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Comparative Study of Cultural Influence on Mental Health Stigma among Pakistani Ethnic Groups

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Abstract: *Pakistan, the fifth most populous country in the world and mental health is a most prevailing issue in the Pakistani society, as mental health care do not meet the needs of the population. Stigma related to mental health is also very common. Negative beliefs of people about those who have a mental illness are referred to as mental health stigma. The aim of this study is to examine the cultural influences on mental health stigma among young adults of different ethnic groups in Pakistan. A cross-sectional study in which the sample (N=200) comprised men (n=100) and women (n=100) university students within the age range of 18 to 25 years. The participants were selected from private and government sector universities in Islamabad and Rawalpindi. Public mental health stigma (MHS) is measured by the Community Attitude towards the Mentally Ill (CAMI; Taylor and Dear, 1981) scale consists of 40 items and four subscales. Results show that men have a more negative attitude towards mental health stigma, particularly in Baloch ethnicity, while women from Punjabi and Sindhi ethnicities have a more negative attitude, influenced by socioeconomic status. Findings help to reduce stigma associated with mental health and also help to design mental health stigma awareness programs to address these challenges in Pakistan. Potential limitations, suggestions, and implications of the study were also been discussed.*

Key Words: *Mental Health Stigma, Cultural Influence, Ethnic groups, Community Attitude Towards Mentally Ill, Negative Attitude, Awareness*

Introduction

According to World Bank estimates in 2023, Pakistan has 240.48 million people living in it, making it the fifth most populous country in the world. Pakistanis have unmet developmental and mental health needs (Grantham-McGregor et al. 2007; Taj, 2016). Consequently, Pakistan has been the subject of international mental health initiatives lately, including Harvard's Global Mental

Health (Yousafzai et al. 2016). Because mental health is heavily stigmatized and because sociocultural, spiritual explanations, religious, and treatment for mental diseases are valued, Pakistanis have less knowledge about mental health (Shafiq, 2020).

According to Çiftçi et al. (2013), mental health stigma among Muslims is recognized to be a significant obstacle to seeking treatment, similar to other cultures. This stigma can lead to many negative social and functional outcomes. Those in the emerging adult demographic (ages 18 to 29) are most affected by this, as they are going through a critical developmental stage that is also linked to an increased risk of mental health issues. Cross-cultural studies typically use vestiges of paradigms like individualism and collectivism to explain why mental health is stigmatized (Triandis 1988, 1995).

A report on mental health by the Surgeon General stated that "the most formidable obstacle to future progress in the arena of mental illness and health" is mental illness stigma, or the devaluing, disgracing, and disfavoring of people with mental illnesses by the general public (Hinshaw, 2007).

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Mental Health Stigma (MHS)

When someone or a group of people deviates from societal norms in any way, for example, in appearance, race, or physical or mental health, they are often stigmatized and given a bad reputation (Falk, 2001). When aspects of discrimination, labelling, separation, status loss, and stereotyping coexist in a power dynamic that permits those processes to happen, stigma arises (Link & Phelan, 2001). People may decide not to associate with mental health clinics or experts in order to avoid being labelled as psychiatric patients; this way, they can escape being diagnosed by not seeking mental health care. Prejudice and discrimination that prevent people from obtaining housing, health care, work, or educational opportunities are known as public stigma. When the broader population accepts and behaves based on preconceived notions about mental illness, it is known as public stigma (Çiftçi et al., 2013).

MHS can have serious negative effects since it can lead to injustice, marginalization, and discrimination (Corrigan,2004; Corrigan et al., 2007). According to the WHO (2015), MHS is linked to poor self-esteem and may make it more difficult for a person to socialize, find work, or find accommodation. According to (Ayazi et al., 2014; Razali and Ismail,2014), experiencing stigma associated with one's mental illness may make it worse. It has been observed that stigma associated with mental illness may even be more detrimental than the condition itself (Finzen,1996; Sartorius, 2012).

In general, MHS rates are greater in men than in women, and MHS is more strongly endorsed by members of racial/ethnic minorities than by members of Western civilizations (Corrigan and Watson 2007). Furthermore, because gender and culture are closely related concepts that overlap in different ways among communities, experiences of MHS are likely to differ at these intersections. According to an analysis of MHS (Çiftçi et al. 2013), a working-class Muslim woman experiencing depression may encounter stigma in a way that is very different from a middle-class White woman experiencing the same stigma, both in terms of severity (i.e., greater stigma) and type (i.e., distinct stigma with distinct effects).

Mental Health Stigma Across Cultures

The personality of a civilization is sometimes referred to as its culture. According to Peacock et al. (1981), a society's culture is shaped and developed by a multitude of interrelated elements. Different cultures have different perspectives, understandings, attitudes, behaviors, and practices of the people (Peacock et al., 1981). In every community, culture has a big impact on people's knowledge, beliefs, experiences, and reactions to mental health and mental illness (Gaw et al., 1993).

Caregiver stigma and burden also have significant implications with respect to cultural differences. For instance, as we compare the United States and India, Morrow and Luhrmann (2012) describe how acceptance of biomedical approaches and psychiatric services, access to and perception of shame, moral responsibility, and family honor lead Indian families to hide their family members with severe psychosis in their homes. In contrast, American families leave their family members on the streets or in institutions. Additionally, Chinese families keep their family members' illnesses a secret to save face (Mak & Cheung,2008).

Because the mind and body are viewed as being intertwined in many Asian cultures (e.g., India, Pakistan, Nepal, etc.), psychological disorders sometimes manifest as physical illnesses, necessitating the use of traditional healers. Significant stigma exists because mental illness is frequently perceived as the product of bad genes, bad behaviors, or divine punishment. Common values like emotional restraint, filial piety, and norm compliance mean that aberrations like mental illness shame the person experiencing them and their family, which exacerbates stigmatization (Abdullah & Brown, 2011).

Additionally, it has been proposed that the individualism-collectivism paradigm (Triandis 1988, 1995) could serve as an explanatory tool for researching mental health services across cultural boundaries, with collectivism being emphasized as a crucial component in the explanation of stigma (Abdullah and Brown 2011; Çiftçi et al. 2013). Strong in-group values (collectivism) might increase stigma since abnormalities (like mental illness) could be viewed as abnormalities and cause social exclusion. But collectivist values also yield greater support during tough times, and in light of the previously mentioned research on social isolation and failure, encouraging collectivism has emerged as a key element of evidence-based family treatments for schizophrenia (Weisman de Mamani et al. 2021).

When dealing with mental and physical ailments, it is customary in Pakistani culture to seek help and treatment from traditional or spiritual healers (Shaikh & Hatcher, 2005). Since mental illness is typically thought to be the product of heavenly powers, in this culture, faith healing is a traditional method to treat mental illness (Saeed et al., 2000). In Pakistan, faith healers play a significant role in providing mental health services, especially for women and low-income individuals. Reciting passages from the Quran aloud, doing "dum," and using ropes or "taweez" on the body are common faith-healing methods. Several fraudulent faith healers employ a variety of different techniques, some of which may be harmful, in addition to those mentioned above (Farooqi, 2006). Traditional healers typically view those who use their services or resources as deficient or ignorant. Yet a number of variables influence how often faith healers seek assistance. In rural areas of the country, where people have a habit of believing in black magic and the evil eye, a firm belief plays a crucial role in leading individuals towards traditional healers (Javed et al., 2020).

Mental Health in Pakistan

People are less likely to disclose that they suffer from mental illness, and mental health issues are rarely considered taboo topics. Due to several reasons, people suppressed discussions about mental health. Most people are in the denial phase when it comes to the acceptance of mental health concerns (Gadit, 2007). The lack of political will and emphasis on mental health in Pakistan is regrettable. The quality of care given to patients with mental diseases is negatively impacted by this. A person's deteriorating mental health is, regrettably, exacerbated by societal circumstances, and after a few useless attempts to find a solution through spiritual healings and faith, the end seems virtually inevitable. Medical specialists have never been seen as having to or even as having a choice in consulting them. Due to their fear of being judged or labelled as insane, women who have mental health issues feel embarrassed to talk about their therapy sessions (Irfan, 2013). People's lives are frequently destroyed and even lost as a result of the sad consequences.

In Pakistan, mental health illnesses can take many different forms, and when they are diagnosed in basic care, their symptoms often coexist with physical ones and can be misdiagnosed (Irfan, 2013). According to Husain et al. (2007), mental health problems are one of the major risk factors for increased susceptibility to further challenges. The stigma associated with mental illness and discrimination against sufferers and their families discourages people from getting mental health care and psychological support. They may also contribute to unintentional or intentional harm to their physical health. Concurrently, certain medical conditions like heart issues, diabetes, and obesity have been linked to a marked increase in anxiety and a higher chance of mental illnesses. Due to contemporary social challenges, like many other countries, Pakistan has the highest frequency of depression (Mirza & Jenkins, 2004). According to Mirza et al. (2006), there is a significant incidence of common mental diseases in Pakistan, with reported rates of depression (6%), schizophrenia (1.5%), and epilepsy (1%–2%).

According to Waqas et al. (2014), who conducted a cross-sectional survey among students at Pakistani universities, stigmatizing views (i.e., more authoritarian and socially restrictive, and less benevolent and community-oriented) were linked to reduce the exposure to mentally ill and mental health literature, the belief that poverty or drug/alcohol use are the primary causes of mental illness, and spiritual/religious beliefs about mental illness. Parents of disabled children in Pakistan were interviewed by Croot et al. (2008), who discovered that while all parents supported theological explanations for their children's illnesses, those who also supported biological explanations used them to counteract stigmatizing beliefs that were common in the Pakistani community.

Current Study

The purpose of this study was to investigate the cultural influences on mental health stigma among young adults from different ethnic groups in Pakistan. Specifically, the study aimed to explore how mental health stigma varies between ethnic groups and genders within the context of university students because Pakistani emerging adults today come from a variety of ethnic backgrounds, speak different languages, and come from a range of socioeconomic backgrounds, and previous research sample is not representative of this population (Ahmad & Koncsol, 2022). The current study aimed to investigate the associations

between MHS (i.e., the Community Mental Health Ideology, Authoritarianism, Social Restrictiveness, and Benevolence CAMI subscales).

We hypothesized that:

1. (H1) There are significant differences in the levels of mental health stigma among emerging young adults across different ethnic groups in Pakistan.
2. (H2) Men are expected to report higher in CAMI than women.
3. (H3) Demographic variables such as age, gender, and family monthly income have a significant impact on mental health stigma.

Method

Two hundred Pakistani emerging adults were included in this study. Convenient sampling was used to gather a representative sample of the population. 200 students from public and private universities in Rawalpindi and Islamabad (100 = men and 100 = women) made up the sample. Participants from several ethnic groups, including Punjabi (n = 20), Sindhi (n = 20), Baloch (n = 20), Pashtuns (n = 20), and Kashmiri (n = 20), were included in the sample, which had an age range of 18 to 25 years. Using a non-probability, purposive sampling technique, the study sample was selected from a number of universities in Rawalpindi and Islamabad. Every university student received a personalized explanation of the current study's objectives. The participants were given an information sheet and the study's instruments after their consent was gained. To measure several important demographic characteristics, a comprehensive demographic sheet was made. The opportunity to quit at any time, the privacy and anonymity of their answers, and the voluntary nature of their participation were all explained to the participants. Because each response is essential to comprehending the phenomenon, they were asked to respond to all of the questions. The researcher responded to their queries and opinions. Completing the questionnaire booklet took ten minutes. The participants' cooperation was praised. Demographic characteristics, frequencies, and percentages are given in Table 1 below.

Table 1

Demographic Details of the Sample (N=200)

Demographic Characteristics	Range	N	%	M(S.D)
Gender				
Men		100	50.0	
Women		100	50.0	
Ethnicity				
Punjabi		40	20.0	
Sindhi		40	20.0	
Baloch		40	20.0	
Pakhtun		40	20.0	
Kashmiri		40	20.0	
Family Monthly Income	20000-750000			136143.3 (89109.1)
Education Level				
BS		122	61.0	
M.Phil.		78	39.0	

Instrument

Demographic Sheet

In addition to the standardized scale which is used in this study, participants also completed a demographic sheet comprising age, gender, education level, ethnicity, and monthly family income. Also asked participants if they have been diagnosed with any physical and psychological problems or disorders, and they also mentioned the problem or disorder. These demographics are used in the study to perform analysis and to establish a link between these demographic variables and the study's main variables.

Community Attitude towards the Mentally Ill (CAMI)

Public mental health stigma (MHS) is measured by the Community Attitudes towards the Mentally Ill (CAMI; Taylor and Dear 1981) scale. It is a 40-item assessment test designed for assessing attitudes

towards mental health facilities, the mentally ill living in one's community, and both positive and negative attitudes towards those who are mentally ill. The CAMI is a 5-point Likert-type scale with "strongly disagree" and "strongly agree" as the possibilities.

Authoritarianism (AR), Benevolence (BN), Social Restrictiveness (SR), and Community Mental Health Ideology (CMHI) are the four aspects, or subscales, of mental health stigma that are measured.

There are 10 questions in the CAMI for each subscale, for a total of 40 questions. Five questions on each subscale are pro-mental illness, and five are anti-mental illness. Reversing the appropriate items and combining the scores yields the total scores for all four subscales, with a maximum score of 50 for each subscale. Each subscale's internal reliability was examined using a Cronbach's alpha test to make sure it could be merged into a single score; all alpha scores were higher than the allowed threshold of .60.

Results

Table 2

Variables	1	2	3	4	5	6	7
1-Age	-	-.300*8	-.414**	-.420**	-.375**	-.430**	-.407**
2-Monthly Family Income			.450**	.400**	.420**	.430**	.460**
3-CAMI_Total			-	.987**	.994**	.995**	.980**
4-AR				-	.978**	.985**	.944**
5-BN					-	.987**	.969**
6-SR						-	.965**
7-CHMI							-

Note: CAMI= Community Attitudes towards the Mentally Ill, AR=Authoritarianism ,BN Benevolence , SR=Social Restrictiveness and CMHI=Community Mental Health Ideology **p<.01

In Table 2, the Pearson product-moment correlation coefficients among the types of variables are presented. The result points towards a significant negative relationship between age, monthly family income, and CAMI and its subscales. Age is negatively correlated with Community Attitudes towards the Mentally Ill, and its subscales: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. CAMI and all subscales are positively correlated with each other.

Table 3

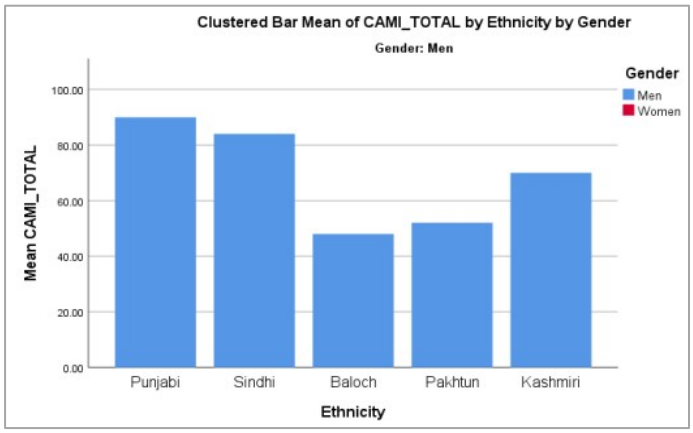
Mean Difference based on gender across ethnicity with study variable CAMI (N=200)

Variables	*Men* (n=20)		*Women* (n=20)				95% CI		Cohen's d
	M	*S.D*	*M*	*S.D*	*t*(200)	*P*	LL	UL	
Punjabi	90.0	12.5	116.0	13.2	-6.40	.00	-2.35	-13.1	-2.02
Sindhi	84.0	3.03	116.0	10.3	-13.3	.00	-20.2	-28.9	-4.22
Pakhtun	52.1	6.42	162.0	11.8	-36.5	.00	-13.02	-23.8	-11.5
Baloch	48.0	4.48	131.0	10.9	-31.5	.00	-89.9	-76.0	-9.96
Kashmiri	70.2	10.7	161.0	14.7	-22.3	.00	-8.42	-23.0	-7.06

Table 3 shows that the mean differences based on gender across different ethnicities for the CAMI variable show that women consistently have higher scores than men, indicating more positive attitudes. For Punjabi women mean score is (116.0), significantly surpasses men's score (90.0) with a Cohen's d of -2.02, reflecting a substantial effect. In Sindhis, the difference is even more pronounced, with a Cohen's d of -4.22, where women's mean (116.0) is much higher than men's (84.0). Pakhtuns exhibit an extreme disparity, with women scoring 162.0 versus men's 52.1, and a Cohen's d of -11.5, highlighting a very large effect. For Baloch, women's mean (131.0) greatly exceeds men's (48.0) with a Cohen's d of -9.96, and Kashmiri women score 161.0 compared to men's 70.2, with a Cohen's d of -7.06. Overall, these results indicate that women across all ethnic groups have significantly more positive attitudes as measured by CAMI, with a very large effect size.

Graphs

Higher scores indicate a more positive attitude.



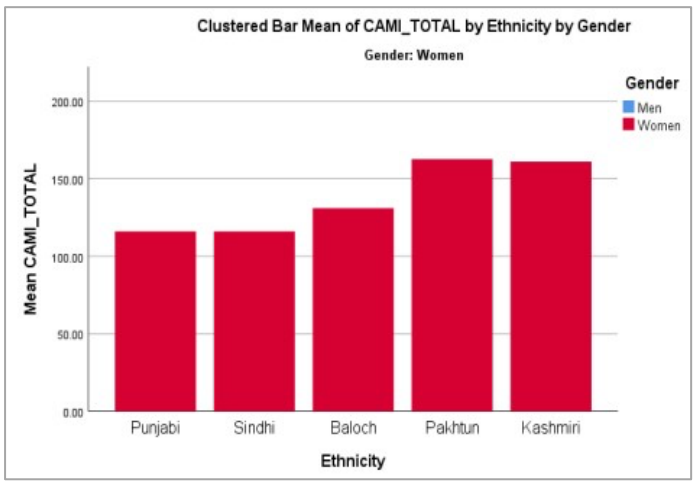


Table 4

Mean Difference across Gender for Study Variable (N=200)

Variables	Men (n=100)		Women (n=100)				95% CI		Cohen's d
	M	*S.D*	*M*	*S.D*	*t*(200)	*p*	LL	UL	
CAMI Total	68.8	16.7	137.3	24.3	-23.2	.00	-74.3	-62.6	-3.28
AR	16.8	3.6	34.7	6.05	-25.4	.00	-19.2	-16.5	-3.60
BN	17.6	4.56	33.2	4.8	-23.4	.00	-16.9	-14.3	-3.34
SR	17.0	3.8	36.0	5.8	-27.2	.00	-20.4	-17.6	-3.38
CHMI	17.4	5.3	33.3	7.9	-16.6	.00	-17.8	-14.0	-2.37

Note: CAMI= Community Attitudes towards the Mentally Ill, AR=Authoritarianism ,BN Benevolence , SR = Social Restrictiveness and CMHI = Community Mental Health Ideology

Table 4 indicates that mean differences across gender for the CAMI variables IT reveals that women consistently score higher than men, indicating a more positive attitude towards mental health stigma. For the CAMI Total Score, women's mean is significantly higher (137.3) compared to men (68.8), with a substantial Cohen's d of -3.28. It is also the same in subscales: women score significantly higher on AR (34.7 vs. 16.8), BN (33.2 vs. 17.6), and CHMI (36.0 vs. 17.0), with large Cohen's d values of -3.60, -3.34, and -3.38, respectively, reflecting strong effect sizes.

Discussion

The purpose of this study was to assess the influence of culture on Mental Health Stigma among young adults. Pakistan is generally a deeply religious and patriarchal nation. Mental health stigma (MHS) is frequently identified as the reason why Pakistan's mental health infrastructure does not meet the demands

of the populace. Research carried out in Pakistan indicates that sociocultural, religious, and spiritual perspectives on mental illness and its treatment are prevalent (Farooqi, 2006), and the general Pakistani public is unaware of mental health issues and how to address them (Shafiq, 2020). The stigma associated with mental illness in the public eye frequently makes people reluctant to disclose their condition, get help, or hang around with other people who are mentally ill.

As the first hypothesis is "There are significant differences in the levels of mental health stigma among young adults across different ethnic groups in Pakistan. Although there is no previous research that compares different Pakistani Ethnic groups. The observed differences in mental health stigma among different ethnic groups show that Baloch men show the highest negative attitude towards mental health stigma as compared to other ethnic groups, and in women, Punjabi and Sindhi women exhibit a negative attitude towards stigma. It is because of various factors, cultural beliefs, and the traditions that are practiced in these ethnic groups that shape their perception towards mental health, which influences the level of stigma. Social norms and historical contexts, which include regional variations in mental health resources and education, also contribute to shaping these attitudes and gender roles and expectations of the societies, with these also affecting how stigma is experienced and expressed (see Table 3).

The second hypothesis is "Men are expected to report high in CAMI as compared to women," was also supported by the present study (see Table 4). A study conducted by Gonzalez et al. (2005) reported that men reported a more negative attitude towards taking mental health treatment compared to women. Young boys were more negative about treatment than young females. Consequently, the most unfavorable attitudes towards getting mental health therapy when one is experiencing a personal or emotional issue stem from early age and masculine role socialization.

As the third hypothesis is, "Demographic variables such as age, gender, and socioeconomic status have a significant impact on mental health stigma". As the age increases, scores of CAMI, AR, BN, SR, and CHMI decrease, which means they have a more negative attitude towards mental health stigma. According to Tijhuis et al. (1990 reported that as the individuals whose age is less age were more inclined to have a positive attitude towards help-seeking. And according to Leaf et al. (1987 people who belong to higher socioeconomic groups and have higher education reported a more positive attitude towards mental health stigma compared to lower socioeconomic groups and less educated people.

Limitations and Suggestions

Limitations of this study are that the sample size is 200 and of university students of Rawalpindi and Islamabad, which do not fully represent the broader population of young adults of Pakistan, especially those who are not attending universities. The study's primary focus was on metropolitan areas, which may not fully represent sentiments in Pakistan's more rural or underdeveloped areas, where cultural norms and access to mental health facilities may differ. The above data is self-reported and may cause bias or overreport their attitudes due to social desirability. Future research should include a diverse and large sample that also contains data from rural areas and different educational backgrounds, that increase generalizability. Future research should also incorporate qualitative techniques, such as focus groups or interviews, which could offer a better understanding of the subtle cultural differences and individual experiences associated with stigma around mental health.

Conclusion

The aim of this study was to examine the cultural influences on mental health stigma among young adults from different ethnic groups in Pakistan. It revealed significant differences in attitudes towards mental health based on ethnicity, gender, and socioeconomic status. Overall, women exhibited more positive attitudes towards mental health than men, and higher socioeconomic status was associated with less stigma as compared to low socioeconomic status. The results highlight the influence of cultural beliefs and social norms on mental health perceptions and also suggest the need for culturally sensitive approaches to address mental health stigma in Pakistan.

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