-seeking attitudes. Furthermore, the effect of residence

Table 2. Codebook

Code	Definition	Inclusion criteria	Exclusion criteria
A. Cultural and social norms for mental health help-seeking			
1. Culture discourages mental health help-seeking	Cultural beliefs or norms that are barriers to seeking mental health support.	Mentions of family or community disapproval, as well as cultural expectations that hinder seeking mental therapy. Example: "Seeking therapy is shameful in my culture."	Statements focusing solely on financial barriers (coded under financial barriers to seeking mental health help). Example: "therapy is expensive, so I cannot afford it."
2. Mental health stigma and fear of judgment	Concern about social stigma and fear of negative perceptions for seeking therapy.	Mentions of fear of being labeled unstable, or judged by others. Example: "people in my community will judge me if I tell them I'm seeing a therapist."	Statements about cultural discouragement (coded under culture discourages mental health seeking) or weakness (coded under seeking mental health is a sign of weakness). Example: "therapy is not something people do in my culture."
3. Seeking mental health is a sign of weakness	Belief that seeking mental health help shows personal weakness, inability or failure.	Mentions of cultural beliefs that those individuals who see a therapist are weak, losers, or incapable. Example: "asking for help means I am not strong enough."	Mentions of community disapproval or stigma of mental health (coded under culture discourages mental health help-seeking and mental health stigma and fear of judgement). Example: "I would not talk about me going to a therapist, people would judge me."; "in our community talking about mental health is stigmatized."
B. Religious influence on mental health help-seeking			
4. Religion has no influence on mental health seeking	Religion is not perceived as affecting the individual's decision to seek mental health help.	Statements separating mental health help-seeking from faith. Example: "religion has nothing to do with my decision to see a therapist."	Statements that explicitly sanction or seek mental health help based on religious beliefs, as well as statements that imply that faith does not prohibit seeking mental health help or that praying is enough (coded under Religion encourages seeking mental help; Religion doesn't forbid seeking mental health help, and my religion is enough). Example: "Islam encourages seeking mental health help"; "Islam does not prohibit seeking mental health help"; "my religion teaches that prayer is enough."
5. My religion is enough	Belief that faith alone is enough in handling mental health challenges without professional therapy.	Mentions of reliance on prayer or God instead of therapy. Example: "I do not need therapy; I just need to strengthen my faith in Allah."	Statements that explicitly sanction seeking mental health help based on religious beliefs, as well as statements that imply that faith does not prohibit seeking mental health help or that my religion has nothing to do with seeking mental health help (coded under religion encourages seeking mental health help; religion does not forbid seeking mental health help, and religion has no influence on mental health seeking). Example: "Islam encourages seeking mental health help"; "Islam does not prohibit seeking mental health help"; "my religion and seeking mental health help are not related."

(cont'd...)

Table 2. (Continued)

Code	Definition	Inclusion criteria	Exclusion criteria
6. Religion does not forbid seeking mental help	Religious beliefs do not prohibit therapy or seeking mental health help.	Statements implying that my religious beliefs do not prohibit seeking mental health help. Example: "my religion does not prevent me from seeking help."	Statements that explicitly sanction seeking mental health help based on religious beliefs, as well as statements that my religion has nothing to do with seeking mental health help and that praying is enough (coded under religion encourages seeking mental help; religion has no influence on mental health seeking, and my religion is enough). Example: "Islam encourages seeking mental health help."; "my religion and seeking mental health help are not related."; "my religion teaches that prayer is enough."
7. Religion encourages seeking mental help	Religion actively supports seeking mental health help as a valid treatment method.	Statements implying that religion encourages seeking mental health help. Example: "faith and therapy work together for my mental care."	Statements that imply that faith does not prohibit seeking mental health help or that my religion has nothing to do with seeking mental health help, or that praying is enough (coded under religion does not forbid seeking mental help; religion has no influence on mental health seeking, and my religion is enough). Example: "Islam does not prohibit seeking mental health help."; "my religion and seeking mental health help are not related."; "my religion teaches that prayer is enough."
C. Attitudes toward mental health help			
8. Therapy is useless	Scepticism towards the effectiveness of mental health help.	Statements implying that seeking mental health help is useless, and/or a waste of time and resources. Example: "therapy does not work, it is a waste of time."	Mentions of personal negative experiences of participants or their acquaintances rather than general scepticism (coded under negative mental help experiences). Example: "I went to a psychologist, but my therapist was unpleasant."
9. Negative mental help experiences	Personal experiences of participants or their acquaintances where therapy was unhelpful, unpleasant, or harmful.	Mentions of ineffective or failed therapy experiences. Example: "my psychologist did not listen to me."; "My psychologist did not understand cultural specificity, so I felt misunderstood."	Statements of rejecting mental health help in general, without specific personal experiences (coded under therapy is useless). Example: "therapy is not necessary."
10. Positive mental help experiences	Personal experiences of participants or their acquaintances where mental health help was useful.	Statements implying successful outcomes of mental health help. Example: "therapy helped me fight my anxiety."	Statements implying that mental health help is generally effective. Example: "I have heard that therapy helps some people."
D. Systemic barriers to mental health help-seeking			
11. Lack of awareness about mental health and available resources	Limited understanding of mental health issues and/or uncertainty about accessing mental health resources.	Statements implying that a participant is confused about mental health help or its accessibility. Example: "I do not know how therapy works or where to find mental health help."	Statements rejecting therapy due to cost or mistrust of mental health providers (coded under financial barriers to seeking mental health help and lack of trust in mental health providers). Example: "therapy is very expensive, even if I wanted it."; "therapists are not professional, and I do not trust them."

(cont'd...)

Table 2. (Continued)

Code	Definition	Inclusion criteria	Exclusion criteria
12. Financial barriers to seeking mental health support	Financial considerations preventing participants from accessing mental health help.	Statements implying that therapy or mental health help in general are too costly. Example: "I cannot afford therapy, it is too expensive."	Statements implying lack of awareness about mental health help and/or its accessibility, as well as statements criticizing mental health help providers (coded under lack of awareness about mental health and available resources and lack of trust in mental health providers). Example: "I do not know how therapy works or where to find mental health help."; "therapists are not professional and I do not trust them."
13. Lack of trust in mental health providers	Scepticism or distrust toward mental health help providers due to perceived incompetence or ill intentions.	Mentions of mistrust in mental health professionals. Example: "I do not trust psychologists, they just take your money."	Statements rejecting therapy in general or due to negative personal experiences of participants or their acquaintances (coded under therapy is useless and negative mental help experiences). Example: "therapy does not work."; "my psychologist did not listen to me."

Table 3. Cohen's kappa inter-rater reliability scores for the qualitative thematic analysis of mental health help-seeking perspectives

Question	Number of responses coded by both coders (n)	Observed proportion of agreement (P _o)	Expected proportion of agreement (P _e)	Cohen's kappa (κ)
1. How do your religious beliefs impact your willingness to seek mental health help?	90	0.856	0.312	0.79
2. In your culture, how acceptable is it for men to seek mental health help compared to women?	75	0.840	0.287	0.78
4. In what ways do cultural attitudes in your community influence your views on mental health support?	102	0.824	0.241	0.77
5. Is there a specific situation that led you to change your perspective on seeking mental health help, whether that change was positive or negative?	95	0.611	0.222	0.51
6. What are the main reasons that might stop you from seeking mental health help?	80	0.875	0.380	0.80

was significant ($F[1, 105] = 4.07, p = 0.046, \eta^2 p = 0.037$), but the effect size was small, indicating that residence accounted for approximately 3.7% of the variance in help-seeking attitudes. Thus, participants residing in Western countries showed slightly more positive ATSPPH than those residing in Egypt. NRC effects on ATSPPH were not significant, whereas PRC had a significant positive effect on the latter ($F[1, 105] = 7.21, p = 0.008, \eta^2 p =$

0.064), indicating a medium effect size. This means that a participant's level of PRC accounts for approximately 6.4% of the total variance in their ATSPPH. Interaction effects of (a) age and gender, (b) age and residence, (c) gender and residence, and (d) age, gender, and residence were not significant. The homogeneity of variances was met ($F[7, 107] = 1.03, p = 0.417$), and residuals were approximately normally distributed ($W = 0.979, p = 0.070$).

Table 4. Three-way analysis of covariance for the effects of age, gender, and residence on attitudes toward seeking professional psychological help, controlling for religious coping

	<i>F</i>	<i>p</i>	η^2p
Overall model	4.0177	<0.001	
Age	0.0688	0.794	0.001
Gender	11.8208	<0.001	0.101
Residence	4.0693	0.046	0.037
PRC	7.2109	0.008	0.064
NRC	2.3826	0.126	0.022
Age $\times$ gender	0.5640	0.454	0.005
Age $\times$ residence	3.6359	0.059	0.033
Gender $\times$ residence	0.4193	0.519	0.004
Age $\times$ gender $\times$ residence	0.4955	0.483	0.005

Abbreviations: NRC: Negative religious coping; PRC: Positive religious coping.

3.2. Mediation analysis

Following the ANCOVA results, a GLM mediation analysis was conducted in Jamovi (version 2.6.19) to examine the indirect effects of gender and residence on attitudes toward ATSPPH via PRC. The GLM framework was selected over full structural equation modeling or traditional stepwise regression approaches because it accommodates multiple categorical independent variables simultaneously. Furthermore, bias-corrected bootstrapping (5,000 in our analysis) within GLM provides robust estimations of indirect effects and confidence intervals (CIs) without relying on strict assumptions of normality, which is optimal for the current sample size.

It was found that the indirect effect of residence (Egypt versus Western countries) on ATSPPH through PRC was significant ($\beta = 0.076$, $z = 2.22$, $p = 0.027$), as estimated using bias-corrected bootstrapping (5,000 bootstrap samples) and a 95% CI of 0.312–2.052. This suggests that Egyptians residing in Western countries had more positive attitudes toward professional psychological help-seeking behaviors through reduced reliance on PRC. The indirect effect of gender on ATSPPH through PRC was not significant ($\beta = 0.018$, $z = 0.71$, $p = 0.476$), as estimated using bias-corrected bootstrapping (5,000 bootstrap samples) and a 95% CI of –0.356–1.086.

The pathway from the residence to PRC was significant ($\beta = -0.276$, $z = -3.08$, $p = 0.002$), indicating that participants residing in Egypt reported higher levels of PRC than those in Western countries. Finally, PRC had a significant negative effect on ATSPPH ($\beta = -0.277$, $z = -3.20$, $p = 0.001$), suggesting that stronger reliance on PRC was associated with less positive attitudes toward professional psychological help. The pathway from gender to PRC was not significant ($\beta = -0.066$, $z = -0.73$, $p = 0.465$).

The direct effect of residence on ATSPPH was not significant, while its total effect was significant ($\beta = 0.231$, $z = 2.65$, $p = 0.008$). This indicates that residence mediated the effect on attitudes towards professional psychological help.

Thus, the overall GLM mediation analysis confirmed the mediating role of PRC only for the relationship between the residence and ATSPPH (Figure 1).

4. Qualitative study results

4.1. Thematic analysis

The thematic analysis of mental health help attitudes resulted in four themes, including: (i) cultural and social norms for mental health help-seeking, (ii) religious influence on mental health help-seeking, (iii) attitudes toward mental health help, and (iv) systemic barriers to mental health access.

- (i) Cultural and social norms for mental health help-seeking. One of the overarching themes elicited in our study sample was related to the idea that it is more culturally acceptable for women to seek mental health help than for men. 65.8% of participants responded that mental health support is more acceptable for women (with 30.6% saying it is “much more acceptable” and 35.2% saying it is “somewhat more acceptable”). In contrast, only 5.9% of participants believed that it was culturally acceptable for men to seek mental health support. 28.3% of participants mentioned that seeking mental health support was equally acceptable in their culture. Some participants explained that in their community, it was believed that having mental health problems and seeking help were signs of weakness. For instance, it was mentioned that “men who seek mental health help are weak compared to men who do not”; “as a person who was raised in Egypt, my culture views mental health (problem) as weakness”; “people find it difficult to open up to other or even professional because we were always taught to be strong and avoid felling weaknesses so in a way they see it as a weakness.” Another participant clarified that

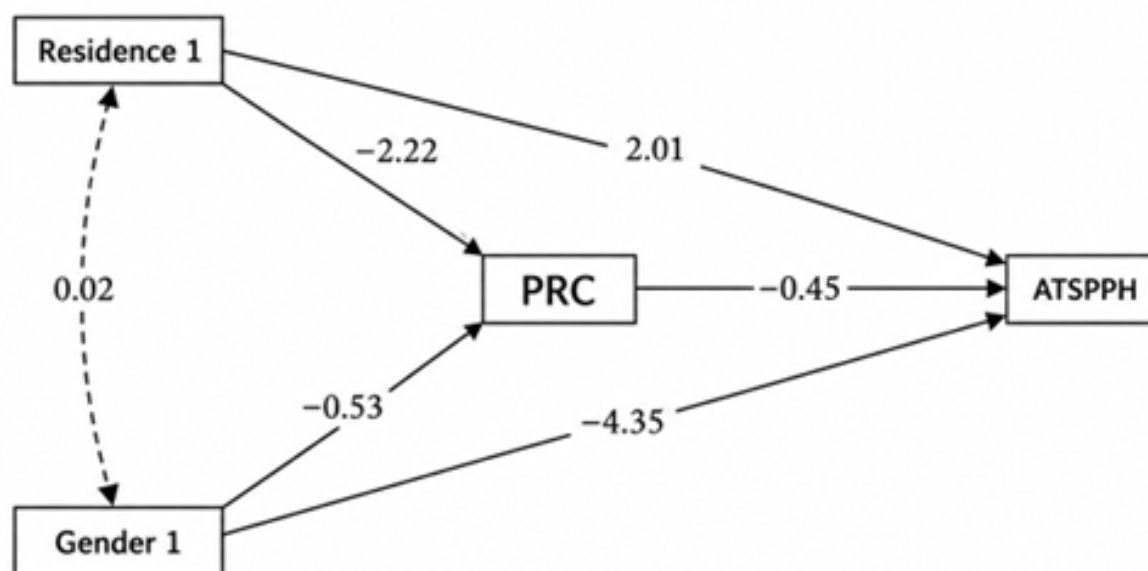


Figure 1. Mediation model. Notes: The model displays unstandardized path coefficients. “Residence 1” denotes the coding of participants’ location (1 = Egypt; 2 = Western countries). “Gender 1” indicates the coding for gender (1 = women, 2 = men). Abbreviations: ATSPPH: Attitudes toward seeking professional psychological help; PRC: Positive religious coping.

“our community does not look well at people who go and seek help from professionals in mental health, and it is usually shamed upon and deemed as weak if you go to one, especially if you are a man.” In addition to the stigma of weakness, mental health problems are often equated to “madness,” which makes it “shameful to ask for help.” For instance, some participants mentioned, “we were raised with strong belief that if you need psychological help, you are a psycho”; “we are not a culture that accepts mental health problems, so whoever goes to a psychologist people would think they are crazy.”

Other reflections that emerged under the theme were related to the fear of being judged if one knows about mental health problems, especially by the older generation in the community. For instance, one participant mentioned: “I had panic and anxiety attacks over the course of three days to the point where my mother did not know what to do, and I was scared; it made my family also think less of me.” Another participant explained that “one would be looked down on if seeking mental help,” highlighting the sentiment of inferiority.

Many participants (16.7%) pointed out that it was the fear of judgment that prevented them from seeking mental health support. Some responses were: “seeking mental help is viewed in a very negative way that makes it so hard to the point it might be impossible for anyone to seek mental

health support”; “my culture views it as quite a taboo subject”; “seeking professional help is frowned upon.”

Age-related norms in mental health help-seeking reinforced the perception that mental health problems and asking for professional support indicated weakness. Most participants, despite having the option to select multiple age groups, chose younger individuals. This pattern revealed a cultural bias in which seeking psychological support would be more acceptable for women and younger individuals. 56.5% of participants identified the 18–24 age group as the most acceptable to seek therapy, 29.6% mentioned that the age group of 25–34 years old was culturally acceptable to seek mental health support, with a further decrease in help-seeking acceptance among older age groups (9.3% mentioned the age group of 35–44 years old, 3.7% in the age group of 45–54, and 0.9% in individuals aged 55 and above).

(ii) Religious influence on mental health help-seeking. Although most participants mentioned their community’s culture as the strongest barrier to seeking mental health help, the opposite was evident in the case of their religion. No participants clearly stated that their religion prohibited mental health help-seeking. However, clear trends were observed. 26% of participants reported that their religious beliefs were enough for their mental health and well-being. Common responses included: “I would rather pray”;

"I leave it to god"; "mental health is a second choice after god"; "my relationship with god is enough" or "god will make it better." Some also felt that their mental health issues stemmed from a weak faith: "pray so you can feel better"; "I think before having the awareness of mental health I felt like if I was close to god my issue would be solved"; "I should rely on god to solve my problems"; "returning to god is always a first choice it is free psychology"; "the more I approach and practice my religion the more it heals"; "becoming more religious will solve all your mental problems"; "mental health problems may be due to a lack of faith"; "I am a weak religious person unfortunately, so my mental health most of the time is at its worst level of overthinking and more."

Among participants, 34% mentioned that their religious beliefs increased their willingness to seek mental health help, with some stating that faith and mental health go hand-in-hand. They believed that god wanted them to take care of their health, making mental health care a priority rather than a last resort. For instance, some participants explained that "my religion encourages mental help because it promotes seeking any knowledge"; "my religion gives me courage to seek mental help"; "in my opinion religion and psychology can be a good combination in solving mental issues"; "I believe taking care of ourselves is part of our religion"; "it is a religious duty to seek knowledge and thus mental help."

A slight majority of participants (52%) reported that religion did not affect their willingness to seek mental health help or did not discourage them from seeking mental health support. One participant specifically mentioned that their willingness was affected more by social anxiety than by religion. Other responses were the following: "I do not think that my religion will have anything to do with seeking mental health help"; "my religious beliefs do not interfere with my decision to seek mental health help"; "religion has no impact on mental help-seeking; religious beliefs and mental help are different things"; "my beliefs do not clash with the idea of seeking help"; "it does not say anything negative about it."

(iii) Attitudes towards mental health help. Participants expressed a variety of attitudes toward professional mental health help. Thus, 24.24% reflected positive view of therapy: "seeking professionals helps people to learn tools and skills on how to cope with life and people"; "I come from a background of medical professionals and educated people who view mental support as a normal procedure and not something taboo and this is what I believe"; "I have never taken a mental health help but I know it would be good."

10.61% also reported positive personal experiences or experiences of their acquaintances in receiving mental health support: "a friend of mine had a great attitude change and positive results after seeking mental help"; "there were situations that made me change my whole point of view about seeking mental health help from neglecting it to acknowledging that it is an important thing"; "my cousin is a therapist and I once went to talk to her and it felt good so I changed my view on seeking mental health."

A small proportion of participants (12.12%) expressed their belief that therapy and professional mental health support were useless: "in reality, it is mostly a pseudoscience"; "therapy is a waste of time and finances"; "that is not something necessary"; "the Egyptian culture makes you think that your problems are not the end of the world and therapy is not necessary"; "mental health is not really an important topic to talk about, instead you may be spending time with friends and family when you are not feeling well." 9.1% of participants shared negative experiences in seeking mental health support: "a friend of mine was deeply traumatized, and they had help and therapy which made things a bit easier sometimes. but ultimately did not change her situation"; "a friend of mine reached out to a mental health professional and was treated horribly and judged"; "I have recently heard stories from people about psychotherapy which has made their cases worse than they were before seeking help, so it is opened my eyes a bit about a dangerous side of psychotherapy, if not done right of course"; "someone I knew prescribed medications ended up having very adverse mental effects and ultimately committed suicide"; "I tried once talking to a mental health supporter before and I did not really like it; it felt overwhelming and stressful, so it was a negative experience."

(iv) Systemic barriers to mental health help-seeking. Participants also mentioned other reasons that would make them hesitant to seek mental health providers. The most often mentioned constraint was financial. 55.6% of participants stated that the high cost of professional help was the major barrier. For instance, one participant explained: "I am not ready to invest a lot of money in so many doubtful therapists, and it is not really easy to find someone who understands, so it is always a financial risk and very costly." Additionally, 44.4% expressed a lack of trust in mental health professionals, e.g., "cultural differences may not help in the bond between the mental health care provider and me"; "they (therapists) offer wellness plans and prescriptions that are leaning towards one size fits all."

A considerable proportion of participants (28.7%) admitted a lack of awareness about mental health and available resources. One participant noted, “I do not even know where to go for mental health help,” which reflected uncertainty about the accessibility of mental health help. In addition, some responses revealed misconceptions about mental health help: “therapy is needed only for severe cases like pedophiles, and rapists”; “seeking mental help is needed only if one experiences severe mental health disorder”; “therapy makes people ‘fragile and dependent’”; “I believe seeking help from psychologists could actually impact me negatively”; “personally, I feel like if they diagnose me with something it would sort of paint the negative image in my head”; “psychotherapy is dangerous; psychotherapy makes the condition even worse.”

4.2. Comparative qualitative analysis

The results of the comparative analysis across the eight demographic groups revealed general patterns in attitudes toward seeking mental health support. The analysis showed that most participants believed that Egyptian culture discouraged mental health support regardless of the place of residence. However, participants residing in the West acknowledged higher acceptance of seeking professional help in Western communities: “Although it (seeking mental health help) is still mocked and not appreciated by many, it is still way more acceptable than other cultures.” At the same time, there were mentions of a cultural shift towards mental health help perceptions: “recently, there has been an increase in mental health awareness campaigns and discussions in social media”; “younger people are more open to seeking mental health support, influenced by global movements advocating for mental health awareness and normalization of therapy.”

Most participants reported the cultural bias in perceiving mental health problems and seeking professional support as a weakness. Notably, most women, regardless of age and residence, believed that therapy was more acceptable for women, while more men believed it was equally acceptable for both genders. Furthermore, the overwhelming number of participants believed that it was more acceptable for younger individuals to seek mental health help. There was also an obvious trend in perceiving religious practices and relying on god first (as “plan A”) as sufficient.

There were also demographic differences in attitudes to mental health help. Thus, both men and women residing in Egypt, regardless of their age, experienced cultural discouragement to mental health support, but it was framed differently. For women, it manifested in feelings of shame and being seen as inferior, judged and misunderstood. For men, there was an added layer of “toxic masculinity,”

where seeking help was perceived as “not manly” (e.g., “they make it seem that men cannot have it because it is not manly of them”).

Compared to women (24–34 years old) residing in Egypt, women (24–34 years old) residing in the West, although reporting fears of being judged, expressed higher acceptance of mental health support. Similarly, women aged 35–45 years old also residing in Egypt highlighted cultural discouragement of seeking mental health help and reliance on religion as a primary approach to dealing with mental problems. In contrast, women of the same age group residing in the West mentioned the need to talk more about mental health and recognized some positive shifts in the community’s mental health perceptions. Both men (24–34 years old) residing in Egypt and men (24–34 years old) residing in the West reported the stigma of weakness associated with seeking mental health help. At the same time, the latter group mentioned growing awareness about mental health support. Among groups of men (35–45 years old) residing in Egypt and the West, the perception that therapy “is not something interesting” and is not worth “investing time and money in it” prevailed. Yet, men (35–45 years old) residing in the West believed that cultural stigma existed, but did not affect them personally.

Men of all age groups, compared to women, predominantly expressed an opinion that their faith was enough and more important in maintaining mental health than professional therapy, while women suggested that therapy and religion could be “a good combination.” This was especially evident among 24–34-year-old men residing in Egypt: “just knowing Allah is by my side makes me already feel better.” Some believed that mental health problems might result from a lack of faith, and praying more could solve them. However, most participants across all the demographic groups acknowledged that their religion did not prohibit seeking mental health help. Generally, religion was seen as separate from mental health help-seeking and not influencing their decisions about mental health support.

Across all demographic groups, perceptions of therapy were mixed, with nearly equal numbers of negative and positive attitudes. All the groups mentioned a lack of trust in mental health help providers; however, Egyptians residing in Egypt expressed doubts about their professionalism, while Egyptians residing in the West mentioned a lack of cultural awareness of local therapists, which made them feel misunderstood and discouraged from continuing therapy. In all the groups, financial constraint was an important factor preventing them from seeking mental health support.

5. Discussion

The current mixed-methods study was conducted to examine the effects of age, gender, and place of residence of Egyptians on their attitudes toward seeking professional psychological help. By integrating quantitative statistical models with the qualitative thematic analysis, several barriers to professional psychological care were revealed.

One of the integrated findings was the profound impact of gender and cultural masculinity norms, which is consistent with existing research.^{33,34} Thus, Egyptian men, regardless of age or residence, reported significantly less positive attitudes toward professional psychological support than Egyptian women. This statistical disparity was contextualized by the qualitative data, which identified that the strongest perceived constraint in seeking mental health support was cultural stigma associated with mental health and seeking professional help. Participants across all demographic groups emphasized that their communities, particularly the older generations, perpetuate beliefs that individuals experiencing mental health challenges were weak and thus shameful/not manly. The idea of weakness associated with mental health problems was reinforced with the almost unanimous opinion that seeking mental health support is more appropriate for women and younger individuals. This aligns with the persistent societal expectation that men should embody strength, which one participant labeled “toxic masculinity.” This was a particularly salient finding of perceived gender disparity in cultural acceptance of mental health help-seeking, which implies that this cultural constraint creates a strong barrier to mental health professional support, especially for men who are substantially more resistant to professional help. This finding is supported by gender socialization theories suggesting that masculine norms discourage emotional vulnerability and thus seeking professional help.^{35,36}

Additionally, the integrated analysis highlighted the role of geographical factors in shaping these stigmas. Egyptians residing in Western contexts, regardless of age or gender, showed slightly more positive attitudes than those residing in Egypt, suggesting that societal and community factors contribute to greater acceptance of professional psychological help in Western societies.^{37,38} The qualitative data expanded on this, revealing both geographical and generational shifts in conceptualizing attitudes to seeking professional mental health support. Specifically, younger Egyptians residing in the West yielded the strongest recognition of a “global movement advocating for mental health normalization,” whereas older generations, regardless of residence, remained anchored to traditional stigmas. Continued lower acceptance of mental health help-seeking among older age groups implies persistence

of the traditional views, which poses a challenge for mental health support for all generations across the lifespan.

Another theme elicited was that mental health challenges were perceived as “madness” and related to only “severe cases like pedophilia,” which contributed to the feelings of shame and the fear of judgement and misunderstanding. Such stigma silences open conversations about mental well-being with relatives or other community members in both Egypt and in the West since discussing such issues openly may lead to social judgment and being looked down upon. These findings align with previous research on mental health stigma within Middle Eastern cultures, which contributes to the avoidance of professional help³⁹⁻⁴¹ and perception of mental health challenges as “madness” rather than a manageable condition.^{13,42}

A critical intersection of our mixed-methods findings centers on the complex role of religion. Quantitatively, it was revealed that NRC, associated with questioning one's faith or attributing hardships to god's punishment or demonic forces, had no effect on attitudes toward professional psychological help. This result challenges prior research, suggesting its role in prompting mental health help-seeking through intensifying distress.⁴³ These mixed findings may be attributed to the fact that in many studies, psychological help is defined broadly as asking for help from friends and family, together with professional support, while in our study, the mental health help was limited to professional support. From a cultural perspective, this inconsistency may result from the deeply ingrained taboo in Egyptian and broader Islamic contexts against openly questioning god or expressing spiritual discontent,¹³ which may suppress the impact of NRC. Furthermore, this non-effect can be linked to the TPB. According to TPB, subjective norms dictate behavioral intentions. It is illustrated that if an individual views their mental health struggle through the lens of NRC, such as perceiving it as divine punishment or similar, the prevailing subjective norms within their community often dictate that the appropriate response is spiritual repentance and increased prayer.⁴⁰ This might be further exacerbated by the internalization of social stigma. Research suggests that in Muslim and other collectivist minority communities, the subjective norm is often protective of the family's reputation, which means that seeking secular help can be seen as a public admission of a spiritual deficit.⁴⁰ Unless the social “gatekeepers,” such as religious leaders, validate secular help, the subjective norm remains a significant barrier to entry for mental health services.^{40,44} Although social support is generally a facilitator in TPB, in collectivist cultures, support is often contingent on adherence to community norms. If the norm is religious coping, the community may withdraw support

if an individual chooses a secular path.⁴⁵ Consequently, NRC does not just fail to foster positive attitudes toward seeking professional help; it actively reinforces avoidance of secular systems, making them inaccessible during psychological distress.

Conversely, the mediation analysis showed that PRC, associated with using religious practices as a source of comfort and strength, significantly mediated the relationship between residence and help-seeking attitudes. Specifically, strong reliance on the PRC, which was higher among those residing in Egypt, was associated with less positive attitudes toward professional help and might discourage mental health help-seeking. Similar patterns were observed in other communities where prayer was often preferred over therapy.^{24,37,46} Our qualitative themes illustrate why this occurs. While participants acknowledged that religion does not strictly prohibit therapy, an overarching qualitative theme of “my religion is enough” emerged. Egyptians noted that practicing religious rituals was their first choice for maintaining psychological well-being. Previous studies also found that religious coping was a prevalent alternative to therapy in faith-centered communities, especially among Muslims.^{46,47} Many participants, especially young men residing in Egypt, reported that prayer and faith were sufficient for addressing mental health concerns. In many cases, religious practices replaced professional help. That was especially evident in participants who believed that mental health problems were a test from god or caused by a lack of faith (as a negative religious coping). Many participants also acknowledged that seeking mental health support was encouraged by their religion as an act of self-care, yet most still admitted that praying is their “plan A” and they should rely on god first. This implies that even with the formal acknowledgment that religion and mental health support may work hand-in-hand, the existing cultural discouragement contributed to the avoidance of professional psychological support. Thus, despite formal acknowledgment that religion and therapy can coexist, cultural reliance on PRC acts as a major barrier to professional care.

Beyond cultural and religious norms, the qualitative analysis identified several systemic barriers and misconceptions that further contextualize the hesitance to seek care. The explicit attitudes toward help-seeking were mixed in our sample: some acknowledged potential benefits of therapy and reported positive personal experiences seeking mental health help, while others expressed negative attitudes toward therapy, supported by negative personal experiences with professional help (e.g., “therapy does not help”). A number of misconceptions and a lack

of awareness about mental health support contributed to the negative attitudes toward the latter. Some participants believed that professional help would make the case even worse, that it was a “pseudoscience” and “hoax.” This aligns with prior studies’ findings that negative attitudes toward therapy often result from misinformation or limited awareness of psychological treatment resources.^{21,48} Some participants explicitly noted that higher-profile publicity and awareness campaigns changed their perceptions of mental health help.

Among other major constraints preventing mental help-seeking were a lack of trust in mental health professionals in Egypt and a lack of cultural awareness of mental health professionals in the West, making effective therapy difficult. Additionally, all the demographic groups mentioned the high cost of mental health help as a major barrier.

Finally, the comparative qualitative analysis across the eight demographic subgroups highlighted the value of this integrated approach. While overarching trends, including cultural discouragement, religious reliance, and systemic financial barriers, were persistent, the intersection of these variables revealed how barriers are uniquely experienced. For example, the intersection of gender and cultural expectations produced distinct psychological barriers: while women predominantly internalized cultural discouragement as fears of judgment and shame, men, especially younger ones, framed their hesitation through the lens of restrictive masculinity norms. By analyzing these demographic axes, our findings confirm that barriers to professional mental health care are not monolithic but are compounded by individuals’ socio-cultural identities.

6. Limitations

One of the key limitations of the study is our sample composition, which focuses exclusively on Egyptian Muslims, limiting the generalizability of the findings. Hence, future research may focus on non-Muslim groups to explore the mental health help-seeking attitudes and factors affecting it.

7. Conclusion

In conclusion, our study offers several novel contributions to the understanding of mental health help-seeking attitudes. Specifically, it highlights the persistent influence of cultural masculinity norms on less positive attitudes to professional psychological help in Egyptian men, regardless of their age and residence (in Egypt or a Western country). Furthermore, our study revealed the nuanced effect of religious coping. In particular, PRC negatively mediated the relationship between residence in the West

and attitudes to professional psychological help in both Egyptian men and women, regardless of their age. This reflects that less reliance on the PRC in dealing with mental health problems was associated with a more favorable attitude to mental health help-seeking.

The qualitative study expanded on these findings. The thematic analysis identified the strong influence of cultural stigma, particularly the perception of “madness” associated with mental health problems and lack of acceptance of mental health help-seeking by older generations, which silenced open conversations and promoted a fear of judgment. The study also confirmed a salient gender disparity in cultural acceptance of mental health help-seeking, where the “toxic masculinity” norm was seen as the strongest barrier for men to admit mental health problems and seek professional support.

The study also reveals the complex role of religion (Islam in our sample) as a systemic constraint in mental health help-seeking. Despite a unanimous acknowledgment that religion does not discourage seeking therapy, many participants prioritized religious practices over professional support. Among other barriers to mental health support seeking were lack of trust in mental health providers, financial considerations, and misconceptions about professional psychological help and its accessibility. Finally, the comparative qualitative analysis revealed the consistency of these trends across demographic groups.

8. Practical implications

The study findings highlight several critical pathways for addressing barriers to mental health help-seeking in Egyptian populations, in both domestic and Western contexts, with a particular emphasis on generational shifts and the younger population's growing recognition of stigma.

Thus, given the finding that young men are discouraged from seeking professional help by “toxic masculinity” and the fear of perceived weakness, interventions must be gender-responsive. This finding may inform targeted psychoeducational campaigns that reframe professional psychological help not as a failure of self-reliance, but as a proactive tool for resilience and strength, and normalize emotional vulnerability, specifically among men.

Additionally, given the reported positive impact of awareness campaigns and the generational shifts identified in the qualitative analysis, large-scale, targeted educational programs in universities and high schools aimed at reducing persistent cultural stereotypes and misconceptions surrounding mental health could be beneficial. Because younger populations demonstrate a growing recognition of the need to normalize mental health, academic institutions

must capitalize on this momentum. They should foster open dialogues that challenge the traditional stigma of mental illness as “madness” and recognize mental health as a manageable, common aspect of overall well-being.

Our findings highlighted the complex role of religious coping, where participants frequently viewed prayer as “plan A” and sufficient on its own, while acknowledging that Islam does not prohibit therapy. A follow-up practical implication is the need for religiously integrated mental health care. Mental health professionals and community “gatekeepers” could collaborate to explicitly bridge the gap between faith and therapy and to promote the narrative that seeking professional medical and psychological help is an encouraged act of self-care that complements religious devotion. This nurturing approach can emphasize that seeking help is a sign of strength, thereby promoting help-seeking behaviors, enhancing resilience, and cultivating a supportive academic environment.

Finally, addressing systemic barriers requires provider-level interventions. The finding that a lack of cultural awareness among local therapists was among the major obstacles for Egyptians residing in Western contexts may emphasize the need for cross-cultural competency training of mental-health providers.

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Conflict of interest

The authors declare no competing interests. This includes both financial and non-financial interests, such as personal, professional, or institutional affiliations, that could be perceived as influencing the work reported in this manuscript.

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Ethics approval and consent to participate

This study was conducted in accordance with the ethical

guidelines of the Committee on Publication Ethics (COPE). All study participants provided informed consent for participation, and their confidentiality and privacy were safeguarded in compliance with institutional and international ethical standards. This study was reviewed and approved by the Ethics Committee of the Faculty of Arts and Humanities at the British University in Egypt (Approval #24-0201). All procedures involving human participants were conducted in accordance with institutional guidelines and ethical standards.

Consent for publication

All participants provided informed consent for their anonymized responses and demographic data to be published. No personally identifiable information was collected, ensuring complete anonymity in the published manuscript.

Availability of data

The data of this study are available upon reasonable request. Access to the data can be granted by contacting the corresponding author, following approval from the FOAH Ethics Committee at the British University in Egypt (BUE).

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