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Original Research

Treatment Adherence, Help-Seeking Stigma, and Attitudes Toward Seeking Psychological Help in Fasting and Non-Fasting Psychiatric Patients During Ramadan

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ABSTRACT

Objective: This study aimed to examine and compare treatment adherence, self-stigma and perceived social stigma of seeking psychological help, perceived social support, and attitudes toward seeking professional psychological help among fasting and non-fasting psychiatric outpatients during Ramadan.

Methods: In this cross-sectional study, 180 *p*atients aged 18–78 years with Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) diagnoses of major depressive disorder, anxiety disorders, bipolar disorder, schizophrenia, or obsessive-compulsive disorder, attending a university psychiatry clinic in March 2025, were included. Participants were grouped as fasting (n = 92) or non-fasting (n = 88) by self-report. Sociodemographic data and validated scales for self- and social stigma, perceived social support, medication adherence (MMAS-8), and attitudes toward seeking professional psychological help were administered. Appropriate univariate tests, Pearson and partial correlations, and hierarchical multiple linear regression (2-tailed, $p < 0.05$) were used.

Results: Fasting status was associated only with education level. Compared with non-fasting patients, fasting patients had significantly lower perceived social support ($p = 0.001$) and higher perceived social stigma ($p = 0.017$). Differences in help-seeking attitudes ($p = 0.058$) and treatment adherence ($p = 0.059$) were in the expected direction but did not reach statistical significance. Social stigma correlated negatively with adherence and positively with self-stigma, whereas social support correlated positively with help-seeking attitudes. In hierarchical regression, fasting status and higher perceived social support independently predicted more positive help-seeking attitudes (final model $R^2 = 0.13$).

Conclusion: Fasting psychiatric patients during Ramadan reported lower perceived social support and higher social stigma; although they tended toward more positive help-seeking attitudes and lower adherence, these differences were not statistically significant. These findings underscore the need for stigma-focused, support-enhancing, culturally sensitive interventions.

Keywords: help-seeking attitudes, psychiatric patients, ramadan fasting, stigma, treatment adherence

INTRODUCTION

Ramadan fasting is defined as abstaining from eating, drinking, and sexual intercourse from sunrise to sunset for approximately 30 days, according to Islamic religious practices [1]. The duration of fasting varies depending on the month of the year and geography, but it is, on average, between 10 and 20 hours. Fasting is seen not only as a state of hunger but also as a spiritual discipline aimed at learning patience and self-control [2]. The month of Ramadan differs significantly from other months in terms of the organization of daily life, including the quality and timing of meals, medication intake, sleep duration, working hours and schedule, and routine activities, and changes in routine activities are observed during this month. Considering that Muslims make up approximately 24% of the world's population, Ramadan fasting affects many people.

Many studies report that religious practices are associated with better psychological well-being and lower perceived stress [3]. Religiousness is generally known to be positively associated with indicators of psychological well-being (life satisfaction, happiness, positive emotional state, and higher morale) and less depression, suicidal thoughts and behavior, and drug/alcohol use/addiction [4]. It is suggested that the prohibition of alcohol and substance use in religion, providing a person with a purpose in life, reducing tension through practices such as prayer and meditation, and providing psychosocial support, a sense of belonging, and social integration positively affect mental health [4]. Religious group activities practiced during the month of Ramadan have also been found to be beneficial for patients diagnosed with psychiatric disorders [5].

Main Points

- Psychiatric patients who fast during Ramadan show more positive attitudes toward seeking professional psychological help than non-fasting patients, despite having similar sociodemographic and diagnostic characteristics.
- Fasting patients have significantly lower medication adherence, higher perceived social stigma, and lower perceived social support compared with non-fasting patients, indicating a clinically risky profile.
- Social stigma is negatively associated with treatment adherence and positively associated with self-stigma, while perceived social support is positively associated with help-seeking attitudes.
- Being married, fasting, and higher perceived social support independently predict more favorable help-seeking attitudes, whereas comorbid physical illness predicts more negative attitudes, underscoring the need for tailored, stigma-focused and regimen-simplifying interventions during Ramadan.

The practice of fasting has multifaceted effects on human physiology and psychology. It has been reported that Ramadan fasting is associated with a decrease in nighttime sleep and an increase in daytime sleep, affecting psychological states, primarily fatigue and attention [6]. This decline in sleep quality also impairs people's quality of life [7] and negatively affects mental and physical health, causing decreased attention and memory, anxiety, depression, and additional physical illnesses [8,9]. Furthermore, anxiety and anger are seen to be more prevalent in the final hours of fasting. Furthermore, studies investigating the relationship between bipolar disorder and fasting show that fasting increases relapse [10]. Another study reports that fasting has a protective effect against manic and depressive episodes [11]. between bipolar disorder and fasting show that fasting increases relapse

Stigma is defined as a situation that damages the reputation of a person or group and causes them to feel shame. Individuals with psychiatric disorders are among the most stigmatized groups [12]. One of the variables that influences stigma is religiosity. Religious beliefs can reinforce or reduce stigmatizing attitudes by influencing how mental illness is interpreted [13,14]. In Islam, mental illnesses are also interpreted within a religious framework. While some believe that psychiatric illnesses come from Allah and must be endured with patience [15], it is also a common belief that mental illness is a punishment from Allah [14]. In many Muslim cultures (e.g., Arab, South Asian, Turkish societies), mental illness is seen not as an individual problem but as a condition that "tarnishes" the entire family. Patients may be socially withdrawn or concealed within the family environment to protect family honor and avoid shame. Muslims, especially in Western societies (such as the US), face discrimination based on both race/ethnicity and religion. When mental illness is added to this, a "double stigma" occurs [13].

Treatment adherence is crucial in the management of psychiatric disorders. However, the rate of treatment non-adherence among individuals with psychiatric illness is higher than in other medical conditions [16]. The most common causes of treatment non-

adherence are medication side effects, lack of insight, economic reasons, and stigma. The literature shows that stigma is one of the strongest predictors of non-adherence to treatment [17]. Patients who adhere to treatment are seen to cope better with stigma, and spiritual coping mechanisms are an important factor that can buffer the negative effect of stigma on treatment adherence [18]. Fasting disrupts treatment compliance due to frequently taken medications that cause side effects such as dry mouth and sedation [19]. In patients who cannot fast for medical reasons (such as medication use), this situation often causes feelings of guilt [19].

A concept related to treatment adherence and stigma is the concept of seeking psychological help. Social norms, personal attitudes, and stigma concerns influence the help-seeking behavior of individuals with mental health problems [20]. One of the most harmful effects of stigma is that people avoid seeking professional help to avoid being labeled as "mentally ill" [21]. In contrast, social support is an important factor that increases help-seeking and treatment adherence [22].

During Ramadan, changes in daily routine and the compression of medication timing into the narrow interval between iftar and suhoor may challenge treatment adherence, while the heightened religious and social context may simultaneously shape how individuals appraise mental illness, experience stigma related to seeking help, and decide whether to seek professional support. Although treatment adherence, help-seeking stigma, and help-seeking behavior have each been studied in relation to religiosity or fasting, these constructs are rarely examined together within the same psychiatric sample, and how they interrelate in fasting versus non-fasting patients during Ramadan remains unclear. Addressing this gap, the present study aimed to compare treatment adherence, self-stigma and social stigma of seeking psychological help, perceived social support, and attitudes toward seeking professional psychological help between psychiatric patients who fast and those who do not fast during Ramadan, and to examine the relationships among these variables and the factors associated with help-seeking attitudes. Specifically, we addressed the following research questions: (1) Do treatment adherence, help-seeking stigma, perceived social support, and help-seeking attitudes differ between fasting and non-fasting psychiatric patients? (2) How are these variables related to one another? (3) Which sociodemographic, clinical, and psychosocial factors are associated with attitudes toward seeking professional psychological help? Clarifying these questions may inform more culturally sensitive, adherence-supportive care for this patient group.

MATERIALS AND METHODS

Research Design and Sample

This study is a cross-sectional and comparative study conducted with patients who visited the outpatient clinics of the Department of Psychiatry at Gaziantep University Faculty of Medicine between March 1, 2025, and March 29, 2025. The study included 180 patients aged 18–78 who had received at least one of the following diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) diagnostic criteria: major depressive disorder, anxiety disorder, bipolar disorder, schizophrenia, or obsessive-compulsive disorder, all of whom provided written informed consent. Participation was voluntary. The study was approved by the Gaziantep University Non-Interventional Clinical Research Ethics Committee (decision no. 2024/474, dated 20 December 2024) and was conducted in accordance with the Declaration of Helsinki.

Participants were divided into two groups: those who fasted during Ramadan (n = 92) and those who did not fast (n = 88). Whether patients fasted or not was determined based on their own statements. The study was conducted during Ramadan (1–29 March 2025), when the daily fasting period lasted approximately 15 hours. Because oral medication cannot be taken during fasting hours, fasting patients took their medications at suhoor (before dawn, before the fast began) and/or at iftar (after breaking the fast). The sample size was calculated using G*Power 3.9.1 software at $\alpha = 0.05$ significance and 80% power (1-β), adopting a conventional medium effect size (Cohen's $d = 0.50$) for the primary comparison between fasting and non-fasting patients; because no previous study had examined the present outcomes in this specific comparison, a conventional effect size was preferred over one borrowed from a non-comparable population. This indicated a required minimum of 64 participants per group (total n = 128). The achieved sample (n = 180; 92 fasting and 88 non-fasting) exceeded this requirement, providing 91.5% power to detect a medium effect, with a minimum detectable effect size of $d = 0.42$.

The inclusion criteria for the study were: (1) being between 18 and 78 years of age and (2) having received one of the diagnoses specified in the DSM-5-TR. The exclusion criteria were: (1) a history of alcohol or substance use disorder within the last six months, (2) a history of seizures or head trauma, and (3) a diagnosis of intellectual disability.

Data Collection Tools

Data were collected using a Sociodemographic Data Form created by the researchers and the following validated self-report scales: the Self-Stigma of Seeking Help Scale (SSOSH), the Stigma Scale for Receiving Psychological Help (SSRPH), the Multidimensional Scale of Perceived Social Support (MSPSS), the Morisky Medication Adherence Scale (MMAS-8), and the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS).

Sociodemographic Data Form: This form includes information about participants' age, gender, marital status, education level, socioeconomic status, smoking and alcohol use, fasting status, psychiatric diagnosis, family history of psychiatric illness, active treatment status, and presence of additional medical conditions.

Self-Stigma of Seeking Help Scale (SSOSH): A 10-item scale developed by Vogel, Wade, and Haake [23] that measures individuals' levels of self-stigma due to seeking psychological help. The scale was adapted into Turkish by Kapıkıran [24]. It is a 5-point Likert-type scale, and high scores indicate a high level of self-stigma. In the present sample, the Cronbach's α coefficient of this scale was 0.565.

Stigma Scale for Receiving Psychological Help (SSRPH): Developed by Komiya, Good, and Sherrod [25], this scale measures individuals' perceptions of being stigmatized by others when seeking psychological help. It is a 4-point Likert-type scale consisting of 5 items. In the present sample, the Cronbach's α coefficient of this scale was 0.803. The Turkish validity and reliability study of the scale was conducted by Topkaya [26].

Multidimensional Scale of Perceived Social Support (MSPSS): Developed by Zimet and colleagues [27], this scale measures the social support perceived by individuals from three different sources: family, friends, and a special person. It is a 7-point Likert-type scale consisting of 12 items. The scale was adapted into Turkish by Eker, Arkar, and Yaldız [28]. High scores indicate high perceived social support. In the present sample, the Cronbach's α coefficient of this scale was 0.896.

Morisky Medication Adherence Scale (MMAS-8): Developed by Morisky, Ang, Krousel-Wood, and Ward, this scale is an 8-item self-report questionnaire used to assess patients' adherence to medication regimens. Scoring is based on "yes/no" responses to the questions. The Turkish validity and reliability study of the scale was conducted in hypertensive patients [29]. Low scores indicate better treatment adherence. In the present sample, the Cronbach's α coefficient of this scale was 0.409, indicating low internal consistency that is addressed in the Limitations.

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS): Developed by Fischer and Turner (1970), this scale measures individuals' attitudes toward seeking professional psychological help. The short form of the scale (10 items) was used. In the present sample, the Cronbach's α coefficient of this scale was 0.681. High scores reflect a more positive attitude toward seeking psychological help [30].

Data Analysis

Statistical analysis of the data obtained from the research was performed using the SPSS (Statistical Package for the Social Sciences) 29.0 software package. Descriptive statistics were presented as mean ± standard deviation ($\bar{x} \pm sd$) and median (minimum-maximum) for continuous variables, and as number (n) and percentage (%) for categorical variables.

Normality was assessed using the Shapiro-Wilk test together with skewness and kurtosis coefficients; given the large sample size and acceptable skewness and kurtosis values, parametric tests were used. The Independent Samples t-test was used to compare two independent groups (fasting and non-fasting). One-way Analysis of Variance (ANOVA) was used to examine the effect of three or more categorical independent variables on numerical variables. When a significant difference was found after ANOVA, the Tukey Honestly Significant Difference (HSD) post-hoc test was applied to determine which groups showed the difference. Relationships between categorical variables were examined using the Chi-square test. Pearson correlation analysis was performed to evaluate linear relationships between variables, and partial correlation analysis controlling for fasting status was used to re-examine these relationships. Finally, hierarchical multiple linear regression analysis was performed to identify the variables predicting attitudes toward seeking psychological help. All tests were 2-tailed, and a significance level of $p < 0.05$ was accepted for all statistical analyses.

RESULTS

The sociodemographic and clinical characteristics of the 180 patients participating in the study are summarized in Table 1. The mean age of the participants was 36.0 ± 14.12 years, and the majority were female (69.4%) and single (53.9%). When their

educational levels were examined, it was seen that university graduates (40.0%) formed the largest group, followed by high school (31.7%) and primary/middle school (28.3%) graduates. Of the participants, 51.1% stated that they fasted during Ramadan.

In terms of clinical characteristics, the most common psychiatric diagnosis was major depressive disorder (50.0%), followed by anxiety disorders (27.8%). While 70.0% of participants had no family history of psychiatric illness, 57.8% were actively receiving antidepressant treatment. When examining the relationship between fasting status and demographic variables, only education level was found to have a statistically significant relationship with fasting ($p = 0.047$). No significant difference was found between fasting status and other sociodemographic and clinical variables ($p > 0.05$).

Between-group difference tests comparing fasting and non-fasting patients are presented in Table 2. The mean perceived social support score was significantly lower ($p = 0.001$), and the mean perceived social stigma score significantly higher ($p = 0.017$), in the fasting group. Differences in help-seeking attitudes ($p = 0.058$) and Morisky Medication Adherence ($p = 0.059$) were in the expected direction but did not reach statistical significance, and self-stigma did not differ between groups ($p = 0.177$).

The results of the Pearson correlation analysis conducted to examine the relationships between scale scores are presented in Table 3. The analysis revealed a weak but statistically significant positive relationship between the attitude toward seeking psychological help and multidimensional perceived social support ($r = 0.207$, $p = 0.005$). A negative and significant relationship was found between social stigma and treatment compliance ($r = -0.148$, $p = 0.047$), while a positive and significant relationship was found between self-stigma and social stigma ($r = 0.237$, $p = 0.001$). After controlling for fasting status in partial correlation analyses, the associations of help-seeking attitudes with perceived social support ($r = 0.252$, $p < 0.001$) and of self-stigma with social stigma ($r = 0.224$, $p = 0.003$) remained significant, whereas the association between social stigma and treatment adherence was no longer significant ($r = -0.126$, $p = 0.09$); thus, these relationships appear largely independent of fasting status.

Hierarchical multiple linear regression was used to identify predictors of attitudes toward seeking psychological help (Table 4). Sociodemographic variables (age, sex, marital status, and comorbid physical illness) were entered in the first block ($R^2 = 0.052$, $p = 0.051$), fasting status in the second block ($\Delta R^2 = 0.013$; $R^2 = 0.065$, $p = 0.038$), and psychosocial variables (perceived social support, social stigma, self-stigma, and treatment adherence) in the third block ($\Delta R^2 = 0.062$; $R^2 = 0.127$, $p = 0.005$). In the final model, only fasting status ($\beta = 0.167$, $p = 0.032$) and higher perceived social support ($\beta = 0.242$, $p = 0.002$) were significant independent predictors of more positive help-seeking attitudes.

Table 1. Distribution of Participants' Sociodemographic and Clinical Characteristics According to Fasting Status

Variables	Total (n = 180)	Fasting (n = 92)	Non-Fasting (n = 88)	p
Age (Mean ± SD)	36.0 ± 14.12	35.6 ± 14.3	36.4 ± 14.0	>0.05
Gender (n, %)				
Male	55 (30.6)	31 (35.2)	24 (26.1)	0.183
Female	125 (69.4)	57 (64.8)	68 (73.9)	
Marital Status (n, %)				
Single	97 (53.9)	51 (58.0)	46 (50.0)	0.285
Married	83 (46.1)	37 (42.0)	46 (50.0)	
Education Level (n, %)				
Elementary and Middle School	51 (28.3)	19 (21.6)	32 (34.8)	0.047
High School	57 (31.7)	34 (38.6)	23 (25.0)	
Bachelor's Degree	72 (40.0)	35 (39.8)	37 (40.2)	
Psychiatric Diagnosis (n, %)				
MDB	90 (50.0)	41 (46.6)	49 (53.3)	0.669
Anxiety	50 (27.8)	26 (29.5)	24 (26.1)	
Other	40 (22.2)	21 (23.9)	19 (20.7)	

*$p < 0.05$

Table 2. Comparison of Scale Scores According to Fasting Status

Scale	Fasting (n = 92) Mean ± SD	Non-fasting (n = 88) Mean ± SD	p
Attitude toward seeking psychological help	3.66 ± 0.41	3.53 ± 0.50	0.058
Perceived social support	4.25 ± 1.69	5.06 ± 1.51	0.001*
Social stigma	2.11 ± 0.76	1.85 ± 0.68	0.017*
Treatment adherence (MMAS-8)	0.50 ± 0.18	0.55 ± 0.21	0.059
Self-stigma	3.55 ± 0.51	3.45 ± 0.48	0.177

*Independent-samples t-test (two-tailed). *p < 0.05. Lower MMAS-8 scores indicate better adherence.*

Table 3. Zero-order and Partial Correlations Among Scale Scores

Panel A. Zero-order (Pearson) correlations					
Variable	**1**	**2**	**3**	**4**	**5**
1. Help-seeking attitude	–				
2. Perceived social support	0.207*	–			
3. Social stigma	0.072	−0.136	–		
4. Treatment adherence	−0.082	−0.031	−0.148*	–	
5. Self-stigma	−0.034	−0.022	0.237**	0.001	–
Panel B. Partial correlations controlling for fasting status					
Variable	**1**	**2**	**3**	**4**	**5**
1. Help-seeking attitude	–				
2. Perceived social support	0.252**	–			
3. Social stigma	0.048	−0.097	–		
4. Treatment adherence	−0.063	−0.068	−0.126	–	
5. Self-stigma	−0.049	0.003	0.224**	0.015	–

**p < 0.05, **p < 0.01. Partial correlations control for fasting status (0 = non-fasting, 1 = fasting).*

Table 4. Hierarchical Multiple Linear Regression Predicting Attitudes Toward Seeking Psychological Help

Predictor	B	β	t	p
Block 1 — Sociodemographic ($R^2 = 0.052$; $F(4,175) = 2.412$, $p = 0.051$)				
Age	0.001	0.038	0.384	0.702
Sex	−0.027	−0.027	−0.371	0.711
Marital status (married)	0.126	0.136	1.440	0.152
Comorbid physical illness	−0.147	−0.142	−1.781	0.077
Block 2 — + Fasting status ($\Delta R^2 = 0.013$; $R^2 = 0.065$, $p = 0.038$)				
Fasting status (yes)	0.154	0.167	2.164	0.032*
Block 3 — + Psychosocial variables ($\Delta R^2 = 0.062$; $R^2 = 0.127$, $p = 0.005$)				
Perceived social support	0.068	0.242	3.207	0.002*
Social stigma	0.058	0.093	1.223	0.223
Treatment adherence	−0.046	−0.020	−0.272	0.786
Self-stigma	−0.069	−0.076	−1.020	0.309

*Coefficients are from the final model (Block 3). β, standardized coefficient. *p < 0.05. Final model $R^2 = 0.127$, $F(9,170) = 2,759$, $p = 0.005$.*

Supplementary Table S1. Descriptive Statistics, Reliability, and Normality of the Scales (n = 180)

Scale	n	Mean ± SD	Median (min–max)	Cronbach α	Skewness	Kurtosis
Attitude toward seeking psychological help	180	3.60 ± 0.46	3.66 (1.50–4.67)	0.681	−0.84	2.33
Perceived social support MSPSS)	180	4.65 ± 1.65	4.55 (1.00–7.00)	0.896	−0.26	−0.88
Social stigma (SSRPH)	180	1.98 ± 0.73	2.00 (1.00–4.00)	0.803	0.42	−0.45
Treatment adherence (MMAS-8)	180	0.52 ± 0.20	0.50 (0.17–1.00)	0.409	0.47	−0.39
Self-stigma (SSOSH)	180	3.50 ± 0.50	3.50 (2.20–5.10)	0.565	0.33	1.50

α, Cronbach's alpha. Normality was assessed with the Shapiro-Wilk test together with skewness and kurtosis coefficients; given the large sample and acceptable skewness/kurtosis values, parametric tests were used.

DISCUSSION

This study compared treatment compliance, stigmatization, and psychiatric help-seeking behavior in psychiatric patients who fasted and did not fast during Ramadan. The main findings of our study show that patients who fasted perceived significantly higher social stigma and lower social support than those who did not fast. Although fasting patients also tended toward more positive help-seeking attitudes and lower treatment adherence, these group differences did not reach statistical significance; notably, in the adjusted regression model fasting remained an independent predictor of more positive help-seeking attitudes. Furthermore, correlation analysis revealed that treatment adherence decreased as social stigma increased (a weak but significant negative relationship) and that self-stigma and social stigma increased together. Perceived social support was likewise a significant independent predictor of help-seeking attitudes in this model.

These findings suggest that the relationship between religious practices and treatment behaviors during Ramadan may not be unidirectional; rather, it may reflect a complex pattern in which biological, psychosocial, and cultural factors interact.

Although treatment adherence tended to be lower in patients who fast during Ramadan, this difference did not reach statistical significance (p = 0.059); it may nonetheless be clinically relevant and warrants attention. The literature indicates that the compression of medication doses into the narrow time window between iftar and suhoor in fasting patients, and the difficulties in administering treatments requiring more than one dose per day, are the main factors disrupting compliance. This trend is in line with the literature pointing to the challenging effects of fasting during Ramadan on psychiatric treatment regimens [19]. In their study, Mbarek et al. reported that treatment compliance decreased in both the fasting and non-fasting groups during Ramadan, stating that this was not related to fasting itself but rather to the disruption of routines caused by Ramadan [31]. Furthermore, clinicians have reported that they advise chronic psychiatric patients not to fast because fasting during the day may disrupt medication adherence [2]. Our findings suggest that, in some patients, the motivation to fulfill a religious duty may be associated with lower treatment adherence, which may increase clinical risk among individuals requiring regular treatment.

Although the bivariate difference in help-seeking attitudes between the groups was only a non-significant trend (p = 0.058), fasting status remained a significant independent predictor of more positive help-seeking attitudes in the regression model. These findings may suggest that fasting individuals demonstrate greater openness toward seeking psychological help during Ramadan; however, the underlying psychological and cultural mechanisms remain unclear and require further longitudinal investigation. Furthermore, an increase in psychiatric symptoms experienced during fasting, sleep disorders, or difficulties with medication regimens may have increased the need to seek professional help [31]. However, the fact that the same group perceived social stigma as higher and perceived social support as lower appears paradoxical. Parallel to our study, Sandu and colleagues reported that religious individuals experience higher social stigma due to overwhelming feelings of guilt [32].

In contrast, another study reported that stigma toward mental illness decreases as religiosity increases [33]. The high perception of social stigma among the fasting group can be explained by the fact that during this period of intense religious practice, the feelings of "difference" and "inadequacy" associated with having a psychiatric diagnosis become more pronounced as they clash with social expectations [1,14]. Individuals who fast may have become more sensitive to society's negative view of mental illness and may therefore feel less social support.

Our study's correlation analysis found that treatment compliance decreased as social stigma increased. This finding reaffirms the previously reported negative relationship between stigma and treatment compliance [16]. Another important finding of our study is that as the level of education increases, both social stigma (p = 0.022) and self-stigma (p = 0.002) levels decrease significantly. In particular, it was found that participants with a bachelor's degree had lower scores on both types of stigma compared to those with a middle school degree. This result is consistent with the literature emphasizing the critical role of education in reducing prejudices toward mental illness [34]. The decrease in social stigma and self-stigma with increasing educational level supports the role of knowledge/health literacy about mental illness in reducing stigma and increasing treatment compliance.

Limitations

This study provides a novel contribution by simultaneously examining fasting during Ramadan, treatment adherence, stigma, and help-seeking behavior in the same sample. To our knowledge, this is the first study to address these constructs together in fasting psychiatric patients during Ramadan. Its principal contribution is the finding that fasting psychiatric patients constitute a group with significantly lower perceived social support and higher help-seeking stigma during Ramadan—a culturally important and underexamined observation with direct implications for support-oriented, stigma-sensitive clinical care.

However, some limitations exist. The cross-sectional design does not allow for causal interpretations. The self-report nature of the scales may lead to social desirability bias. In addition, the sample was diagnostically heterogeneous, including patients with depressive, anxiety, bipolar, psychotic, and obsessive-compulsive disorders; because treatment adherence and stigma processes may differ substantially across these diagnostic groups, the pooled findings should be interpreted with caution, and the present design did not permit adequately powered subgroup comparisons. Furthermore, the low internal consistency of the treatment adherence scale requires careful interpretation of this finding. In addition, the sample may have been insufficiently powered to detect medium-sized between-group differences; accordingly, the borderline, non-significant differences in help-seeking attitudes (p = 0.058) and treatment adherence (p = 0.059) should be regarded as preliminary trends that warrant confirmation in larger, longitudinal samples. Another limitation is the lack of a detailed assessment of variables such as fasting duration, partial fasting, medication classes used, and sleep patterns.

CONCLUSIONS

In conclusion, psychiatric patients who fast during Ramadan perceived lower social support and higher social stigma, and tended toward more positive help-seeking attitudes and somewhat lower treatment adherence. Considering that fasting affects a large population, clinicians should choose medications with fewer side effects, avoid polypharmacy, and prefer medications that are dosed once or twice a day or long-acting injectable medications. Furthermore, during Ramadan, they should proactively communicate with their patients about their intentions to fast and provide supportive interventions that reduce perceptions of stigma. In future studies, the longitudinal examination of factors that increase and decrease compliance in fasting patients is critical to protecting the mental health of this vulnerable population.

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Informed Consent: Informed consent was obtained from all individual participants included in the study.

Data Availability Statement: The data that support the findings of this study are available from the corresponding author upon reasonable request. The datasets used and/or analyzed during the current study will be made available following publication upon request to the corresponding author and with appropriate ethical approval.

Ethical Approval: All procedures performed in this study involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. Ethics Committee:

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Author Contributions: Conception: M.S., B.D., G.E., A.A. - Design: M.S., B.D., G.E. - Supervision: G.E., F.B., A.A. - Fundings: - Materials: E.Y., Y.B. - Data Collection and/or Processing: E.Y., Y.B. - Analysis and/or Interpretation: M.S., B.D., F.B. - Literature: M.S., E.Y., Y.B. - Review: G.E., F.B., A.A. - Writing: M.S., B.D. E.Y., Y.B - Critical Review: G.E., F.B., A.A.

Author Statement Regarding the Use of Artificial Intelligence-Enhanced Tools: The authors declare that DeepL (an AI-powered translation and language processing tool) was used solely for the purpose of language editing and improving the grammatical structure of the manuscript. The AI tool was not used for data collection, analysis, or the generation of scientific content. All AI-edited content was thoroughly reviewed and verified by the authors to ensure accuracy and integrity.

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