Religious Mosque Leaders (Khateebs): Awareness, Perceptions, Practices and Attitude towards Mental Health, Riyadh Region, Saudi Arabia

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Authors' contributions

This work was carried out in collaboration among all authors. All the authors managed the study, performed the statistical analysis and wrote the protocol. Author NAQ wrote the first draft of this manuscript and revised it once. All authors managed the literature searches. All authors read and approved the final manuscript.

Original Research Article

ABSTRACT

Background: Mosques are the most holy places in the eyes of Allah-Exalted and Glorified, and the religious mosque leaders (Khateebs) who read 15-20 minutes Khutbah prior to Friday Prayers have great knowledge in religion of Islam and are considered the peace-building leaders through delivering the pertinent Friday sermons around the world.
Objective: This online consenting cross-sectional survey explored the mental health awareness, perceptions, attitudes and practices of Khateebs of Riyadh region, Saudi Arabia.
Methods: This survey used 14-items self-designed culturally competitive questionnaire and sociodemographic proforma to tap religious mosque leaders' knowledge, perceptions, practices and attitude towards mental health.

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Results: Majority of mosque leaders were middle aged with higher education and extensive experience as a model of true interlocutor (Khateeb). Their knowledge and practices revealed were replete with religious and spiritual healing approaches but religious mosque leaders did not completely overlook the role of psychiatric medications and mental health professionals in the management of mentally ill persons. However, religious mosque leaders showed some negative attitudes towards patients with mental disorders, and recommended 10 corrective guides including integration of mosques and religious leaders into mental health system.

Conclusion: Despite mosque leader's good mental health literacy, they need further training to plug certain loopholes traced in their mental health literacy. Researchers should conduct further similar research overcoming the caveats of this survey not only in Saudi Arabia but also globally in Muslim world.

1. INTRODUCTION

Mosques linked with faith-related education and sermons are the most sacred places of our Allah (He-Exalted and Glorified), and Islam based on Quranic stance guides Muslims to pray five times in mosques and other religious practices for better public mental health around the world [1,2]. The Friday prayer (Noon, Zuhr) has special meaning and is the most important prayer of the week. Mosque religious leaders (Khateebs) deliver sermons on diverse subjects including physical diseases (PDs) and mental health (MH) conditions linked with the well-beings of Muslims around the world [3-7]. In addition, Friday has special meanings and values to Muslims worldwide. Of note, on Friday Allah's actions include creation of Prophet Adam (PBUH), the resurrection of all people for judging their deeds; acceptance of supplications of congregants between Friday (Zuhr) and evening (Magrib) prayers, and mitigation of peoples' sins of the past one week. Furthermore, Friday (Jummah) is a feast day for Muslims as Christians and Jews consider Saturday and Sunday their feast days, respectively. The gates of Heaven remain open on Friday only. Reciting noble Salawat (Darood Sharif) prior and after Jummah prayers ensures solution of all the problems congregants have in their life. Friday is one of the chapters (Surahs) of Holy Quran and after Friday prayer, people stay in mosques for reading Surah Al-Kahf (The Cave) for asking His unlimited bounties. Similarly, religious mosque leaders (RMLs) deliver highly important sermons on two major Muslim festivals, Eid al-Fitr and Eid al-Adha. In addition, Imams who regularly lead the five prayers with the exception to Friday prayer tend to preach Muslim congregants in the mosques after prayers. Imams also read specific Prophet Hadiths after prayers and, hence, mosque goers listen to the nicest religious and health messages. Furthermore, Imams often invite well known Islamic religious scholars from mosque organizations to preach public attending prayers in their mosques [1,5-7]. On such occasions, public often consult RMLs and imams about their diverse personal or family problems including mental and physical conditions. Do these RMLs have sufficient awareness about MH illness, and how they address MH problems when they are consulted in mosque congregations, on television and social media? These queries are the core components of this online research.

Islam is the second largest religion for propagating peace and wellbeing of people in the world. Evidently, huge pertinent literature is available about diverse functions and roles of Islam including theological, geopolitical, traditional and modern medical practices, conceptions, health interventions given in mosques, emphasis on prayers and other religious Quranic practices, and prevention of physical and mental diseases [4,8-16] that these RMLs often address in their Friday sermons across the world. The RMLs have in-depth knowledge in the Holy Quran, Hadiths of Prophet Mohammed (Peace be upon him) and other religious scripture and possibly the holy books of other major religions that can be assessed by using Islamic religiosity scales [17-20]. Of note, Imams and Khateeb have multiple mental health literacy (MHL) sources for enhancing their knowledge, perceptions and attitudes towards MH for increasing well-beings of Muslim communities around the world [21]. An extensive search of Google Scholar concerning Imams and Khateebs awareness of MH and MHL retrieved huge literature, specifically about religion of Islam, Imams and mosques [8-16,21-24]. To our knowledge, unlike Imams no study has explored the awareness of MH among Khateebs in Saudi Arabia, and probably elsewhere in the Muslim

world. Therefore, we chose only Khateebs for this pilot research, and Khateebs are those who give sermons before leading Friday prayers in mosques, and do have great knowledge of Islam, the holy Quran, Shariya and Hadiths of prophet Mohammed (PBUH). The relevance of this online survey is that it will identify the MHL among RMLs, and will provide guide how to increase their knowledge, perceptions, and attitudes towards MH, and, thereafter, engaging them in delivering religious and spiritual health service in a holistic way. The significance of this research is that it is first of its kind in Saudi Arabia and may provide relevant data to MH policy makers as to how enhance MHL of RMLs and utilize their faith-based MHL in MH settings including mosques that will influence public wellbeing at large and promote mental health of congregants.

1.1 Aim of the Study

The objective of this pilot study was to assess the awareness, perceptions, and attitude of Khateebs towards MH conditions, and how they consult and provide solutions for those congregants who put forward their MH problems either within or outside the mosques. The hypothesis of this pilot study is that Khateebs may have relatively good MHL but with some knowledge and attitudinal gaps.

2. METHODS

2.1 Setting

The National Center for Mental Health Promotion (NCMHP) and Ministry of Islamic Affairs, Call and Guidance (MIACG), Riyadh, collaborated for finalizing and conducting this research only in Riyadh region.

2.2 Design and Participants

It is a cross-sectional consenting online survey that included only Saudi Khateebs who lead Friday prayers in Riyadh region. There is no non-Saudi RMLs in Saudi Arabia. One thousand and five hundred official Khateebs in Riyadh region were invited to participate in this study.

2.3 Exclusion and Inclusion Criteria

The primary inclusion criterion was Islamic religious mosque leaders (Khateebs) who regularly lead Friday prayers in mosques of Riyadh region. Another inclusion criterion was that the participant resides in Riyadh region. Of note, all Khateebs have great understanding of

Arabic language (read, write and interpret). The main exclusion criterion was age below 20 and above 60 years.

2.4 Designing the Questionnaire

First, the relevant literature was searched and retrieved important articles [17-20,25-27] were reviewed extensively by two authors. Then, the questionnaire was designed in Arabic language by three experts according to the survey objectives and concerned information in the retrieved articles. The questionnaire was based on semi "mixed model" [25,26] in terms of closed ended questions with 'yes' or 'no' answers and open ended questions with or without Likert scale. In fact, mixed model questionnaire provides larger space to participants for expressing their knowledge, perception, attitude, and practice compatible with the asked questions and take reasonable time to complete the questionnaire which depend on multiple factors [28]. Overall mixed model represents quantitative and qualitative dimensions; the latter method includes focus group and in-depth interviews which were not part of our survey. We simply used some open-ended probes. Concerning participants' suggestions or recommendations only, we did thematic analysis and included those themes which were saturated and no new theme was emerging. All the three experts agreed upon all the questions without any discrepancy. The 14-item questionnaire along with sociodemographic proforma were scientifically and linguistically reviewed by an internal scientific committee in consultation with a specialized healthcare team to ensure it is reliable, culturally competitive and easily useable among Khateebs. However, it would have been better to assess the validity and reliability, the latter in terms of Cronbach's alpha that reflects internal consistency of a questionnaire; all this would require an independent study which is beyond the scope of this pilot study. This questionnaire takes about 20 minutes for completion.

2.5 Data Collection

The National Center for Promotion of Mental Health emailed the self-designed consenting questionnaire link to the Ministry of Islamic Affairs, Call and Guidance (MIACG), Riyadh on August 21, 2019. Both the self-designed 14-item questionnaire and semistructured sociodemographic (SD) proforma were sent electronically to 1500 religious mosque leaders (Khateebs) by the assigned employee of the

aforesaid Ministry on August 25, 2019. The participants were informed that in case they do not understand any question, they can contact directly NCPMH via using this number; XXXXXX-XXX or using email ID: XXXX@XXX.org.sa. Khateebs were given two weeks to complete the questionnaire and then send back to the Ministry of Islamic Affairs, Call and Guidance (MIACG) server. Only 260 RMLs returned the completed questionnaire despite multiple soft reminders to them. The response rate was about 17%.

2.6 Data Management

Data was entered in computer using Statistical Package of Social Sciences (SPSS) version 21, was cleaned first and then analyzed. We calculated mainly percentage (%) frequency (f) distribution (descriptive statistics) of data-responses of participants and presented in Tables and bar graphs. No association and correlation statistical tests were used to analyze the data because our objective was to describe the MHL of Khateebs without determining any association between sociodemographic variables and level of MHL.

2.7 Ethical Consideration

This study was approved by the internal ethical committee of the National Center for Mental Health Promotion. As aforesaid, the assigned employee of aforesaid Ministry of Islamic Affairs, Call and Guidance sent questionnaire and SD proforma link to all 1500 RMLs about the voluntary participation in this survey. Khateebs were informed that participation in this survey will automatically reflect your consent to share your views to this online questionnaire. NCPMH clarified any query raised by the participant and informed the participant that completion of questionnaire will not take more than 20 minutes or so and no other person except the research team will have access to the collected data. All the participants were assured that their data will remain anonymous and their identity will not be disclosed to any third party. The participants were told that the data submitted for publication in scientific journal will also be anonymized.

3. RESULTS

3.1 Sociodemographic Variables

One thousand five hundred official RMLs were invited to participate voluntarily in this online survey. Only 260 Khateebs who lead Friday noon prayers responded to the survey. The response rate was about 17%. More than 50% of Khateebs were adults, and 33% were of middle age. About 94% of the mosque leaders were highly educated, from university degrees to post-graduate education. Three fourth of the RMLs were highly experienced, from 6 years to 21 years (Table 1).

Table 1. Sociodemographic variables (SDV) of mosque leaders (N=260)

SDV	N (%)
Age	
≤35-	33 (12.7)
36-45	108 (41.2)
46-55	86 (33.1)
≥56	33(12.7)
Education	
≤12 grade	16 (6.15)
University	168(64.6)
Adv. Education	76 (29.2)
Experience of Khateebs	
≤5 years	162 (23.9)
6-10 years	56 (21.6)
11-20 years	71 (27.4)
≥21 years	71 (27.1)

3.2 Participants Responses to the Individual Items of the Questionnaire

About 72% of RMLs reported that public or worshippers having MH problems consult them within or outside mosques. The mosque leaders address the clients' MH problems by multiple dynamic ways, which are general advice or informal counseling (55%), recommendation to see MH professionals (44%), offer healing by reciting holy Quran-Roqiya (12%), and an integrative approach that provides simultaneously religious-spiritual therapy and psychiatric treatment (37%). Alternatively, when mosque leaders were asked specifically to whom consultees should visit; 73% and 24% of them advised to see Roqiya experts and psychiatrists, respectively. Concerning rough idea about epidemiology of MH problems, 27% expressed that psychiatric problems are uncommon in Saudi Arabia while 58% commented in opposition. In response to dangerousness and social exclusion of patients with MDs, mosque leaders' opinion was not widely varied,45% (yes) versus 55% (no). Concerning MH problem deteriorated by family interactions, 64% of mosque leaders reported positively while 36% of them answered in opposition. A proportion of 63% of RMLs informed that psychiatric patients respond to given treatment with good

improvement while 29% of them had no idea about patient outcome. Concerning psychotropic medications' efficacy in MDs, 64% of RMLs reported their usefulness and 32% and 12% reported other effects including sedation and addiction, respectively. Twenty-six percent as opposed to 30% opined that MH professional did not consider the therapeutic role of religious and spiritual therapies in the management of MH problems, and about half of them (44%) were not aware of this information. At etiological level, Khateebs expressed a number of causes of MH problems including weak personality (9%), lack of faith (38%), substance abuse (20%) and biopsychosocial factors (76%). Transient depression cold be induced by adverse circumstances and stressors, most Khateebs (72%) confirmed this notion but 10% disagreed and another 19% were not knowing the answer. Concerning factors underpinning suicide and suicidal attempts, 66% and 46% of religious mosque leaders reported the main reasons behind suicide are a lack of loyalty to religious faith and mental illnesses, respectively, and another 9% expressed that suicide and suicidal attempts never occurred in Saudi society (Table 2).

3.3 Religious Mosque Leaders' Suggestions

In response to an open-ended Q14 of the questionnaire, about 54 from 260 participants provided several suggestions, which we read carefully and common themes were selected from the given. Religious mosques leaders' main concerns were ramping up the role of religious and traditional therapies, need education and training, coordination and integration into MH system, and selection of MH prioritized topics to be spoken in sermons of Friday prayers (Fig. 1 & Table 2).

4. DISCUSSION

This online survey using a sociodemographic proforma and 14-items self-administered questionnaire explored the MH awareness of religious mosque leaders (Khateebs) who lead and give sermons 15-20 minutes prior to Friday prayers in mosques of Riyadh region, Kingdom of Saudi Arabia. A concise review of literature found no study that explored the MH awareness of Khateebs in Saudi Arabia and most probably elsewhere in the Muslim world. Therefore, results of our online survey will be interpreted using most relevant health or MH collateral information concerning Imams, Islamic religious scholars, traditional faith healers, MH professionals, health practitioners and allied healthcare providers, and community and general population. According to this survey, most of the participants were adults and middle-aged leaders with long experience and higher level of education as found in other health surveys involving public and mental health professionals [28-30].
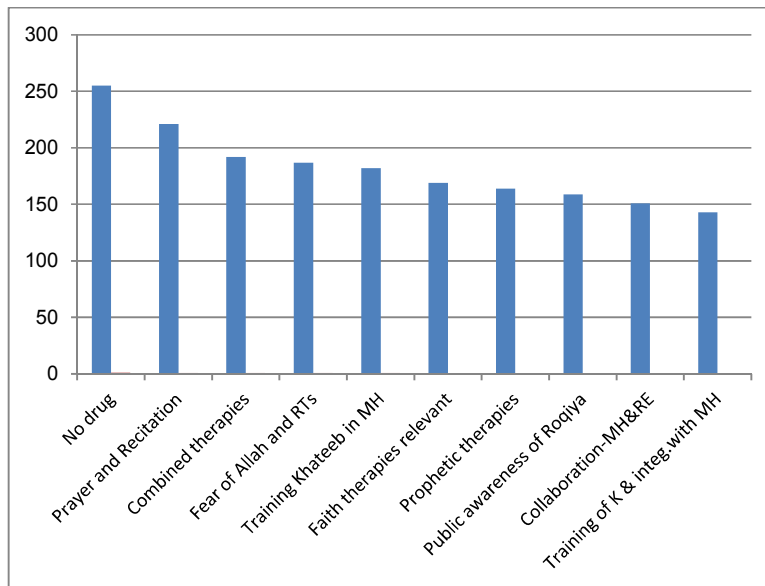

Fig. 1. Chart showing ten themes with frequencies suggested by mosque leaders

Table 2. Responses to the individual questionnaire item (n=260)

Questions	Responses, N (%)
1. Sex of the consultees (M/F)?	1. Males, 190 (73); and 2. Females, 70 (27)
2. Do public consult you about MH problems?	1. Yes, 179 (71.7); and 2. No, 81 (31.2)
3. If you said yes to Q1, how do you deal with your clients (choose ≥one answer)	1. Give general advice, 110 (55.3); 2. Apologize, 9 (4.5) 3. Referral to psychiatrist,88(44.2) 4. Treatment by reading holy Quran (Roqiya), 23(11.6) 5. Refer to psychiatrist plus treatment by Roqiya,73(36.7) 6. Others, 20 (6.2)
4. If people or their relatives consult you for MH problems, you advise them to visit one of the following: 1.Roqiya experts, 2. Psychiatrist, 3. and both	1. Roqiya experts, 189 (72.6); 2. Psychiatrist, 63 (24.3); and 3. Both, 8 (3.1)
5. In your opinion, are MH problems uncommon?	1. Yes, 70 (26.9); 2. No, 150 (57.7) and 3. Do not know, 40 (15.4)
6. Do you perceive people with MDs are dangerous and need isolation from the society?	1. Yes, 32 (12.3); 2.No, 142 (54.6) and 3. Probably, 86 (33.1)
7. In your opinion, family members worsen the MH condition of the patient?	1. Yes, 125 (48); 2. No, 94 (36.2); and 3. Probably, 41 (15.8)
8. In your opinion, most of MDs neither improve nor respond to the treatment?	1. Yes, 23 (8.8); 2. No, 163 (62.7); 3. Do not know,74 (28.5)
9. Do you think psychotropics are effective medications in MDs: choose ≥one answer?	1. Ineffective, 9 (3.5); 2. Sedation only, 83 (31.9) 3. Cause addiction, 32 (12.3); and 4. Useful drugs,166 (63.8)
10. You perceive that MH experts do not care about the role of religion/faith in improving MH.	1.Yes, 68 (26.2); 2.No, 78 (30.0); and Do not know, 114 (43.8)
11. In your opinion, what are the causes of mental disorders? (choose ≥one answer)	1. Weak personality, 24 (9.2); 2. Drug abuse, 51 (19.6); 3. Weak faith-away from Allah,99 (38.1); 4. Multiple biopsychosocial factors = 200 (76.2); and 5.Others = 20 (8.0)
12. Can depression be the temporary phase due to bad circumstances and life stresses?	1. Yes, 186(71.5); 2. No, 26 (9.8) and 3. Do not know, 48 (18.5)
13. In your opinion, reasons for suicide and deliberate self-harming behavior (choose ≥one answer)	1. Weak faith-away from Allah,171 (65.8); 2. MDs needing treatment, 119 (45.8); 3. Never happened in our society = 23 (8.8); and 4. Do not know = 13 (5.0)
14. If you have any suggestions and observations, please mention here!	1. Traditional healers allowed not to prescribe medications to clients (98%); 2. Significance of prayers and reciting Quran by clients (85%); 3. Combine medications and R/ST (74%); 4. Fear of Allah & address MH problems by religious and spiritual beliefs (72%); 5. MH topics related sermons in FNP (70%); 6. Faith-based therapies good in upbringing of children and MDs (65%); 7. Use of Prophetic therapies (63%); 8. Roqiya training programs and public campaigns (61%); 9.Link MH experts with religious law scholars (58%); and 10. Education and train RFH and integrate with MH experts (55%).

Public and mosque congregants with or without MH problems consult RMLs who use several dynamic therapeutic ways including brief counseling, referral to MH professionals, Roqiya

(reciting holy Quran and blow on them), and recommend simultaneous use of other religious-spiritual therapies and advise to continue with prescribed psychiatric medications. The modus operandi of Khateebs to guide consultees mainly include Roqiya experts and psychiatrists and this trend is quite compatible with other religious scholars including Imams (those who lead regular prayers in mosques) across the world [6-8,11,15,16]. In an exploratory study, 12 community leaders pinpointed the roles of Imams in the community health (physical) which are discussion of healthy behavior using religious-based messages in sermons, consideration of religious rituals during times of disease and health crises, offer culturally competent training to in-patients during hospital stay and finally help Muslim patients in healthcare decision making [11]. In another study, Selamu and colleagues (2015) reported rich community resources including 150 traditional healers, 164 churches/mosques and 401 religious groups, and emphasized the role of religious leaders in awareness-raising, detection and referral of people with mental illness, improving access to medical care, supporting treatment adherence, and protecting human rights and these findings partially support our results [31]. According to another study, mosques and Imams (by extension mosque leaders (Khateebs) may offer a variety of services such as educational, resolution of multiple family and individual conflicts and political welfares, and emphasized the collective role of social workers, Imams and mosques in maintaining social harmony in the Muslim community [12].

Concerning plausible idea about prevalence of MH problems, more than one fourth religious mosque leaders (27%) expressed that psychiatric problems are not common in Saudi Arabia while more than half (58%) commented conversely. Evidently, the prevalence of MDs, determined by age, gender, marital status, ethnicity socioeconomic status, rural residents, migration and displacement, unemployment, poverty, associated physical diseases, life events, disastrous wars, and conflicts varies across the world and is on the rise globally [32-37] evidenced by Mosque leaders who perceived common occurrence of MDs in Saudi Arabia. Despite global concerted efforts to improve the image of patients with MDs, stigma, negative attitudes, social exclusion, being dangerous to society, and discrimination contingent on multiple factors still persist against mentally ill population around the world and our study supported this

notion [38-43]. Unlike family therapy and family and socio-religious supports that mediate protective role [44-46], unhealthy family interactions embedded in unhealthy criticisms, over-involvement and hostile attitude towards mentally ill patients tend to worsen their condition, cause relapse, acute psychotic decompensation, rehospitalization and poor outcome [47,48] that partly substantiated by the present online survey.

According to this survey majority of Khateebs (>60%) informed that psychiatric patients respond effectively to given psychiatric interventions. Furthermore, religious mosque leaders (>60%) supported the usefulness of psychotropics in mental disorders. Khateebs highlighted drugs' adverse effects in terms of sedation (>30% of them), addiction and poor outcome (>10%) and these findings more or less are consistent with other public surveys, randomized clinical trial, comparative studies and reviews [49-51]. In addition, psychotropics especially benzodiazepines, serotonin re-uptake inhibitors, atypical antipsychotics and amphetamine derivatives used in anxiety disorders, mood disorders, psychotic disorders and attention-deficit hyperactivity disorders, respectively are reported to have therapeutic benefits but a great potential to cause abuse and addiction in psychiatric population; however additional therapeutic benefits are found with their adjunctive use in various MDs [51-54]. About one third of RMLs lack knowledge about such good outcomes among mentally ill patients and this gap needs address by targeted training of RMLs in future also suggested by relevant literature concerning public MHL [55].

There is a huge literature on MH and religious faith practitioners-driven religious and spiritual intervention in mental and physical health conditions showing overall better outcome in mentally ill population [56-60]. In a related development, Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) incorporated the "culture" component that reminds and guides clinicians to explore cultural contents while assessing mentally ill patients and address those concerns in making a diagnostic formulation and treatment plan for individual patients, though some critics having self-vested interests currently criticized the "Culture Section" of DSM-V [61]. Since half decade or so, majority of MH professionals impressively have been dealing with religious and spiritual issues of mentally ill patients and combine religious therapies with

psychiatric medications to further improving the outcome of mentally ill patients. According to this survey only one third of mosque leaders were aware of the fact that MH professional use religious and spiritual therapies in the treatment of MH problems and the rest either responded in opposition or were not aware of this information. The implication of this finding is that Khateebs need to update their knowledge regarding MH experts who always address the religious and spiritual contents of a patient with a mental disorder across the world.

Evidently, elucidation of etiologies of MDs is a very complex terrain. Majority of RMLs expressed biopsychosocial (genetic, personality disorders, stressful traumatic events, substance abuse, unhealthy social milieu, life styles, lack of religious convictions and weak morality in the religion of Islam, etc.) risk factors underpinning mental disorders, and many studies support such global etiological interpretations (holistic model) of MDs [62-65]. Of note, majority of Khateebs revealed that stressful life circumstances and biosocial crises compatible with current researches could induce transient depression [66-69]. Furthermore, almost all Khateebs supported that the main reasons underlying suicide include both the fragile religious faith and mental illnesses, and other studies [70-72] partially supported these findings. One tenth of RMLs expressed that suicide and suicidal attempts never occurred in Saudi society that is not tenable [73-75]. Religious mosque leaders need training workshops that target suicide, suicidal ideation and suicidal attempts and non-deliberate self-injurious behaviors, and presently Khateebs are taking MH training organized by NCPMH. In a study from Turkey, imams perceived suicide which is not acceptable in Islam and suicides will be punished after death. Imams (and Khateebs) need to counsel congregants during times of suicidal crises, the study suggested [76].

This survey has some limitations. The sample was from only Riyadh region and, hence, the findings of this online consenting survey are not generalizable to all the religious mosque leaders of Saudi Arabia. The response rate concerning this online survey was 17%, which is acceptable (10% to 30%).Conversely, for non-online surveys, the response rate needs to be 80% or so [77]. We have used single self-designed questionnaire that might not have captured all the facets of MHL among religious mosque leaders. In a study, Wang et al. [78] used more than four questionnaires to explore relationship between religiosity and MHL among community dwellers and found high religiosity linked with better MHL, reduced social exclusion, and less occupational problems of individuals with MH conditions. Religiosity varied with different ethnicities including Hui practitioners of Islam and Han respondents practicing Buddhism, Taoism or Confucianism [78]. Overall, it is better to use a pair of standardized questionnaires for assessing the MHL of public, healthcare users, health professionals, and religious leaders. The strengths of this online surveys is that it is first of its kind in Muslim world, used an authenticated self-administered questionnaire, and reported reasonable results concerning MH perspective among religious mosque leaders in Riyadh region, Saudi Arabia. This survey will provide a solid foundation for future research related to religious mosque leaders' role in addressing peoples' MH conditions and promoting wellbeing of Muslims in particular and by extension multi-cultural societies of the world. This survey found some gaps in the MHL of religious mosque leaders, and, therefore, they need training programs to plug their knowledge gaps in future.

5. CONCLUSION

In summary, this pilot online consenting survey explored the MHL among religious mosque leaders (Khateebs) who lead Friday Noon Prayers and found reasonable findings along with some loopholes. Mosque religious leaders emphasized mainly religious and spiritual therapies but they did not overlook the combined use of psychiatric medications and non-drug therapies in mentally ill population. Overall religious mosque leaders need training in mental health for further increasing their mental health literacy, which they will use while consulting mosque congregants, and select a topic of high interests concerning Khutbah for the Muslims on Friday prayer and by extension diverse-cultures of the world. Researchers should conduct further similar research overcoming the caveats of this survey not only in Saudi Arabia but also globally.

CONSENT

As per international standard or university standard written participation consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

This study was approved by the internal ethical committee of the National Center for Mental Health Promotion.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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Peer-review history:
The peer review history for this paper can be accessed here:
http://www.sdiarticle4.com/review-history/54289