



An Analysis of Conceptual Understanding of Depression among The Saudi Arabian Community in London

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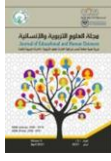
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ABSTRACT

Depression is one of the most prevalent psychiatric disorders, and despite the recent waves of Saudi Arabian immigration into London, there is a dearth of information concerning the cultural perceptions of Saudi citizens regarding depression. Cross-cultural literature on depression is difficult to interpret because of the discrepancies in the conceptualizations and methodology used to study it. It is generally accepted, however, that an individual's understanding of depression is largely determined by the social and cultural context in which they live. This study explores whether Saudi nationals in London hold traditional cultural views regarding depression and whether demographic factors and level of acculturation influence the degree to which those beliefs are espoused. Eighty-two adult Saudi nationals were recruited to complete a demographics sheet, questions regarding acculturation, and a Likert scale to assess their perceptions of depression. A regression analysis indicated that the respondents moderately supported their culture's most known traditional beliefs regarding depression. However, neither the demographic factors nor the number of years in the UK contributed to the variance of those traditional beliefs, and only the frequency with which the English language was used at home predicted the agreement with traditional views regarding depression. This study found that some measurements of acculturation predicted stronger Saudi Arabian cultural beliefs about depression in the sample. Results must be interpreted with caution due to the study's exploratory nature, and further research is warranted to explore the implications for clinical practice fully.

Keywords: Depression, cultural perception, traditional views, immigration, Saudi Arabia community.



Introduction

Depression is a complicated and multi-level phenomenon. By 2020, it is expected that depression will rank among the world's leading killers. Depression is a serious health problem that causes both psychological and physical morbidity. Other explanations have been supplanted by the biopsychosocial approach, which incorporates biological, psychological, rational, and cultural factors (Wilhelm, 2006). The difficulties in comprehending these intricate interfaces are immeasurable. Some researchers contend that major depressive disorders are racially and geographically correlated, and cultural perspectives on depression influence people's propensity to recognize symptoms and seek treatment (Falicov, 2003).

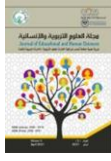
This study aims to analyze the research on depression, examine how Saudi Arabian residents in London perceive depression, and determine whether acculturation and demographic factors affect the level of support for traditional Saudi Arabian cultural beliefs about depression.

The Prevalence of Depression and the Effects of Culture on Depression Rates

Depression is a mental health disorder defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). It involves a significant emotional change that affects daily life, social relationships, and employment. The core features of depression include low mood and loss of motivation. To diagnose depression, an individual must exhibit at least five out of nine symptoms, including negative mood, guilt, suicidal thoughts, concentration difficulties, reduced interest in life, exhaustion, weight loss, psychomotor retardation, and disturbed sleep. Symptoms must last over two weeks, with less than two weeks characterized as a 'depressive episode' (American Psychiatric Association, 2013).

The World Health Organization conducted a comprehensive study on depression prevalence in 14 countries worldwide, using criteria from the DSM-5 and ICD. The study found that global estimates of major depressive disorder ranged from 2.6 to 29.5% among adults in different countries. The WHO reported that Chile, The UK, the Netherlands, and Brazil had the highest rate of depression, while Japan, China, Nigeria, and Italy had the lowest incidence (WHO, 1992). However, the study's classification of mood disorders as a single disorder has been criticized for using poor diagnostic methods. Some researchers, like Kessler et al. (2004), argue that the results underestimate the actual rate of major depressive disorder across the lifespan, which is believed to be higher than 50% in some countries.

However, a study on depression prevalence in ten countries revealed significant differences, with extremes in Beirut reaching 19% and Taiwan at 1.5%. The study revealed that women in all participating countries had a higher rate of depression than men, with the mean age of onset being around the late 20s. Individuals with depression were at higher risk of panic disorder, co-morbid alcohol dependence, and obsessive-compulsive disorder. Korea had twice as high rates of depression as



Taiwan, while Paris had a rate that approached Beirut's, despite wars. Factors contributing to these variances include various risk factors, social stigma, cultural disinclination, and survey restrictions (Weissman et al., 1996)

Bhugra (2004) found higher depression prevalence in African, Caribbean, Indian, and Bangladeshi/Pakistani groups than the dominant population. Rehman and Owen's 2013 survey showed that 50% of respondents had depression diagnoses, with Asians having higher rates. Challenges in capturing depression prevalence include inconsistent diagnostic criteria. Ferrari et al. research on global depression rates often presents methodological issues, lacks causal evidence, and lumps depression with other mood disorders, limiting understanding across cultures and regions.

The Role of Culture in the Understanding of Depression

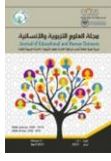
Culture significantly influences depressive symptoms, treatment preferences, and perceptions of treatment usefulness. Studies show that Mexican Americans and African Americans have lower lifetime depression prevalence rates compared to Caucasians, suggesting fewer recurrences. Somatic symptoms are associated with overall depressive mood severity, while cognitive symptoms are not normally correlated with depressive episode severity. Treatment preferences among African Americans, Latinos, Asian/Pacific Islanders, and Native Americans suggest that non-clinical approaches like counseling and prayer may be effective. These minority groups are more likely to prefer counseling over antidepressant medication and view depression as having a biological basis. Cultures may differ in their conceptual models of depression and beliefs regarding the causes of psychological disorders (Kawabata, Crick, & Hamaguchi, 2013).

Karasz (2005) found that ethnic minority groups are less likely to seek professional treatment for depression due to their perception of symptoms as social problems rather than disease-related. This is particularly true for Eastern population members living within Westernized cultures.

The Prevalence and Conceptual Understanding of Depression in the Middle East and Saudi Arabia.

Middle Eastern members experience high rates of depression, with a major depressive disorder prevalence ranging between 5-20%. Depression is the leading illness affecting Middle Eastern and North African women, while men face it only seventh. However, psychosocial health screenings are rare, and understanding of depression's causes and consequences is limited. Future studies should assess depression based on cultural-specific factors within the Middle Eastern population.

Depression rates in Middle Eastern populations are linked to climate and socioeconomic status, but the exact reasons are unclear. One possible explanation is women's lack of independent choices, leading to learned helplessness and chronic depression. Limited employment opportunities may also contribute to increased



depression rates. However, no known causal evidence exists regarding the incidence of depression in Middle Eastern populations (Koenig et al., 2011).

Despite high rates of depression among Middle Eastern nationals, few seek professional treatment due to societal views of religious underpinnings or the stigma associated with depression. Many view their problems as moral or spiritual and may not consider psychological interventions necessary. Weiner and Craighead (2010) suggest a more componential and symptom-based approach to treatment. The understanding of mental health problems in the Middle East is generally vague compared to Western nations, and the use of expert assistance is comparatively infrequent. This reluctance to seek help has significant mental health implications for these populations, given the high prevalence of depression in the region.

Research on depression prevalence, understanding, and treatment in Saudi Arabia is limited, with complex causes, incidence, and perceptions. Living in remote areas, poor housing, and limited privacy are moderate predictors of depression among Saudi Arabians (Abolfotouh et al., 2001). Research indicates that depression in Saudi Arabian communities is often linked to work and family stress, economic concerns, grief, and physical illness. Impaired physical health, reduced functional capacity, and loneliness are common sources of depression. This differs from Western populations, who view depression as an individual issue. Additionally, religious practice may be a protective factor for first-generation Saudi immigrants in the UK (Dabbagh et al., 2012).

Rationale

This study explores the cultural beliefs and perceptions of depression among Saudi citizens living in London. It will evaluate whether Saudi immigrants adopt these beliefs and how demographic characteristics and acculturation affect their adoption. Research on the beliefs of the Saudi population abroad can help identify their inclination to seek treatment, provide insights into facilitating access to mental health services in London, and improve their responsiveness to treatment.

Research Hypothesis

Focusing on the specific population of Saudi immigrants, the study first seeks to examine the following research hypothesis:

H1: To determine if Saudi Arabian nationals living in London endorse traditional Saudi Arabian cultural beliefs about the nature and cause of depression.

H2: To determine if demographic factors and level of acculturation affect the level of endorsement of traditional cultural beliefs about depression



Method

Procedure and Participant Recruitment

This study conducted a cross-sectional survey on perceptions of depression in the Saudi Arabian community in London. Recruitment began in October 2014, using convenience sampling methods. Participants were identified through the Royal Embassy of Saudi Arabia's Cultural Bureau in London. The study aimed to recruit as large a sample as possible during the five-week recruitment period. Participants were notified via email about the study's purpose, rights, and the online survey, allowing them to complete the study within a narrow time frame. The study involved identifying prospective participants over 18 through an electronic mail message. Participants were informed about the study's purpose, rights, and the online survey website. They were asked to consent to their information being used and provide their time in the UK. The data was then analyzed using simple regression and independent t-tests. The study's professional and ethical issues were discussed. The study included 97 Saudi nationals aged 18+, with a minimum of one year of residence in Greater London, and proficient in English. Fifteen respondents were excluded due to non-completion of a second questionnaire, resulting in only 82 valid questionnaires used in statistical analyses. The questionnaires were only available in English.

Measures

The questionnaires used three types of scales.

1. A demographic questionnaire: The demographic questionnaire contained items that sought to determine the Gender, age, ethnicity, home country, education, marital status, employment and religion of each participant
2. An acculturation questionnaire: In the present study, acculturation was measured through a separate sheet requesting the number of years a participant has resided in the UK and a question included in the demographic questionnaire regarding the frequency with which the English language is used at home.
3. The Cultural-Based Understanding of Depression Questionnaire: The Cultural-Based Understanding of Depression Questionnaire is a 32-item, 5-point Likert Scale questionnaire designed for a study in Saudi Arabia. The questionnaire, selected from the literature and the researcher's work, allows participants to rate their agreement or disagreement with the included statements. The score ranges from 0 to 128, indicating a higher degree of agreement (Mir, 2005).

Ethical Issues

The study investigates the perceptions of depression among Saudi nationals in London. The sensitive nature of the material may cause psychological harm, so participants were informed that they could exclude any items they found disturbing. Information about a telephone hotline for depression and the NHS Depression



Resource was provided in invitation letters and debriefing forms. The research used an exclusively adult sample; no compensation or incentives were used to recruit or retain participants.

Data Analysis and Results

The survey data was analyzed using SPSS 20.0 software, with central tendencies and frequency tables. Simple regression analysis and independent t-tests were performed to find the relationship between independent and dependent variables, aiming to determine if demographic characteristics and acculturation predict traditional beliefs in depression.

Result

Description of Sample

Table 1

Frequencies of demographic characteristics.

Demographic Variable		Frequency	Percentage
Gender	Male	55	67.1
	Female	27	32.9
Religion	Muslim	82	100
	Other	0	0
Ethnicity	Arab	80	97.6
	Other	2	2.4
Education	Some university	16	19.5
	1 st degree	9	11.0
	Some postgraduate studies	14	17.1
	Postgraduate	43	52.4
Marital Status	Single	43	52.4
	Married-partnered	34	41.5
	Separated	2	2.4
	Divorced	2	2.4
	Widowed	1	1.2



Employment Status	homemaker	3	3.7
	student	37	45.1
	students who work	9	11.0
	employee	15	18.3
	military	3	3.7
	self-employed	9	11.0
	unable to work	2	2.4
	job hunting	4	4.9
	Age	18-29	35
30-39		28	34.1
40-49		11	13.4
50-59		5	6.1
60 or over		3	3.7

N= 82

Table 2

Descriptive of age and number of years in the UK.

	Mean	SD
Age	34.22	11.98
Number of years in the UK	4.76	3.94

N=82

Note. In Tables 1 and 2, the frequencies and means for the demographic variables of the sample are provided. The majority of respondents were male (67%), relatively young (42% between 20 and 30; 34% between 31 and 40; mean age 34.22 years, SD= 11.98), and of Arabic origin (97%). All participants stated they were Muslim. It is also worth mentioning that the sample was highly educated, with all respondents having received at least some tertiary education and the majority being students (56%), as evident from their responses regarding employment status.

Table 3

Frequencies of acculturation variables.

Variable	Frequency	Percentage (%)
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	1-2 years	22	26.8
Number of years in the UK (categories)	3-5 years	38	46.3
	6-10 years	15	18.3
	11-20 years	6	7.3
	more than 20 years	1	1.2
	Not at all	2	2.4
English language spoken at home	Some of the time	41	50.0
	Most of the time	27	32.9
	All of the time	12	14.6

Note: N= 82

As illustrated in Table 3, almost half of the participants have been residents in the UK for between 3 and 5 years (46% of the sample, mean 4.76 years, SD= 3.94), and about a quarter of them for 1 or 2 years (26%). Only a small sample has lived in the UK for over 10 years (8%). With regards to the use of English at home, the results are divided between frequent and non-frequent use, with approximately half of the sample speaking English some or none of the time (52%) and the other half most or all of the time (48%); it must be pointed out however, that the percentage of participants that do not speak any English at home is far smaller than those that speak the language all the time (2% and 14% respectively).

Table 4

Descriptive for subscales.

Scale	Mean	SD
Stereotypes regarding economic well-being	11.79	3.59
Social distance from depressed people	18.57	6.54
Factual medical understanding of depression	22.89	5.03
Traditional beliefs regarding depression	9.87	2.09

N= 82



Note: As can be seen in the table above, the participants who used English as their primary language at home (mean 10.44, SD= 2.04) scored higher on the 'traditional beliefs about depression' subscale than those who used it as a secondary language (mean= 9.35, SD= 2.02); ($t(80) = -2.42, p < .05$). This suggests that participants who spoke English more frequently at home maintained more traditional beliefs regarding depression. It was also found that Female participants (mean 10.44, SD= 1.74) scored higher than male participants (mean 9.58, SD= 2.20), although this difference only approached statistical significance ($t(80) = -1.781, p = < .10$). This could suggest that female participants tended to be more supportive of traditional beliefs about depression.

Table 5

Descriptive statistics for traditional beliefs questions.

Traditional belief questions	Mean	SD
Usually, people who have depression don't pray or practice their religion.	1.79	1.11
Someone who has depression is likely to live alone.	2.60	.78
Sensitivity causes depression.	2.77	.69
Our environment causes depression	2.71	.79

Note: N= 82

Note. In three of the questions ('Someone who has depression is likely to live alone,' 'Sensitivity causes depression,' and 'Our environment causes depression'), the means range between 2.6 and 2.71, i.e., fall between the answers 'neither agree nor disagree' and 'agree.' On the contrary, the response to the statement 'Usually people who have depression don't pray or practice their religion' has a mean of 1.79 (SD= 1.11), indicating slight disagreement.

Table 6

Correlations between subscales.

	Economic well-being	Social distance	Factual understanding	Traditional beliefs
Economic well-being		.36**	.24*	.48**



Social distance	.14	.07
Factual understanding		.46**

** p <.001* p <.05

Note. The results revealed that stereotypes regarding the economic well-being of depressed individuals ($r_s = .48$, $p < .001$) and factual medical understanding of depression ($r_s = .46$, $p < .001$) had significant positive correlations with traditional beliefs about depression. This suggests that participants with more stereotypes about the economic well-being of depressed individuals and a better understanding of the medical facts relating to depression also held more traditional beliefs regarding depression.

Table 7

Summary of regression analyses for variables predicting traditional beliefs about depression.

Variable	B	SE B	B
Gender	.86	.48	.19
Age	.02	.02	.12
Employment	.02	.13	.01
Marital status	-.02	.30	-.03
Education	.04	.50	-.01
Number of years in the-08 UK		.06	-.15
English spoken at home	1.09	.45	.26

Note. The only variable that predicted scores on the traditional beliefs subscale was the dichotomized variable 'English spoken at home' ($\beta = 0.26$, $p < .05$). Gender, though not a statistically significant predictor, also approached statistical significance ($\beta = 0.19$, $p < .10$).

Table 8

Shows the relationship between English being spoken at home and Gender about traditional beliefs about depression.

Variable	Mean	SD
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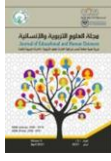
English spoken at home	English as secondary language at home (n= 43)	9.35	2.02
	English as primary language at home (n= 39)	10.44	2.04
Gender	Male (n= 55)	9.58	2.20
	Female (n= 27)	10.44	1.74

Note. Levene's test for equality of variance was found statistically insignificant for both variables. Therefore, the assumption of homogeneity of variance was met in both cases. As can be seen in the table above, the participants who used English as their primary language at home (mean= 10.44, SD= 2.04) scored higher on the 'traditional beliefs about depression' subscale than those who used it as a secondary language (mean= 9.35, SD= 2.02); ($t(80) = -2.42, p < .05$). This suggests that participants who spoke English more frequently at home maintained more traditional beliefs regarding depression. It was also found that female participants (mean= 10.44, SD= 1.74) scored higher than male participants (mean= 9.58, SD= 2.20), although this difference only approached statistical significance ($t(80) = -1.781, p = < .10$). This could suggest that female participants tended to be more supportive of traditional beliefs about depression.

Discussion

The findings support the research hypothesis and suggest that individuals conceptualize depression based on their cultural context. A study of first-generation Saudi immigrants in London found some acceptance of traditional beliefs about depression, with moderate endorsement of attributes like environment, personal sensitivity, and loneliness. However, there was disagreement with the view that depression reflects a distancing from religion (Dritschel et al., 2011). In particular, perceiving depression as a condition linked to the environment and social circumstances is consistent with prior research on Saudi Arabian and Middle Eastern causal attributions or experiences of depression.

Previous studies have shown that religion can be a coping mechanism against depressive symptoms among ethnic minorities in the US and Asian immigrants in the UK (Ayalon & Young, 2003 & Dabbagh, 2012). However, the current study does not support the idea that abstinence from religious practices is linked to depression. This could be due to acculturation, where high levels of education and increased knowledge diminish the perception of religion as a protective factor. Participants in the study appear to be moderately well-informed about medical facts regarding depression, as demonstrated in their scores. Researchers have consistently established correlations between education and attitudes towards depression, with higher-



educated individuals being more positive and open about professional treatment (Jorm et al., 2000). This congruence can be attributed to acculturation, where the well-educated are exposed to medicalized models of depression. Education and immigration are significant causes of such acculturation, which may influence conceptual categorizations of depression and other mental illnesses (Angel & Thoits, 1987).

The study found that demographic characteristics like age, employment, Gender, marital status, and education did not predict traditional Saudi Arabian beliefs about depression. However, women were more attached to traditional beliefs compared to men. The use of English as the primary language at home predicted higher levels of acceptance of traditional Saudi Arabian views on depression. Saudi participants who spoke English more frequently at home conceptualized depressive symptoms more consistent with their traditional beliefs. Higher levels of acculturation may reaffirm an individual's traditional values and views, but this hypothesis is only partially substantiated. Being in a foreign country alone might motivate individuals to seek out familiar faces with similar cultures and values, thereby reestablishing their network of social support back in Saudi Arabia, making them more entrenched in their culture, regardless of their language.

Limitations of the Study

Despite the effort to overcome the limitations stemming from the convenience and self-selecting recruitment methods by increasing the number of participants, the characteristics of the sample were very homogenous in terms of education and religion and quite uniform in terms of Gender and age. Consequently, it is impossible to infer whether the degree of endorsement of traditional beliefs found is comparable to or following the beliefs of non-immigrant Saudi populations.

It should also be noted that the vast majority of the sample were residents in the UK for up to five years; this relatively limited time in the new country may have obscured the relationship between acculturation and the endorsement of traditional Saudi Arabian beliefs about depression.

Recommendations for Future Research

As this study did not consider demographic variables such as income level, children's presence, and time spent in the home country, examining these demographic factors may lead to a further interesting insight into what influences Saudi nationals' adherence to traditional views about depression. The adoption of the English language at home and the number of years in the UK were used to assess acculturation in the present study. Since research regarding minority groups' perceptions and understanding of depression may help inform service provision and psychiatric treatment, it would be useful to extend this exploration of traditional Saudi Arabian



beliefs about depression to clinical populations amongst this minority group, especially to compare depressed Saudi nationals who have sought professional help in the UK to those of them who have not.

Conclusions

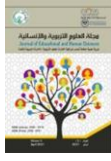
The study investigates the beliefs of depression among Saudi nationals in London, aiming to improve their mental health care and access to services. It found that while demographic characteristics did not influence agreement with traditional views, an increased level of acculturation, measured by English language preference, predicted greater concordance with Saudi views about depression. The study's generalizability is limited due to its exploratory nature and limited previous literature. Future research with larger, more diverse samples may help facilitate service access for Saudi Arabian immigrants in the UK.

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