Effective Mental Health Care in Morocco, a Glimpse into the Future by Moroccan Psychology Students

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Abstract

Although the importance of culturally sensitive mental health care is widely acknowledged, little is known about the attitudes of future mental health care professionals about this topic. The main purpose of this research was therefore to fill this knowledge gap. As such this research explored the attitudes of Moroccan psychology students by means of semi-structured interviews. It focused on possible approaches to culturally sensitive mental health care in Morocco, with special attention to stigma reduction, the integration of traditional and modern psychological practices and the future of mental health care in Morocco. Results indicated that students, after initial hesitation, appeared to be familiar with cultural sensitivity in their surroundings. Respondents reported experiences with stigma, involving family, society, education and government funding. Religion played a central role in respondents' narratives, although distinctions between religion and superstition varied. Mixed thoughts were found about the possibility to integrate traditional healing practices with modern mental health care. All respondents envisioned an active contribution to a more inclusive mental health system. In conclusion Moroccan psychology students underlined the importance of culturally sensitive mental health care but also expressed their concerns. Improving education, accessibility and governmental support remain crucial for implementing mental health care that aligns with the cultural realities of Morocco. Suggestions for future research will be discussed.

Effective Mental Health Care in Morocco, a Glimpse into the Future by Moroccan Psychology Students

The still growing acknowledgment of the importance of mental health has strengthened the need for culturally appropriate mental health care (Bhui, 2007). Researchers and practitioners recognize more and more that mental health does not exist in a social vacuum, but is heavily shaped by cultural norms, beliefs and understandings (Kirmayer et al., 2011). Mental health issues have different manifestations across diverse societies. Therefore, each community needs mental health services that fit in its unique requirements. The position of Morocco between modern and traditional cultures makes it an interesting case study. Trenberth (2017) explains that Morocco's dual heritage of modernization and traditionalism generates multiple challenges for mental health management. The combination of Western psychological methods with traditional healing practices leads to treatment disagreements. Western educated mental health professionals who advocate for culturally sensitive Western approaches seem not yet to have found a way to include the Moroccan society who is familiar with traditional care (Wollie et al., 2024).

Moroccan society has its own cultural factors influencing the perception of mental illness including religious beliefs, family relationships and societal expectations (Al-Krenawi et al., 2009). People may believe that mental health disorders stem from spiritual elements like possession or divine retribution thus might rather seek help from religious leaders, then

psychologists. The dependence on cultural and religious beliefs differs from Western psychological models. Therefore, if it is preferred to implement evidence-based theories, these models need proper cultural modifications before implementation (Stein, 2000). According to Stein (2000), implementing contemporary treatment methods without accepting traditional healing practices will drive away communities and the ancient rituals and systems will remain their primary source of care. This does not have to be a problem, nevertheless, the young population has growing criticism about the way mental health is treated by the older generation in Morocco (Ouazzani Housni Touhami et al., 2022).

The traditional and modern mental health care does not seem to complement on each other. On the one hand, students and future healthcare professionals are increasingly exposed to evidence-based mental health practices from worldwide sources and modern psychology standards. On the other hand, the cultural framework, traditional practices and stigmatizing attitudes toward mental illness do not seem to change with the increase of information from the Western world (Ouazzani Housni Touhami et al., 2022). Most of Moroccans keep seeking mental health care in ways they are used to. They find help with all sorts of problems by imams, read the Quran or take herbal ‘medicine’ (Khoury et al., 2024). In most cases the effects are positive, and the symptoms reduce (Khoury et al., 2024). The problem is that this form of care substitutes medical treatments and whenever it’s not working, the symptoms have gotten much worse. Knowing this, the reaction to the invasion of the Western biomedical model in the Arab world, can be dangerous. Islamist intellectuals proposed the ‘Islamic medicine’, in which they referred to herbal medicine as the only working medicine. These beliefs were funded by a broader political agenda trying to avoid the Westernization of Muslim societies (Adib, 2004). Without bridging this gap, future mental health professionals will face difficulties in integrating their methods successfully. Therefore, the preference will remain to traditional healers or informal support systems only.

New studies show both the obstacles and prospects regarding mental health care delivery in Morocco. The research by Ouazzani Housni Touhami et al. (2022) investigated modern mental health perspectives among medical students in Fez. The respondents demonstrated stigmatizing attitudes about mental illness even though they were receiving modern psychological education. Stigma could not be reduced by education only, since it stems from cultural and social norms which have a long history and influence personal beliefs. Results showed that female respondents along with married students and those who experienced mental illness before, demonstrated lower levels of stigma. This shows how individual life experiences together with social environment, influences attitudes toward

mental health and the deep-rooted nature of stigma. This effect can be seen in broader surroundings as well. In the Arab countries similar trends have been found (Zolezzi et al., 2018; Fekih-Romdhane et al., 2023). These studies show how global mental health paradigms coexist with local stigmatizing beliefs.

The traditional healing practices of herbal remedies and spiritual ceremonies continue to dominate Moroccan help seeking methods according to Khoury et al. (2024) which demonstrates the need for culturally sensitive interventions. Trenberth (2017) along with Al-Krenawi et al. (2009) demonstrate that traditional healing methods can be integrated with modern psychology to develop hybrid models which follow local cultural traditions. The two approaches could work together for instance by having imams discuss mental health stigma in their sermons and by having traditional healers work with mental health professionals. Trenberth (2017) and Al-Krenawi et al. (2009) bring up these ideas to make sure the cultural practices will be respected and included and therefore hopefully enhance the accessibility of mental health services.

As discussed before, to enhance the accessibility of mental health services and combat stigma, systemic changes need to occur alongside educational reforms. According to Schultz et al. (2024) healthcare providers need educational programs that teach cultural competence to help them recognize and value the cultural backgrounds of their patients. After carefully evaluating the curricula of social studies in different Moroccan universities, it became clear that no implementation of cultural beliefs was present (Daoudi & Adlouni, 2024). They also found that most of the teachers did not have a clear understanding of culture and interculture competence. According to Schultz et al. (2024), adding this to the psychology curriculum can have a positive effect on implementing culturally sensitive mental health care.

Psychology students in Morocco will serve as future mental health professionals who must handle complex situations. The viewpoints of psychology students regarding mental health evolution, provide essential understanding of possible developments in Moroccan mental health services. The assessment of their knowledge, beliefs and attitudes will offer important insights about the challenges and possibilities for (culturally sensitive) mental health care in Morocco.

Theoretical and Empirical Background

According to the U.S. Department of Health and Human Services (2001), cultural frameworks play an important role in mental health care because they explain how cultural beliefs and societal structures influence both mental health perceptions and treatment

approaches. The integration of cultural perspectives in clinical practices is necessary to achieve accurate assessments and effective treatment, especially for diverse populations living in Morocco.

Culturally sensitive assessment and consultation

Among other factors, cultural context determines how psychological distress manifests in society as well as which methods people choose to seek help. According to Kirmayer et al. (2000) cultural beliefs determine how symptoms present themselves and how they are perceived. This demonstrates the need to use culturally sensitive assessment methods to prevent diagnostic errors right at the start of psychological consultation. Practical tools like the DSM-5 Cultural Formulation Interview (CFI) (Bäärnhielm., 2024) provide clinicians with structured methods to include cultural information in their assessments. The function of cultural consultation goes beyond the basic principles of cultural sensitivity. According to Kirmayer et al. (2011) cultural consultation represents a joint effort of cultural specialists with clinical professionals to enhance diagnostic accuracy and treatment results. This method highlights the three critical components of language, communication styles and cultural beliefs that define the therapeutic relationship. Cultural consultation delivers a wider understanding of the patient's sociocultural environment than the CFI through its involvement of communities and professionals. Bäärnhielm (2024) explains that the CFI provides concrete tools for cultural integration, yet its effectiveness depends on both clinical training and institutional organization. Clinicians who lack proper preparation might use the CFI as a mere checklist instead of a tool for real cultural engagement.

Culturally competent care has progressed, but many obstacles continue to exist. According to Constantine and Sue (2005) there are two major risks that stem from cultural misunderstandings; over-pathologizing or under-pathologizing behaviors which result in misdiagnosis. They believe that, because of cultural differences of the clinician and the client, misinterpretations are likely to happen. In consultation with a clinician and client from the same cultural background, over- and under-pathologizing are much less common. Constantine and Sue (2005) focus on developing individual cultural competency through awareness, knowledge and skills. To make this possible Schultz et al. (2024) advocate for structural reforms to overcome systemic barriers and create the possibility for professionals to gain the much-needed knowledge and experience.

These perspectives demonstrate the need to integrate theoretical comprehension with practical instruments together with systemic reforms. Kirmayer et al. (2000) introduce cultural

sensitivity as the fundamental principle and Constantine and Sue (2005) describe how to build individual cultural competence. Bäärnhielm (2024) introduces a useful framework through the CFI and Schultz et al. (2024) establish the necessity of systemic reforms. The cultural consultation model from Kirmayer et al. (2011) enables healthcare providers to integrate expert collaboration into their clinical practice. Taken together, mental health professionals can create a comprehensive and effective cultural strategy for mental health care by implementing these approaches.

Stigma and the Arab culture

Despite medical improvements in mental health, mental illness still seems to be often coupled with misconceptions and negative attitudes (Pescosolido et al., 2013). Therefore, people suffering from mental illness continue to be the victim of stigma, that influences their social position in life (Ditchman et al., 2013). In the Western world, the origin from this stigma is said to descend from the New Testament, in which the diagnoses of possession were often given to people showing signs of mental illness (Sawma et al., 2024). When referring to Arab countries, the focus is on the Middle East and North Africa (MENA) region. Although Arabic culture is certainly not the only culture present in this region, it is the most widespread. Therefore, the theoretical framework focuses specifically on Arabic culture. In the Arab countries, people who are suffering from mental illness have been viewed as a curse of the ‘evil eye’ or a ‘djinn possession’ for the Muslim believers (Kishore et al., 2011) or a devil-possession for Christian believers (Waldmeier, 1897, pp. 42-45), or a state of awakening bringing a message from God (Mehraby, 2009; Scull et al., 2014). In Morocco it is also seen as a case of contamination, in which people believe it can be ‘contracted’ by accidentally coming into contact with sorcery, by stepping on or ingesting a bewitched substance (Stein, 2000; Mehraby, 2009).

When developing strategies to reduce mental health stigma in the Arab countries, knowledge of students and younger population dynamics become essential. The emerging professional community and their active societal roles make students valuable for showing how educational elements, cultural beliefs and modern concepts shape mental health attitudes nowadays. Students serve as an essential group for stigma research because their experiences, beliefs and attitudes demonstrate how cultural stigma functions. In addition, they show the effects of practical methods for stigma reduction (Fekih-Romdhane et al., 2023).

Stigmas exist on multiple levels: public stigma, internalized stigma, institutional stigma and cultural stigma. Focusing on the stigma on mental health, Corrigan & Penn (1999)

define public stigma as the widespread social stereotypes combined with prejudices and discriminatory behaviors that affect people with mental health disorders. When stereotypes penetrate personal beliefs, individuals develop internalized stigma which create feelings of shame along with decreased self-esteem and avoidance of seeking help. The broadest level of stigma exists when healthcare systems and workplaces along with their policies develop barriers that discriminate against patients and prevent them from obtaining care. This is called institutional stigma (Corrigan & Penn, 1999). Additionally, cultural stigma is shaped by traditional beliefs that often attribute mental illness to supernatural causes, such as black magic or divine punishment, this strongly affects the Arab countries (Zolezzi et al., 2018; Kishore et al., 2011). The traditional cultural explanations strengthen public and internalized stigma about mental health, which leads to decreased professional help-seeking behavior from individuals.

Mental health perceptions and help-seeking behavior receive substantial influence from cultural backgrounds according to the U.S. Department of Health and Human Services (2001). Patel et al. (2018) demonstrate that cultural elements produce different levels of discrimination that impact how people view mental illness and their willingness to use mental health resources. Zolezzi et al. (2018) performed a meta-analysis which combined data from 34 studies to show mental illness is commonly blamed on black magic, evil spirits or divine retribution. That belief system creates fear towards people with mental health problems and leads many individuals to avoid medical help and instead visit traditional healers. If stigma and discrimination are experienced at this very first help-seeking step, the chances for seeking further mental health treatment are reduced or even eliminated. If, on the contrary, the person's illness is not stigmatized at this first step, then chances for mental health help-seeking and recovery are increased (Sawma et al., 2024).

The research of Fekih-Romdhane et al. (2023) expands existing findings through their investigation of more than 6000 students across 16 Arab countries via a cross-sectional study. The research demonstrates that familiarity together with gender and education level act as determinants of stigma levels. The researchers discovered that religiosity exhibited both constructive and adverse effects in the study. The protective effect of religiosity becomes visible through their emphasis on compassionate behavior toward others which fosters better attitudes toward people with mental health issues. On the contrary, some religious beliefs about mental illness such as divine punishment or spirit possession end up reinforcing stigmatizing behaviors and beliefs. Results showed that being more familiar with mental

health, being a female and having a better understanding of mental illnesses has a positive influence on reducing stigma.

While women show significant lower level of stigma than men, women in Arab cultures face additional stigma due to gendered expectations and cultural taboos. Douki et al. (2007) showed that traditional societal standards make women bear most of the mental health discrimination which results in severe social stigma. The combination of cultural elements and gender-based factors creates complex stigma patterns which require complete solutions to achieve fair treatment.

A fundamental approach to minimize stigma in the Arab society is to have well educated and informed students. According to Patel et al. (2018) future mental health professionals can act as cultural mediators to link traditional beliefs to modern practices because they are familiar with both sides. Apart from that, policy changes are important because, stigma about mental illness exists where care for mental illness is considered to be too specialized to be part of primary care (Meer et al., 2013). Adding onto this, Sweileh (2024) suggests that health policies must include anti-stigma interventions because institutions need to actively support the breakdown of cultural-based stigma.

To conclude, stigma towards mental health in the Arab countries is deeply influenced by cultural, religious, and gendered factors. Research among students, such as the work by Fekih-Romdhane et al. (2023) demonstrates how these social dynamics work and shows how education acts as an essential tool to reduce stigma. However, stigma continues to exist on multiple levels. The implementation of cultural competence training together with policy reforms, represents essential systemic changes for overcoming both institutional and societal barriers. A culturally sensitive mental health care system requires a lot of acknowledgement, time and money, which does not seem possible without policy implementation.

Objective

The main purpose of this research is to determine the views of Moroccan psychology students on the future of mental health care in Morocco and the use of culturally sensitive approaches. Using qualitative interviews, the research aims to determine how these students view the combination of traditional healing practices with modern psychological practices. By examining their attitudes toward stigma (reduction), education and accessibility of mental health care, the research aims to contribute to strategies for improving mental health care in a culturally respectful way.

Research question

What are Moroccan psychology students' attitudes towards culturally sensitive approaches to mental health care and what are their perceptions of traditional and modern practices in the context of stigma and the accessibility of mental health care?

Sub-questions

1. Cultural Sensitivity: How do Moroccan psychology students define culturally sensitive mental health care, and what cultural elements do they consider most critical to include?
2. Addressing Stigma: How do these students think about the impact of education and community outreach on the reduction of mental health stigma?
3. Integration of Practices: What are their views on incorporating traditional healing practices with modern evidence-based health care?
4. Future Roles: What challenges and opportunities do they predict as future mental health practitioners in balancing traditional practices with Western evidence-based health care?

Expectation

The Moroccan psychology students will probably emphasize the significance of culturally sensitive mental health care, which should encompass traditional healing practices alongside modern psychological interventions. This fits within the context of Morocco, where mental health is affected by social stigma, spiritual beliefs, and traditional practices (Al-Krenawi, 2009; Gopalkrishnan, 2018). However, since many of these students come from relatively privileged backgrounds, often speak English and have more financial resources than the average Moroccan, their views may have been influenced by Western mental health ideas and systems. Therefore, it is expected that their attitudes might be more nuanced and less traditional as the ideas of most of the Moroccan population.

Students are expected to view education and community outreach as the most important strategies for reducing stigma, especially by engaging leaders such as imams and family members, which are very important in the Moroccan culture (Hassan et al., 2015).

These students are predicted to identify challenges of integrating traditional practices with evidence-based therapies but are predicted to be positive about the opportunities for the integration of the two approaches (Kirmayer et al., 2011; Trenberth, 2017). As they are

familiar with English and global mental health ideas, they will probably support the adoption of hybrid care systems.

They are likely to advocate the need to change their education and training system to better prepare them to address Morocco's cultural complexities. This may include more practical experiences that will help to close the gap between their relatively global perspective and the needs of Moroccan communities (Schultz et al., 2024; Trenberth, 2017).

Method

The research used a qualitative design to explore how the psychology students in Morocco perceived mental health care. A qualitative design is known to fit well when the goal of the research concerns respondents' thoughts, opinions and ideas (Kleemans et al., 2008). This research is based on the constructivist paradigm, which seeks to reveal the experiences and interpretations of respondents within their cultural and academic contexts.

Researcher Characteristics and Reflexivity

The researcher is finishing her master's degree in clinical psychology by conducting this research. She has a special interest in Morocco and has been traveling through the country consistently since 2017. As a white woman with a Western educational background in psychology, she recognizes the potential for bias.

Procedure

The research is conducted at three Moroccan cities with a large university: Rabat (Mohammed V University), Marrakesh (Cadi Ayyad University) and Agadir (Ibn Zohr University). These places were selected to create a variety of students from different parts of the country, thus providing a range of views on mental health. A snowball procedure is used to recruit 20 to 25 psychology students for the research. The respondents were undergraduate students, graduate students, or recently graduated, but they had to be students or graduates of the university. The respondents' characteristics can be found in appendix A. The recruitment was mostly done through social university networks. The researcher asked young looking people on the streets, in Airbnb's and in restaurants if they were or knew somebody who was researching psychology. Via via she spoke to many youngsters, was invited to many (online)groups, dinners and café's and therefore was able to reach out to multiple students. She also visited universities and ended up in management offices. After spending multiple days wondering around in waiting rooms for people in high functions, filling out lots of

paperwork and not being allowed to speak to any student, the researcher continued to recruit only outside university buildings. Roughly 200 students were initially willing to do the interview, about 100 interviews were planned and 25 have been executed. This resulted in 20 successfully transcribed interviews. Due to some technical difficulties five interviews could not be used. The following inclusion criteria were used: respondents had to be psychology students or students with many psychology courses in their curriculum and had to be willing to express their views on mental health. Since mental health can be seen as a private topic in Morocco, and people often don't feel comfortable speaking about it, especially not to a Western foreigner, their own willingness was very important to include. To make sure the answers were open and honest, people who felt too uncomfortable speaking about it could not be included. This possible discomfort in discussing mental health may have contributed to the fact that many students did not attend the appointment.

Data Collection Methods

The data was collected through semi-structured interviews of students' opinions on mental health care. The interviews featured open-ended questions, that rose from the theoretical framework. The questions covered students' perception and experience regarding mental health care, with a special focus on (a) cultural sensitivity, (b) addressing stigma, (c) combination of traditional and modern practices, and (d) potential challenges and opportunities for the future. These questions were based on well-established theories and were expected to evoke information that can help explain mental health care in Morocco's specific cultural setting. Theories like those of Kirmayer et al. (2011) of how cultural beliefs influence perceptions of mental health, which was a foundation to discuss culturally sensitive care (a). Fekih-Romdhane et al., (2023) and Meer et al., (2013) provide information about the importance and impact of stigma and education (b). Gopalkrishnan (2018) underscores the significance of cultural adaptation and local tradition in mental health intervention which signifies questions about implementing tradition in mental health care (c). Furthermore, the questions were based on frameworks that address the coexistence of traditional and modern approaches (Trenberth, 2017; Patel et al., 2018)) (c and d). These theoretical perspectives have been integrated to ensure that the interviews offer a deep understanding of the challenges and opportunities in Moroccan mental health care. The research and interview questions are included in Appendix B.

The interview began with introductory questions. Demographic information, including age, gender, academic level, and university affiliation, was collected to have a good

distribution of answers, followed by the interview questions. Each research sub question was covered by three interview questions. Interviews were conducted in English, with translators assisting where needed, and were audio recorded for transcription and analysis.

The data collection continued until the planned amount of observation was reached. Leading to the point where no new themes or ideas emerged from additional interviews. This is called data saturation and shows that the data was sufficient to answer the research questions (Guest, Bunce, & Johnson, 2006).

Planned Data Processing and Statistical Analyses

Each interview was recorded and transcribed by the researcher. The dictate function of Word was used to roughly transcribe the audio footage. Next, the transcripts were completed and corrected by the researcher. This could also have been done using generative AI but because of the sensitivity of the information it is intentionally chosen not to do so. If a translator was involved, the transcripts were double-checked (once by the researcher and once by the translator) to ensure the translation matched the original conversation. This step in careful transcription will serve as a basis for the analysis (Braun & Clarke, 2006).

The statistical analysis followed the Directed Content Analysis (DCA) (Elo & Kyngäs, 2008). In contrast to content analysis often used in social scientific research, DCA uses a combination between the inductive and deductive method. Where content analysis focuses on inductive analyzing and forming codes from the collected data, deductive analysis tests the data in the theoretical framework. As such, this method contributes to the theory by adding information of the specific analyzed group.

The DCA includes three phases: the preparatory phase, the organization phase and the reporting phase. In the preparatory phase the researcher decided on the unit of analyses (the students) and reread all interviews carefully. This raw data was then uploaded into ATLAS.ti. In the organization phase the categories matrix was designed. Based on the interview questions, a topic list was made. Then the main categories were divided into subcategories. The data was coded deductively by thematic codes that rose from the theoretic framework. The thematic coding was first done by the researcher and then by two Dutch professionals who grew up in Morocco, to minimize possible bias. One is a transcultural psychologist working in the forensic psychology and the other is a psychiatrist specialized in Moroccan healing methods, also working in forensic psychology. After careful comparison the following subcodes were added: Financial situation; Djinn; Illiterate; Living situation; Community; Duty of Assistance; Mindset of the new generation. The complete codebook is included in

Appendix C. The data that did not fit into one of these codes was later analyzed inductively and followed the process of open coding.

Open coding starts with thematic exploration; this enables data to reveal patterns and ideas naturally. The researcher read every piece of transcript that did not fit into a code extensively until essential statements and reoccurring topics were found that aligned with the research questions. These critical findings formed the basis of the initial code. After creating the initial codes, connections were examined to create broader themes. To ensure the themes were consistent and meaningful, new data was compared with existing codes and themes. This iterative comparative method enables researchers to reach complete understanding of diverse experiences while integrating all relevant perspectives (Glaser & Strauss, 2017). The open codes are included in the codebook in appendix C. Next the 'code manager' of ATLAS.ti was used to check whether all interviews were coded systematic and consequently.

Because this research is explorative and it was very difficult to find a second coder, it was decided to only use the qualities of two professionals in the process of thematic coding. Whenever there was an uncertainty about the coding process, the two professionals were informed, and they quickly came to an agreement. Therefore, there is no reason to assume that including a second coder would have led to any different results.

Finally, the reporting phase presented the (head)categories based on relevant quotes and comparisons between the respondents. The quotes are original quotes from the interview. Any protentional language errors in the quotes are not corrected. Whenever it was needed, generative AI was used to correct English grammar and help to be concise in writing.

Multiple strategies were implemented in this research to achieve trustworthiness.

- Multi-perspective analysis: combining insights from various data methods, as combining the deductive and inductive analyzing method, and having a second and third opinion in deciding on the thematic coding
- Audit trail: the research includes thorough documentation of all process decisions and research procedures, to enhance reliability of this research
- Reflexivity: the researcher maintained continuous self-analysis about personal involvement and possible biases throughout the research process.

Informed consent

Respondents were fully informed about the research purpose and received a written consent form (Appendix D) with a short description of the research, its goal and the privacy rules. All respondents signed the informed consent form to demonstrate their clear

understanding of information usage. Respondents received full freedom to participate in the research and had the right to leave the research at any point without facing any negative consequences.

All data is protected through anonymization, securely stored and erased afterwards. All data handling procedures maintain the highest level of protection for participant privacy from the beginning of the research process till the end.

Results

Cultural sensitivity, challenges, values and religion

To examine the first research question, the following themes will be discussed: the definition of culturally sensitive mental health care, its challenges, cultural and religious values and religion versus superstition. That last theme was not specifically mentioned in the research question but arose from the answers as an important theme.

The definition and challenges of culturally sensitive mental health care

None of the respondents fully understood the term culturally sensitive mental health care without further explanation. When they were told that the cultural context determines how psychological distress manifests and which methods people choose to seek help (Kirmayer et al., 2000), all respondents stated that mental health care in Morocco differs significantly from Western contexts. A respondent from Agadir explained: *"Okay so I think as a Moroccan, they do not think mental health is important, so they don't give it much value. This is a problem, because Morocco has a lot of people are sick because of the neglecting of mental health. That's something that should be different you know, it should be educated, that is important. Cultural people that are sick will go to the imam. If they see someone that is sick, they will just go to the imam and they say oh that guy, probably someone did magic to him. The imam is going to read the Quran and then it is good. But it's not, it's not, it's not that*."

All other respondents similarly emphasized the importance of religion in Moroccan mental health care, including consulting imams, using religious practices and reading the Quran. Another frequently mentioned theme was the difference between older and younger generations in attitudes toward seeking mental health care. A respondent from Marrakech stated: "*The older they are, the harder it is to get along in this specific topic, because they have a different mentality than we do. They don't necessarily respect privacy and the boundaries, so they try to pull you into their traditions, and you end up not being comfortable,*

whether it is with them or with yourself." Another respondent from Marrakech added that this generational gap persists because older generations are difficult to convince: "*So like, it's so hard to try to convince them. If we're going to convince the youth, they are already convinced, now there's social media, we see a lot of things there, we can learn a lot of things there, but in the old generations, they didn't have social media, they didn't have smartphones or whatever, they can't see those things or hear about those things."*. When reflecting on their education, respondents reported limited training in traditional approaches. A respondent from Rabat stated: "*My teachers always say that we should separate between our culture and our ideology from the psychology. But when I'm in the observation internship, I see the opposite of what our teachers say. For example, here in Morocco, we believe, people believe in Ghosts. And here I saw how culture and mental health, how culture influenced people's mental health."*. Most respondents agreed that their education insufficiently prepared them to address traditional beliefs in practice.

When initially asked about culturally sensitive mental health care, many respondents stated that everyone should be treated the same way. A respondent from Marrakech said: *"No, no, no, everyone should be treated the same way, because the mental health is one thing. We don't, it doesn't relate to culture."*. After carefully repeating a broader definition, respondents reconsidered this view. The same respondent added: *"I would not treat everyone the same way, like in a good way, in a like understanding way."*. This shift in perspective was observed among multiple respondents.

When asked about the challenges the respondents saw to ensure that the mental health care was culturally sensitive, by far, most of them mentioned education and the mindset of the older generation. Almost all the respondents said that they think education about mental health should start earlier in high school or even in middle school. Also often mentioned was that in their eyes, some teachers were not qualified enough and did not give them all the information about mental health that seemed to be important.

Other challenges they foresee, were the illiterate population of Morocco, the accessibility of mental health care especially in the rural areas and the language. A respondent from Rabat stated: *"Language. I think about it a lot in the context of sex education in Morocco. We can either do it in French, which doesn't feel authentic, or in classical Arabic, which feels... Again, it's not authentic because our dialect is a language. It shouldn't be considered a dialect. It's Darija. It's a mix of a lot of things. And if we could explain mental health and have, I don't know, content about it or classes on it in Darija, perfectly tailored for*

either young people or old people, that's going to be good. But language could be an obstacle and the pre-constructs that people have right now, I think is the first obstacle."

Another obstacle they mentioned was the many different cultures in Morocco, which can make it difficult to adapt the mental health to a suitable culture. A respondent from Rabat said: *"There are a lot of different cultures here. They are Hassan here, they are Arab, they are Amazigh.. and you should make Amazigh is not the same culture as here. That's why you should be intelligent to mix it and to be flexible to all cultures."*. This point was made by multiple respondents from either Agadir, Rabat or Marrakech.

Overall respondents reported mixed feelings toward culturally sensitive mental health care. Some showed their enthusiasm and trust, but there was also serious doubt. The most mentioned challenges were the quality of education, the beliefs of the older generation, language barriers and the accessibility of mental health care.

Most important cultural and religious values

To investigate the subject more thoroughly, respondents were asked what cultural and religious values they believed were critical to include in mental health care. They all reported that religion was the most important one. Besides that, most of them spoke about community and family. For instance, one respondent from Rabat said: *"The first one that comes to mind is the importance, the value of parents, the relationship between children and their parents. In Morocco and I think most Muslim cultures- if you have a toxic parent in most cultures- the advice would be to just yeah, cut them off. Don't talk to them. And I know that's probably for the best, but I think in Morocco and similar cultures, there should be workarounds, before getting to that point. Maybe limit, setting boundaries at best, rather than cutting off a toxic parent, for example, because parents are sacred."*. This point was made by multiple respondents. Other cultural values that were mentioned were the importance of language, the wide variety of cultures in Morocco and the traditional way of living in the rural areas of Morocco.

Religion versus superstition

When asked about important religious values, a dichotomy arose. The theme religion versus superstition was brought to the attention. Religious values that were mentioned often were 'living by the rules of the Quran', 'djinn' and 'Ruqia'. The most mentioned superstitions values were 'black magic', 'the evil eye', 'possession' and 'Ruqia'. To investigate where the difference between religion and superstition is located, respondents were asked to explain

what falls under religion and what is superstition in their opinion. A respondent from Rabat says about that: "*I would say, for example, like... Ruqia is always really related, mostly related to people that are dealing with a superstitious thing, like djinn that have the evil eye. That's why most people go a lot of times, it can help in the sense that it will make the symptoms of, for example, hallucinations or episodes, you have some manic episode, less severe, but it's not helping*.". When asked where he sees the deviation, he said: *"Yeah, I would say the line isn't as, well-defined as I would hope. And I think that is the challenge. Just making clear lines between those two things. So, for me, I see a very, I see a very vague line. For example, seeking guidance from an imam, for example, about the problem that you are dealing with I would say, feeling a deep sadness, you consult an imam. And the imam tells you, maybe you should do this in the prayer, like recite this surah, or this dhikr. That's the culturally thing for me. A superstitious thing would be going to imam and saying, there is, for example, a djinn that is watching me all the time. Or I feel nothing is working in my life. I think that there is someone has a bad eye or evil eye.".* Most of the respondents had a similar observation and said religion and superstition were two separate things. A respondent from Marrakech said: "*Like for me, religion doesn't have a big connection of tradition. No. For me, traditional ways, it's just like the old ways that they were used in the past. But for me, because the Quran is not a traditional thing, it's a religion that we respect, that we use, the faith in our heart is the most important thing. And it does heal in a way or another. So, for me, the spiritual things, like it started to being benched like here in Morocco like they started like know that it's just nonsense.".*

Nobody mentioned that the evil eye, or black magic fell under religion. For Ruqia, demons, and djinn, the opinions were divided and often the context of the beliefs were crucial to decide whether it was seen as religion or superstition.

Views on stigma, imams and rural area's

To examine the second research question, the following themes will be discussed: stigma, community leaders and imams, and challenges in rural areas. As the rural areas are in a lot of aspects quite different from the cities, it was found necessary to investigate that region as well and its unique challenges.

Mental health stigma

When asked about their own experience with mental health stigma, all the respondents had concrete examples. They reported interactions in which they were called crazy, possessed

or in general misunderstood whenever they said that they were studying psychology. A respondent from Marrakech said: *"At first my family was against it. And since I was already studying philosophy before psychology, and they kept telling me, why would you want to work with crazy people? They think that the direction I'm taking is just not good. And not useful. Because of tradition. They keep telling me, study more about religion, study more about Arabic. You don't need to go and seek further education somewhere else. That isn't ours."*. Most respondents had similar stories about their interactions with the older generation. However, more positive attitudes towards mental health were experienced with peers or even with the older generation after more explanation. The same respondent continued: *"With time, I kept explaining to my parents over and over until they became more and more understanding. And I explained that I'm not treating crazy people. I'm helping people to not become crazy. I could help kids with autism and help them avoid places that would make them uncomfortable and stunt their growth. And even distant family, when they ask, "Why did your daughter start studying psychology, and why is she doing it?" My parents start explaining it to relatives. And with time, everyone just became more and more understanding."*.

Almost all the respondents reported that education, or informative interactions can help reduce the stigma or have already done that. A respondent from Rabat said: *"It will help reduce the stigma, 100%, and I see the difference because in the radio stations and in the television, we did a lot of programs that talk about mental health and how people should go to psychologists, and they shouldn't just accept the suffering. And people now, they are really sensitive about this matter. They know that people sometimes need help, different help, different than talking to someone. You need a professional to help you."*. Part of the respondents agreed and noted that there is already a lot of awareness now. The other part said that education is still lacking a lot of mental health information. A respondent from Agadir explained what should be added in the education nowadays: *"Education is really important in this, so for example we are going to explain for someone in our ages that physical illness can provoke a mental illness when you are going to study for a long time, that will stress you, this is related to mental illness. So, it's not limited to magic or something horrible, it's more like a physiological thing. If you put that in the education, it will reduce the stigma."*.

Summing up, all respondents showed multiple examples of encounters with mental health stigma. Nevertheless, most of them also reported that the newer generation is already changing and that they see possibilities to inform their surroundings about mental health. Education or other informative interactions are seen as the biggest factor in reducing mental health stigma.

The role of community leaders and imams

To investigate the current influences on mental health and mental health stigma, community leaders and imams seemed to play an important role. All respondents reported the importance and influence the imams have on the Moroccan society. What kind of information imams give in their prayer varied per respondent. Some respondents said that imams don't ever talk about mental health, like this respondent from Agadir: *"No. imams don't speak about mental health, mental issues. They speak just about rules, etc."*. Most respondents said that some imams are a bit more educated and mention mental health on occasion, but they also mentioned that it's limited and should be improved. A respondent from Agadir explains why he thinks it's important to educate people via imams: *"Traditional people believe the imam more than anyone else. There is a saying in Morocco: ask the experienced, do not ask the doctor. In reality it's, ask the experienced but do not forget about the doctor! But you know it's a saying. A lot of traditional people, they neglect the doctor completely. And then go with the experienced people that causes problems too. I think we should educate people more."* This thought, including the imams in the education of the population about mental health, is funded by some other respondents who perceived an active role for the imams. A respondent from Marrakech elaborates: "*I believe the role of the imam is to make the community seek the world being in many forms. And in Morocco, we have like a study that said that every Moroccan have a mental health issue, you know. So now it's not a luxury to talk about mental health. It's a must and people are suffering. And the imam has this power to make people like see and trust to go to see some professional help. The imam has a lot of influence, because people listen to them like every once a week. So, this is an opportunity to make, make them see things as they should.*".

Not all the respondents agreed with this, a respondent from Agadir thought that imams have a big role in society but didn't think they should say anything about mental illnesses: *"I do not think that an imam has a role in healing mental illness. But in society people do believe that the role of imam is really important. When you are feeling stressed or depressed and you didn't know about that, people will tell you you look strange you are not okay, so you should read some Quran, you should do something else. But I think you should not associate the both of them."* Approximately half of the respondents agree with this point.

When asked about the possibility to have imams included in mental health education, a respondent from Rabat says: *"I don't, I'm just, I'm out of words because I don't think if that's possible ever……. If we could have imams, educated on mental health and have them include that in their speeches, that would be too good. I don't know if that's possible, if that's doable,*

but that definitely would be great because they do have a big a big impact on their followers.". This seems to be the tenancy of most of the answers.

When asked about community leaders and their perceived role, most respondents said that they were only prevalent in the rural areas and that they did not have a clear idea about their role. A respondent from Agadir said: *"They have a big role, especially for rural areas now that they have no internet or media. In the mountains they're going to do a big difference because like this is the only people that they talk to. They don't even have doctors. If you educate people, they are going to do a big difference in these areas."*. Even though there seems to be a less clear view on what the role of community leaders is, most respondents were more positive towards the possibility to include them in mental health education. Another respondent from Rabat said: "*Community leaders, that, yeah, community leaders would be different communities. Yes, we should. We should educate the people with influence, like mental leaders, and then they can do the job. That's doable and ideal.*".

Altogether, the idea that imams should be included in metal health education was seen as positive but hard to reach by most of the respondents. The inclusion of community leaders showed more potential.

Challenges of rural areas

To investigate stigma and the influence of imams further, rural area's form an important focus. With its unique characteristics, unique challenges to mental health can emerge. Community outreach and accessibility of mental health care seem to be the biggest problem in the rural areas of Morocco. A respondent from Agadir described the situation: *"There is people in the mountains in Morocco that don't know anything about mental health. They maybe know about it, but they don't give it a value. Even if we give them the knowledge and they want us to treat them, we still have so many difficulties like transportation and also like they cannot leave their houses and everything."*. Another respondent from Rabat elaborated on this point by saying: *"And the thing is, people in rural areas don't have accessibility to a lot of things. So, I would say good water, electricity, the basics. So, a lot of people don't have even the time or energy to think about their mental health because they're thinking they're more concerned about like the basics needs."*. Another respondent from Rabat who has been there herself, had quite the same opinion: *"They have more other struggles that they are facing, poverty and other things. I went to a place that you can't even see in Google Maps, and they don't even know whereabouts. You can't even talk to them about mental health. No, they have no idea."*.

When asked how they can be reached, most respondents admit that they don't really know how. A respondent from Marrakech said: *"It takes one person to be aware of it, for the group to become more aware of it. So that if there's one person in the village that has a way to learn about it. It would help the entire village."*

Overall, most respondents seem to agree that current living conditions of people in rural areas might cause a problem to implement culturally sensitive mental health care.

Views on incorporating traditional healing practices with modern mental health care

To examine the third research question, the following themes will be discussed: integrating methods and challenges when integrating methods. When investigating the respondents' views about the possibilities of integrating methods, the possible challenges they predicted are reviewed as well.

Integrating methods

When the possibility to combine between the traditional healing methods and modern mental health care was proposed, most of the respondents reacted negatively at first. A respondent from Agadir said that she doesn't think it will improve the overall mental health in Morocco: "*It's going to make it worse. Because, as I told you, it's two ways, one is going forth and one is going back. So, we can't do this. It needs to be separate. If someone want to heal with the traditional way, go ahead. If someone believes that he can get better with the new methods, go ahead. So, we cannot just make them together."*. Other respondents were less outspoken but also had their doubts. After asked how they would handle some specific situations, respondents showed nuances. A respondent from Marrakech said: *"It depends on the patient. If he really believes in those traditional ways, we can combine and go progressively. We can help him by traditional ways and progressively starting a modern treatment.*". The same approach was mentioned by multiple respondents. Adding to this, a respondent from Rabat said that a combination will only work for some illnesses: "*Not all the diseases. For example, let's talk about schizophrenia. Is it not possible to combine psychological interventional approach with the traditional practices, it's not. Or even, for example, paranoia, bipolar, it's not. Not all of mental disorder can be treatable. But just a few of them. I can combine anti-personality disorders. Because it requires ethics. You see, because people with antisocial personality disorders have no ethics, no empathy. So that's why we may integrate religions to raise or to improve empathy and ethics in such people.".*

Some respondents were immediately positive about integrating methods. A respondent from Marrakech said: "*I believe they will go hand in hand. When the patient believes something that's going to help him, like herbal stuff or special stuff, it's a good thing. And you're going to combine this kind of belief on this kind of stuff with the modern and logical science, because it's going to help them because sometimes even the belief is not enough.".* Another respondent from Agadir agreed with this point and added the following: "*So the doctor and the Islam is something, they are both strong. So, if you take them both and combine it will work very well. It will make a huge difference.".*

Only a couple of respondents continued to have negative thoughts about the integration, also after being asked how to reach the Moroccan society or how to handle some specific situations. A respondent from Rabat said: "*I think the mental health care would improve by sticking to the modern scientific way.*". Another respondent goes a bit further and explains how she will show them how going to the imam doesn't improve anything: "*I'm going to just make him go to the psychologist and make him take treatments and then he's getting better. And once I will tell him to go to the traditional methods, so the traditional methods for us is the Imam. He's using his ways to help people with mental illness, and he is going to hit him in the name of healing. Then he sees he is already some steps forward towards modern treatment.".*

Overall, students reported mixed opinions about the possibility and benefits of integrating methods of mental health care. Their initial answers were quite strict, but after some follow up questions about how they would treat traditional thinking patients, they showed nuances.

Challenges when integrating methods of mental health care

When asked about the possible challenges when integrating methods of mental health care, respondents both mentioned about the same number of times, either 'the older generation' or 'the younger generation' as a challenge. About the older generation a respondent from Agadir said: "*It is hard, when you take someone from the town, an old one who is very religious. He got his religion from his father and he from his grandfather. When you take him to the city to a doctor and they talk about science, he will not easily take it. When you mix the modern way with his tradition it will be difficult.".* Half of the respondents agree with this point. Other respondents argue that the mindset of the younger generation and their beliefs in modern psychology methods might form an obstacle. A respondent from Rabat said: "*One challenge that comes to mind could be it could deprive psychology of its or*

therapy of its scientific. That's where we've been trying for so hard to claim because yeah, there is this stigma around psychology to be not rigid enough in research. And if you add to it other aspects it would lessen the scientific. Especially that you wouldn't be able to properly verify the traditional methods in a, for example, in a therapy session, if they helped and how, is this quantifiable? Can you reproduce it later? Is it, it's too individual, maybe.".

Building onto the mindset and the beliefs of the younger generation, another often mentioned obstacle is the education the younger generation has had. Most of them said that they don't feel comfortable treating people according to the traditional standards, because they haven't been educated to do so. A respondent from Agadir said: "*We have a background, but we need to know the other cultural way, because I know Ruqia and somethings like this. We know a lot of things but there are other things the patients use that we don't know.*". Some respondents agreed with this and said that their teachers taught them some things about traditional healing methods, but it was never fully included in the curriculum.

Ideas about the future

To examine the fourth research question, the following themes will be discussed: challenges in the future, needs for change and their own contribution. To form a comprehensive understanding of the respondents' ideas about the future, next to challenges and things that need to change, their possible own contribution forms an important theme as well.

Challenges in the future

When questioned about potential challenges they may face as future mental health professionals, most respondents indicated that convincing patients (to engage in treatment) would be a major challenge. A respondent from Marrakech said: "*As I said, people blindly believe in those thoughts. So, it's going to be hard to convince them to get modern treatments."*. A respondent from Agadir goes a bit further by saying that you should also educate the family, before you will see any beneficial effects: "*I think again you know not enough people are educated so everyone that comes, it will start from the beginning. Educate them how important mental health is, what we do to you in this hospital, we try to help you, you gotta educate the patient and you also have to educate the family. Because the family is uneducated as well. If the family is not good with it, the patient will not be okay as well and that causes a problem too. The public always criticizes, so we got to fix that too. I think that's a problem."*.

Another challenge that was mentioned multiple times was the difficulty of knowing their own position. A respondent from Rabat says about this: "*It's a challenge for me to make peace with my culture, be at peace with my own culture, because you would find a lot of younger people, maybe even older people who have this love-hate relationship with Morocco, with their culture, with their religion. And I think that if you're going to be a mental health professional, the first step would be to, if not accept your culture, at least put your issues with it aside when dealing with patients*."

Most answers were in line with the ones mentioned above. One student did not really predict any big challenges in the future and said the following: *"So, I believe even the cultural sensitivity is going to be less in the future because somehow, we are making people the same in the way of thinking, the way of living the life, you know. So, I believe it's going to be like a worldwide, kind of how we suffer. It's going to be like similar whenever you go, even in America."*.

In short, most respondents predicted to have difficulties in the future with convincing their patients to receive treatment and deciding on what kind of treatment would be suitable to give.

Needs for change

Having the challenges in mind, possible changes for the future are investigated. When asked what needs to change to be better prepared for these cultural complexities in mental health care, education was mentioned the most. A respondent from Agadir said about that: "*We have university and we have psychology, but it's very limited. So, people do the study here in Morocco and to finish they go to Europe or America. But when they come back, they are so far away from the traditions and culture here. What they study in Europe is good but does not work here. So, we have to start investing in better education here in Morocco and in our tradition and culture. Or after the full studies you can have extra information about the culture before you can start working in Morocco."*. The quality of the university and the fact that a lot of respondents go to Europe are topics that were mentioned often. Adding to this, a lot of respondents said that they think it would be better to start mental health education at a younger age. A respondent form Marrakech said: *"I always had in mind the idea that they should implement psychology and mental health in the educational system for kids. And that the teachers as well should be educated about the topic, no matter what they teach. Because if they are more aware of it, it would help the kids as well."*. This point was mentioned several times. Some respondents also talked about the importance of using psychoeducation with their

patients. A respondent from Agadir said: *"And the second thing is education. Maybe you should inform the patient that his illness is related with physical things, emotional things, and the magic does not play any role in this. But in a good way, to go step by step, it's all about taking time and a lot of patience."*.

A couple of respondents also said that education does not need to change. A respondent from Marrakech said: "*Yes, my teacher already discusses the fact that they are separate and that there is modern and the traditional. They are aware of the stigma, and they are working to identify them both. Our teacher actually explains to us and talks to us about the difference between both, gives us examples about the mental health problems. For example, he gives us examples, this is the mental problem that they have, and this is what they think it is. So, the education it's good that it is, as it is."*.

Imam participation and family inclusion were also mentioned a couple of times. Insurance coverage was mentioned more often. A respondent from Rabat said: *"No, psychology, no therapist is reimbursed by, for example, social security. You get that with psychiatrists…… That's a big issue, exactly, because psychologist sessions in Morocco are, they're considered a luxury. It's a bourgeois thing. It's 400-dirham, 500-dirham, half an hour in big cities. No one can afford that. Even rich people, they would be like, I'd rather go to the spa or something. Way out of reach, based on that, compared to the Moroccan income. So that's another issue to be considered. Yes, educating people would be good, but also making it available to them and reachable, not even available. That would be also very important."*.

Overall systematic changes such as the adjustment of the school curriculum, funding by the government for research and insurance coverage were often mentioned.

Thoughts about their own contribution

All the respondents described an active role for themselves in ensuring to improve the mental health care in Morocco. Different ideas about their own contribution were mentioned. Some respondents said that they don't think the study of psychology should be open for everybody. A couple of respondents wanted to implement tests beforehand to make sure that all the respondents are truly interested in psychology and not just want to fix themselves or their family or have very traditional thoughts about psychology. A respondent from Marrakech said: "*Well, in my experience, unfortunately, the psychology student, or the one who tends to do psychology, alleges like they want to be coaches and trying to go and heal people, or they have someone in the family want to help themselves. I believe in psychology is the most dangerous field, because I'm dealing with the persons in the deep dimension. So, you need to*

be passionate and to be really smart and you have the tool, like language tools. You have a lot of drive to understand how the human works, especially when it comes to the brain or the muscle, and in every way possible ..... I believe the first step is when you are going to psychology, you should ask yourself, why are you doing it? And are you given to do the, you need to work on the sacrifice to be a good one? Because that's, it's going to affect a lot of patients.".

Most of the respondents mentioned that they want to be more sensitive to the culture in their treatments. A respondent from Marrakech said: "*I should become more aware of the cultural traditions of the place that I am in. And that the cultural traditions differ from place to place. Like each different place in Morocco could have, for example, different traditions and different cultural ideas. And when you know about the cultural the traditions, you can either avoid them so that to not offend or heighten the reaction of the patient or try to adapt to it respectfully.".* Another step some respondents said they are willing to take is to try to convince an imam and set up a cooperation. A respondent from Agadir said: *"Maybe we need to talk with the imam, to help him to tell the patient that he has to take his medical treatment too, to be more better. So, it's a lie from the imam but it will help us."*.

Some other initiatives were mentioned; trying to add more cultural awareness to the curriculum of high schools, starting a podcast about mental health, posting on social media, and trying the educate their direct surroundings. The overall tendency of the answers was about their own active contribution to a more culturally sensitive way of providing mental health care.

To conclude, when talking about their own contribution, all respondents showed willingness to be part of the improvement of mental health care. Most of them want to treat culturally sensitive, by educating themselves about the traditions or by offering a collaboration with traditional healers to their patients.

Discussion

Although culturally sensitive mental health care has gained acknowledgement in recent years and is widely discussed in research, little is known about the stances of future mental health care professionals in Morocco. Earlier research in Morocco has mainly focused on traditional help-seeking methods and mental health stigma, rather than on the thoughts and opinions of psychology students who will be responsible for shaping future mental health care. Their views on mental health stigma reduction, the integration of traditional and modern

practices, accessibility of care and their own anticipated professional role form an important body of knowledge for understanding the future Moroccan mental health care landscape.

The findings show a complex and ambivalent pattern. A notable finding was the initial unfamiliarity with the term culturally sensitive mental health care itself. This was contrary to what was expected. When considered in light of the research from Kirmayer et al., (2000), this may indicate that culture is often present in an implicit way rather than as an explicit concept. Although respondents initially struggled to define the term, most were able to provide clear examples once it was explained. Cultural elements were described as being embedded in everyday mental health practices but seemed so normalized that they did not recognize it as a distinct concept. This might indicate that cultural sensitivity just exists in Morocco, without it being recognized as cultural sensitivity. Therefore, Western ideas about other regions should be critically evaluated, especially about their (lacking) attention to cultural sensitivity. This may represent yet another Western perspective on how other parts of the world should develop, potentially overlooking the needs, capacities, and preferences of local communities.

In line with what was expected, religion played a central role in respondents' narratives, although distinctions between religion and superstition varied. Most respondents identified themselves as practicing Muslims and agreed on the importance of the Quran and consulting an imam, while practices such as black magic and the evil eye were more often classified as superstition. Whether something was considered religious, depended largely on whether it was mentioned in the Quran and on the underlying reason for seeking help. These findings align with research from Hoffer (2024) describing superstition as a culturally meaningful explanatory model shaped by long-standing traditions that differ across communities, rather than as a single, uniform belief system.

Respondents reported experiences with internalized, public and institutional stigma (Corrigan & Penn., 1999), involving family, society, education and government funding. In line with the expectations and results of the earlier mentioned research from Fekih-Romdhane et al., (2023), the ongoing prevalence of stigma was notable. About that, transcultural psychologist Khalid Torki proposed that being stigmatized as 'being possessed', instead of suffering from a mental illness, can benefit the patients because they reduce feelings of guilt or responsibility. However, most respondents reported experiencing less stigma in contact with the younger generation and educated people. As expected, education and familiarity with mental health were repeatedly identified as the most important factors in reducing stigma, not only through formal schooling but also through peers and family. Many respondents

expressed a willingness to educate their surroundings. By doing so, respondents seemed to be willing to take the role of ‘cultural mediators’, a term Patel et al., (2018) mentioned for people who may play an active role in reducing stigma.

On the contrary to what was expected, attitudes towards integrating traditional and modern psychological methods were initially mixed. Some respondents expressed concern about losing scientific legitimacy. This is in line with what Schultz et al. (2024) explained in their research by saying that the field of mental health is structurally vulnerable because of the way it is built. Respondents felt that incorporating religious practices conflicted with their professional identity. Younger respondents, often newer to their education, tended to express more black-and-white positions and a strong desire to break with older ways of thinking. This reflects broader generational patterns worldwide, but also in Morocco (Wafqui et al., 2025). MAwebzine (2025) posed that the young generation demand increased mental health awareness and better education, funding and accessibility. These ideas might make Morocco better aware and thereby might improve the mental health care. On the other hand, traditional or culturally sensitive treatment is not mentioned in any plans of the youngsters in the article. Because of the way this young generation distances themselves from traditional treatment in a country where most of the population relies on this type of care (Arraji et al., 2024), this attitude might come across as recalcitrant or even a bit exclusive. Older or more experienced respondents, as well as those who were not practicing Muslims, generally expressed more nuanced and open attitudes. As interviews progressed, many initially rigid views became more balanced when respondents discussed concrete patient situations.

A potential way of bridging traditional and modern approaches emerged through the stepped care method (Bower, & Gilbody., 2005). Respondents described how allowing patients to initially seek help through religious practices, like going to an imam, might lower treatment intensity and trust barriers, while gradually introducing evidence-based methods. Some respondents also expressed openness to potential placebo effects contributing positively to treatment outcomes. Educating imams about modern mental health and including them in culturally sensitive treatment seemed to be unreachable for most respondents. A collaboration with community leaders in rural area’s was more likely to succeed according to the respondents.

In line with what was expected, when discussing their future professional roles, all respondents envisioned an active contribution to a more inclusive mental health system, despite earlier hesitations. Respondents appeared more open to cultural integration when thinking about specific patients rather than abstract professional ideals. This could be an

example of the Construal Level Theory by Trope and Liberman (2010). These authors stated that people find it easier to form abstract thoughts about general and hypothetical situations. These abstract thoughts often lead to rigid and ideological judgements. About specific situations nearby on the other hand, people are often more concrete and nuanced, which leads to context-sensitive considerations. These differences in first raw opinions and secondar nuanced opinions about specific versus general situations were clearly notable in the data. Uncertainty about professional boundaries and appropriate treatment choices was common, particularly among younger respondents. According to Eraut (2004) uncertainties like these reflect normal developmental doubts at the start of a career rather than a lack of competence.

Structural barriers such as limited funding, insufficient education and lack of policy support were repeatedly identified as major obstacles following the expectation and earlier discussed research (Kirmayer et al., 2000; Schultz et al., 2024). Although respondents expressed motivation and ideas for improvement, they often lacked opportunities to translate these into practice. A generational gap was described between younger, highly educated students, who were motivated and eager for change (Wafqui et al., 2025). In contrast, the older generation was less educated, had fewer resources, and often did not have the freedom during their upbringing to consider renewal (Arif et al., 2025). Despite their mutual dependence, these generations did not yet appear able to overcome these obstacles. The most mentioned conditions for improving mental health care were cultural training, financial support and collaboration with religious educators. Given the fact that nearly 50 % of the Moroccan population is expected to suffer from a psychological disorder during their lives (Morocco World News., 2024), respondents emphasized the need for governmental and public support to enable future professionals to meet growing mental health needs.

Strengths and limitations

Strengths of this research include being the first research to assess the attitudes of the future mental health professional in Morocco. As this respondent's group has not been heard about this topic before, it gives valuable new insights. Other strengths are the relatively large qualitative sample, the inclusion of respondents from different cities and educational stages, and the involvement of Moroccan professionals in the coding process. The safe interview setting and anonymity seemed to contribute to open and authentic responses.

Several limitations should be considered when interpreting these findings. Language barriers were present in all interviews. Some interviews required the use of translators. The interviews without translator were conducted in English, which was a non-native language for

the respondents. To limit possible misunderstandings as much as possible, the translators were other students with whom the respondents felt comfortable. Afterwards, the transcripts were checked by the translator to ensure that all information came across as accurate as can be. The cultural background of the researcher may also have influenced the data. To an outsider, people might give other information than to someone that feels a lot like themselves (Kirmayer et al., 2011). This was minimized by the researcher by explaining a bit about herself and this research beforehand. In addition, the researcher had a thorough preparation in which she made herself familiar with the culture and lived amongst Moroccans for a year. To double check whether the cultural interpretation of the researcher was correct, the coding was discussed with two Moroccan professionals.

Additionally, the focus on three large cities is specific. Urban populations tend to be more Westernized and educated which cannot be said about the rest of Morocco (Atia & Samlali., 2021). There is no specific evidence that the results indeed would have been different. However, future research that includes a more diverse sample is very much welcome. Given the fact that the researcher was on her own, had limited time and resources and did not speak the language, the focus on these cities was the highest achievable option for now.

Implications for research

A methodological recommendation for future research is to focus on other generations, people living outside of the big cities, people from other cultural backgrounds and people less familiar with psychology. For a deeper understanding of the data provided, it could be beneficial to conduct research using focus groups. Future research could for instance use the respondents from this research and ask them how they feel about the answers of the other respondents. Grouping their answers and setting up brainstorm groups for the respondents could give valuable information at the start of new research. Participants of these focus groups might be able to learn from each other and gather their strengths to make concrete plans. This might result in a more culturally sensitive mental health care system in Morocco.

Conclusion

Overall, this research showed that while the concept of culturally sensitive mental health care is often unfamiliar at an explicit level, its principles are implicitly recognized by Moroccan psychology students. Initial hesitation towards integrating traditional practices largely stemmed from uncertainties either about their own position or about the future impact

of the integration rather than rejection. When reflecting on concrete situations, respondents showed openness and enthusiasm to contribute to culturally sensitive care. All of them reported experiences with mental health stigma, but most of them also experienced more awareness about the importance of mental health care within the younger generation and within their informed surroundings. Improving education, accessibility and governmental support remain crucial for implementing mental health care that aligns with the cultural realities of Morocco.

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Appendix A

Frequency Distribution of Respondent Characteristics

Characteristic	N
Gender	
Female	13
Male	7
Age (years)	
18–20	10
21–25	4
26–30	3
31–35	3
Location	
Rabat	6
Marrakech	8
Agadir	6
Religious affiliation	
Practicing Muslim	18
Distanced from faith	2
Study year / Work status	
1st year	3
2nd year	4
3rd year	3
4th year	5
5th year	2
Working	3

Appendix B

Research Question

What are Moroccan psychology students' attitudes towards culturally sensitive approaches to mental health care and what are their perceptions of traditional and modern practices in the context of stigma and the accessibility of mental health care?

Sub-questions 1

Cultural Sensitivity: How do Moroccan psychology students define culturally sensitive mental health care, and what cultural elements do they consider most critical to include?

Interview questions

1: Understanding Cultural Sensitivity:

- How would you personally define culturally sensitive mental health care and do you have any experience with it?

2: Cultural Elements:

- Which cultural or religious values do you think are most important for mental health care practitioners in Morocco to understand and respect?

3: Barriers to Sensitivity:

- In your opinion, what are the biggest challenges to ensuring that mental health care in Morocco is culturally sensitive?

Sub-question 2

Addressing Stigma: How do these students think about the impact of education and community outreach on the reduction of mental health stigma?

Interview questions

4: Role of Education:

- Have you experienced any form of stigma and how do you think education about mental health could reduce stigma in Moroccan society?

5: Community Engagement:

- What role do you see community leaders, such as imams or local educators, playing in changing perceptions of mental health?

6: Challenges in Outreach:

- What do you think are the biggest obstacles to effective mental health education and outreach in Morocco?

Sub-question 3

Integration of Practices: What are their views on incorporating traditional healing practices with modern evidence-based health care?

Interview questions

7: Personal Views on Integration:

- How do you feel about combining traditional healing practices, like herbal remedies or spiritual rituals, with modern psychological therapy?

8: Effectiveness of Integration:

- Do you think integrating traditional practices with modern psychology can improve mental health outcomes in Morocco? Why or why not?

9: Potential Challenges:

- What challenges do you think might arise when trying to combine traditional healing methods with modern mental health care?

Su- question 4

Future Roles: What challenges and opportunities do they predict as future mental health practitioners in balancing traditional practices with Western evidence-based health care?

Interview questions

10: Future Challenges:

- What challenges do you think you will face as a mental health professional in balancing cultural traditions with modern psychology?

11: Opportunities for Innovation:

- How can psychology students like yourself contribute to creating innovative approaches that respect cultural traditions while advancing mental health care?

12: Preparing for the Role:

- What do you think needs to change in your current education or training to better prepare you for addressing these cultural complexities in mental health care?

Appendix C

Codebook for thematic coding

1. Definition in Morocco
    - **Definition:** description of how culturally sensitive mental healthcare is perceived, including the role of traditional and religious practices
    - **Subcodes:** Reading the Quran in therapy; Going to the imam; Old vs new generation; Financial situation
2. Experience with culturally sensitive mental health care
    - **Definition:** personal experience and observation with mental health care that fits cultural and religious backgrounds
    - **Subcodes:** Having other opinions than parents; Teachers teaching traditional; Teachers teaching modern
3. Thoughts about cultural sensitivity
    - **Definition:** all attitudes and opinions about the importance of cultural sensitivity in mental health care
    - **Subcodes:** Positive; Negative; Neutral
4. Cultural values
    - **Definition:** cultural aspects that influences stance, identity and care seeking behavior.
    - **Subcodes:** Family; Food; Living situation (rural vs cities); Community; Duty of Assistance; Language
5. Religious values
    - **Definition:** religious aspects that influences stance, identity and care seeking behavior.
    - **Subcodes:** Rules of the Quran; Position of the man and woman; Roqya; Djinn; Duty of Assistance;
6. Superstition
    - **Definition:** superstitious believes about mental health that are common in Morocco
    - **Subcodes:** Roqya; Evil eye, spirit; Divine retribution/punishment; Possession; Black magic; Message from God; Contamination
7. Challenges (general)
    - **Definition:** structural, social and generation bound obstacles that influences the adaptation of culturally sensitive mental health care.

- **Subcodes:** Mindset of the old generation; Mindset of the new generation; Accessibility of mental care; Language; Illiterate; Living situation; education; social media

8. Mental health stigma
    - **Definition:** personal and institutional forms of stigma, attitudes and misconceptions about mental health
    - **Subcodes:** Own experience: Being misunderstood, Being called crazy, Being called possessed; Opinion on education
9. Role of community leaders
    - **Definition:** influence of community leaders on the perception of mental health
    - **Subcodes:** Influence; Engagement in mental health; perceived role
10. Role of Imam
    - **Definition:** influence of imams on the perception of mental health
    - **Subcodes:** Influence; Engagement in mental health; perceived role
11. Rural-area challenges
    - **Definition:** challenges in rural areas that can influence the accessibility, knowledge and attitudes about mental health
    - **Subcodes:** Accessibility of rural areas; Ways of living; Beliefs; Lack of social media/connection; Illiterate;
12. Thoughts about integration (modern & traditional)
    - **Definition:** thoughts about the integration of modern and traditional practices
    - **Subcodes:** Positive; Negative; Neutral
13. Does integration improve the overall mental health care?
    - **Definition:** perceptions about the effectivity and outcome of using culturally sensitive mental health care
    - **Subcodes:** Yes; No; Partly
14. Challenges when combining
    - **Definition:** practical and cultural barriers when trying to combinate between the modern and traditional practices
    - **Subcodes:** Older generation resisting new methods; Younger generation resisting traditional methods

15. Future challenges when combining
    - **Definition:** future challenges when trying to combine between the modern and traditional practices
    - **Subcodes:** Difficult to know own position; Difficult to convince people
16. Thoughts about own contribution to innovation
    - **Definition:** thoughts about their own position and role in contribution to new approaches to mental health care
    - **Subcodes:** Active; Passive
17. What needs to change (for better preparation)
    - **Definition:** improvement in the current education or training to be better prepared for addressing cultural complexities in mental health care
    - **Subcodes:** Education; Family inclusion; Social media; Imam participation; Mental health insurance coverage; Accessibility, incl. rural areas

Codebook for indictive coding

18. Challenges
    - **Definition:** structural, social and generation bound obstacles that influences the adaptation of culturally sensitive mental health care.
    - **Subcodes:** Many different cultures; No challenges; Not enough research; No differentiation in illnesses; No value to mental health
19. Religion vs superstation
    - Definition: what falls under religion (Muslim) and what is superstation

Appendix D

Consent Form

Effective Mental Health Care in Morocco: A Glimpse into the Future by Moroccan Psychology Students

Date:

Researcher: Else Valentine Harland

Thesis Advisor: Paul Kocken

Independent Reviewer: Özgül Uysal-Bozkir

Introduction

Dear Participant,

My name is Else Valentine Harland, and I am conducting research for my Master's thesis in Clinical Psychology at Erasmus University Rotterdam. This research aims to explore the perspectives of Moroccan psychology students regarding the integration of traditional healing practices with modern psychological methods in mental health care. Your participation will help contribute to a better understanding of culturally sensitive mental health practices in Morocco.

If at any point you have questions, concerns, or require clarification, please feel free to ask. Participation is entirely voluntary, and you may withdraw at any time without providing an explanation.

Purpose of the Research

This research investigates how Moroccan psychology students perceive culturally sensitive mental health care, focusing on integrating traditional and modern practices while addressing stigma and accessibility challenges.

Why You Have Been Invited to Participate

You have been invited to participate because you are a (psychology) student enrolled at a university either in Agadir, Marrakech, Casablanca or Rabat. Your perspectives are essential for understanding how future mental health professionals navigate cultural and systemic complexities in Morocco.

What to Expect

If you choose to participate, you will take part in:

- A Semi-Structured Interview: This will involve open-ended questions about your views on mental health care, cultural sensitivity, and stigma in Morocco. The interview will last approximately 60 minutes and will be audio-recorded for transcription and analysis.

All data collected will be anonymized to protect your identity, and no identifying information will be published.

Voluntary Participation

Participation in this research is entirely voluntary. You are free to withdraw from the research at any time without any consequences. If you choose to withdraw, any data collected from you will be deleted unless it has already been anonymized.

Potential Risks and Benefits

Risks:

- Some questions may evoke emotional discomfort as they address sensitive topics like mental health stigma or traditional practices.
- Support will be available should you feel distressed during or after the interview.

Benefits:

- While there is no direct benefit to you, your participation will contribute to the development of culturally sensitive mental health practices in Morocco, benefiting future professionals and communities.

Confidentiality and Data Use

All data will be anonymized, securely stored, and only accessible to the research team. Your name and other identifying details will not appear in any publication. Data will be retained for 10 years following the completion of the research to allow for research verification.

If you consent, anonymized data may also be used for future educational or research purposes. Any direct quotes used in publications will only be included with your explicit permission.

Compensation

Respondents will receive a little gift as a token of appreciation for their time.

Questions and Contact Information

If you have any questions about this research or your rights as a participant, please contact:

- Researcher: Else Valentine Harland

Email: elsevalentine@hotmail.com

Phone (only whatsapp): 0031645358670

Consent

By signing this form, I confirm that:

1. I have read and understood the information provided about the research.
2. I voluntarily agree to participate in this research.
3. I consent to the audio recording of the interview.
4. I understand that my data will be anonymized and securely stored.
5. I understand that I can withdraw from the research at any time.

Optional:

☐ I consent to my anonymized data being used for future research.

☐ I consent to direct quotes being used in publications without identifying me.

Participant's Name: _____

Participant's Signature: _____

Date: _____

Researcher's Signature: _____

Date: _____