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Beliefs and Attitudes towards Mental Illness in Pakistan in an Era of Increasing Awareness: Perspectives from Pakistani Adults

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Abstract: *There has been an increase in the awareness of mental disorders around the world, including in Pakistan, and thus the attitudes and belief system of mental illness and its treatment have been changing. This research studies educated adults' perception of mental disease and its treatment in the urban areas of Pakistan in the light of increasing publicity. Using a qualitative method, a sample size of 12 participants was recruited through snowball sampling and interviewed using semi-structured questions. The interviews were transcribed and analyzed thematically. Five major themes were identified from the data, including: general knowledge of mental health, perceived barriers to seeking treatment, attitudes towards people with mental illness, facilitating factors for seeking treatment and perceived changes in attitudes towards mental health. Participants had a high acceptance of the biopsychosocial account of mental illness. However, religious interpretations, negative parental attitudes, fear of stigma, and high costs of treatment were found to be essential factors that discourage people from accessing professional services. All participants attested that there has been increased awareness about mental health in Pakistan, mainly because of social media, but also agreed that there needs to be more education for the public in general and more easily accessible mental health services. The results speak of the increasing awareness of educated urban Pakistanis toward mental health issues and their increasing awareness of therapy-seeking from mental health professionals as the most qualified medical specialists in this regard.*

Keywords: mental health awareness, attitudes, treatment-seeking, stigma, Pakistan, qualitative research

INTRODUCTION

The incidence of mental illness has been steadily and steadily rising around the world with the World Health Organization (WHO, 2017) stating a 13% increase in these cases around the globe in the period between 2007 and 2017. This growth has led to an international response to promote

mental health awareness and further access to mental health services, as seen in the WHO's Mental Health Atlas (WHO, 2017). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) also put more thought into defining mental illness and making a clearer cut between what is normal human behavior and what is symptomatic of psychological dysfunction. According to the American Psychiatric Association (2013), a mental disorder is "a syndrome involving clinically significant disturbance in an individual's ability to think, regulate emotions or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20).

Depression alone has become the foremost cause of disability worldwide (Rudd & Beidas, 2020), affecting approximately 264 million people. The Global Burden of Disease Study reported that the number of cases of depression worldwide went up nearly 50% between the year 1990 and 2017 (as cited in Liu et al., 2020). Mental illness is also closely related to physical health conditions. Comorbid mental disorders have a major impact on mortality rates from major illnesses such as coronary artery disease and cancer (Rudd & Beidas, 2020). On the contrary, the presence of depression itself creates more risk of developing heart disease (Hu, Okereke, Pan, Rexrode, Sun et al., 2011). Overall, mental illnesses have an adverse impact on quality of life, interpersonal relationships, educational attainment, job stability and increase the risk for substance abuse (Corrigan, Druss & Perlick, 2014; Doran & Kinchin, 2019). Economically, mental illness costs the global economy $1 trillion a year (WHO, 2018), thus making the need for comprehensive interventions for the successful public health response essential.

While mental health is a global issue, it is also especially prevalent in developing countries where about 161 million people - nearly one-half of the world's cases of depression - can be found (WHO, 2017). In low- and middle-income countries up to 85% of people living with serious mental disorders go untreated (WHO, 2013). The gap between accesses to professional care is deceitful: in developing countries, an average of 0.05 psychiatrists per 100,000 people compared to 8.6 psychiatrists per 100,000 in higher-income countries (Rudd & Beidas, 2020).

Pakistan, the background for this study, is a lower-salaried and strictly Islamic nation and currently the 6th most populous country globally with a population of around 220 million (Javed, Nasar & Rasheed, 2020). The prevalence of mental illness in Pakistan has grown by over 100% in the period from 2001 to 2011, partly because of terrorism and political instability over a decade (Chaudhry, 2016; Khalily, 2011). It is estimated that more than 50 million people in Pakistan have some kind of mental illness (Mumtaz, 2020) and there are only about 400 trained psychiatrists in Pakistan (Begum et al., 2019).

This extreme shortage of mental health professionals is related, among other components, to low mental health literacy among the entire population (Begum et al., 2019). Jorm (2012) defines

mental health literacy as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p. 231). It covers the knowledge of how to prevent mental illness, symptoms, available treatment, and psychological first aid. Despite rizing global awareness, Pakistan still has low levels of Mental Health Literacy and prominent levels of stigma (Waqas et al., 2014).

Culture plays a central role in shaping the beliefs and attitudes to mental illness (Farooqi 22006). In the context of the religio-cultural milieu of Pakistan, beliefs stem from Islamic traditions blended with local customs and traditions, promoting a system through which health issues and illness are interpreted (Farooqi, 2006). Shafiq (2019) highlights that cultural beliefs are an important determinant in the way mental illness is perceived understood and treated and therefore any discussion of attitudes towards mental illness must take into consideration the cross-cultural differences.

In Pakistan, it has been reported that many people locally seek help from faith healers instead of medical professionals due to a popular thinking that mental illness has supernatural etiology (Mubashar and Saeed, 2001). Such causes may include the evil eye, aka, perceived ability of envy to inflict harm; black magic; and divine punishment (Mullick, Khalifa, Nahar & Walker, 2013; Haddad et al., 2016). People who attribute mental illness to these causes tend to have stigmatizing attitudes and to distance themselves socially from people with mental health conditions (Haddad et al., 2016). Stigma is prevalent in Pakistan and the roots of stigma, fear of being ostracized socially, and of being labeled as weak deter an individual from seeking treatment (Husain, 2020). Negative perceptions are not only found in the general population; research shows that negative attitudes are also present among doctors and medical students (Waqas et al., 2006).

Those who do go for treatment often feel like a failure or ashamed of needing to return for follow-up care after relapse (Ahmad, Hallahan, Khalily & Shah, 2019). The stigma that results leads to underreporting of mental illness and an avoidance of professional support (Javed et al. 2006; Suhail 2004).

However, there seems to be a change in the way things are shifting for Pakistan's mental health. Researchers have noticed an increase in awareness of mental health in recent years (Javed et al., 2020; Shah, 2019; Shah et al., 2019). Organizations like the Pakistan Association of Mental Health (PAMH) have conducted educational campaigns via free seminars and media broadcasts focusing on the fact that mental illness is treatable (Javed et al., 2020; Shah, 2019). The Pakistan Medical Council (PMC) has made the study of psychiatry mandatory in medical schools (Javed et al., 2020), and public figures - actors, zingers and other celebrities - have started to speak up openly about their own experiences of mental health problems (Mehmood, 2020). These

developments are indicative of the possibility that Pakistan might enter a new phase where openness and awareness towards mental health issues will increase (Javed et al., 2020).

Despite such promising changes, there are limited studies focusing on changing attitudes and beliefs towards mental illness in Pakistan. Earlier studies (Javed et al., 2006; Suhail, 2005) involved small, local samples or had been undertaken a long time ago, and were thus not very representative of the current views. Moreover, many previous investigations were based on a quantitative design; such a design does not get the depth and the complexity of the cultural attitudes (Waqas et al., 2014). Shafiq (2019) identifies this gap and urges further qualitative research to better understand the beliefs of the public towards mental illness.

In light of a growing awareness of this issue, the current study attempts to fill the gap by examining the beliefs and attitudes of educated urban Pakistanis towards mental illness and its treatment. Specifically, it tries to answer the question: What are beliefs and attitudes about mental illness and its treatment in Pakistan in the era of growing awareness?

The objectives of the research are threefold:

i. to investigate the beliefs related to mental disorders among educated Pakistanis living in urban areas; and
ii. to investigate attitudes related to mental illness and persons experiencing mental illness; and
iii. to identify perceived barriers as well as facilitating factors regarding mental health treatment-seeking behavior among this demographic.

It is expected that the findings will provide valuable information to mental health professionals, educators, and policy makers in terms of design to develop culturally sensitive awareness programs and interventions which are relevant to the changing mental health perspectives of Pakistan's urban educated population.

LITERATURE REVIEW

This chapter will next present some of the past studies that were conducted on the beliefs and attitudes of mental illness in Pakistan. To do so, it will first address theoretical models to put things into perspective. Next, the discussion will focus on the relationship between culture, attitudes towards the mentally ill, beliefs concerning mental illness, and treatment seeking. The beliefs and attitudes towards mental illness that were found to be prevalent in the context of Pakistan would subsequently be discussed in detail. Lastly, the preliminary indications of an increase in mental health awareness in Pakistan will be discussed.

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Theoretical Models

The correlation of culture, beliefs and attitudes is something that has long been of interest to sociologists (Chaudhry, Khan, Mani & Ming, 2016). Many theoretical models have been put forward to explain the role that cultural and cognitive factors play in human behavior. Vygotsky (1986, a behaviorist from the sociocultural theory, suggests that things are learned through the beliefs and social interactions that are culturally dominant, and thus people tend to mold their way of thinking and act according to what is socially and culturally correct. Similarly, Bandura's social cognitive theory (1986) suggests that observational learning is a part that plays an important role in human behavior as humans develop their behavior through the interpersonal and environmental factors (Fabian, 2000).

Another influential framework is the Health Belief Model (HBM) proposed by Rosenstock, Strecher and Becker (1988) which states that when people are making decisions around health issues, it is the perception of the person's susceptibility to illness, severity of the illness, value of the treatment and the barriers that influence their behavior toward seeking care. The HBM has identified personal beliefs as a key factor in determining health behavior. This even applies to the field of mental health where a lot of studies have established that beliefs about the causation of mental illness directly determine attitudes towards persons with mental disorders and their treatment-seeking behavior (Adewuya & Makanjuola, 2008; Shafiq, 2019; Sheikh & Furnham, 2000).

Complementing the HBM, Engel's biopsychosocial model has helped to advance the understanding of mental distress as one having biological, psychological and social dimensions of illness (Babalola, Noel & White, 2017; Tripathi, Das & Kar, 2019). This model broadened the lens from strictly biomedical explanations and focused the lens on the fact that the cultural and social contexts are intrinsic to understanding mental illness and its manifestation among different populations (Tripathi et al., 2019). Importantly, the biopsychosocial model has informed the development of culturally adapted psychotherapies that are superior to directly transplanting Western models in non-Western contexts (Babalola et al., 2017; Tripathi et al., 2019).

The WHO has adopted the biopsychosocial approach in the conception of international mental health strategies, as it realized that culture plays a central role in mental health intervention (Babalola et al., 2017). However, the DSM-5 also recognizes that psychological disorders are affected by local traditions and belief systems (APA, 2013). Together, these frameworks highlight the importance of mental illness and the treatment of mental illness cannot be understood adequately without reference to the broader cultural, cognitive and social aspects of the ways in which individuals conceptualize these phenomena.

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Culture, Beliefs and Attitudes towards Mental Illness

Culture has a significant impact on the perception and understanding of mental illness (Shafiq, 2019). Beliefs and attitudes towards mental illness are influenced by a number of factors such as personal knowledge, social interactions, media portrayals, and cultural stereotypes that are embedded in the cultural context (Chaudhry et al., 2016). The scientific view on mental illness by Western countries is usually strongly biomedical, and the opposition between individualistic and collectivist cultures is of particular interest, because the view by Eastern societies of mental illness is more likely to be social, moral or spiritual (Papadopoulos, 2009).

In Western settings, mental illness is primarily attributed to biological or psychological factors. For instance, Schnittker (2013) reported that 67 % of Americans believed that depression is caused by biological factors such as genetic inheritance and chemical imbalance, whereas the same %age of Americans believed that depression is caused by everyday stressors. Only a few offered the divine will or moral weakness as an explanation. There are methodological limitations on the study conducted by the General Social Survey (which was used in the said study) however, similar studies have also been documented in other studies (Gopalkrishnan, 2018; Hechanova & Waelde, 2017; Jiloha, Daumerie, Bantman & Roelandt, 2019). In contrast, cross-cultural comparisons have revealed that Indian subjects tended to attribute mental illness more often than French subjects to sins in previous lives, anger of the deities, or evil spirits (Jiloha et al., 2019). Similarly, in a study of UK Muslims, many of them attributed mental illness to a lack of spirituality or irregular religious practices (Cinnirella & Loewenthal, 1999), a result later replicated by Ahmed et al. (2018) and Pargament and Lomax (2013).

Beliefs concerning the causes of mental illness have a great impact on attitudes towards people with those illnesses (Hampton, 2017). Stigmatizing attitudes (prejudice) and/or stigmatizing behaviors (discrimination) toward individuals with mental illness are widespread in societies (Krendl & Pescosolido, 2020, p. 150). Some of the dominant stereotypes about people with mental illness portray them as dangerous, weak, or incompetent (Riffel & Chen, 2019). Consequently, such associations can cause social distancing and discrimination (Schnittker, 2013). The existing research indicates that stigma is more severe in Eastern cultures, which tend to attribute mental illness to moral failing (Krendl & Pescosolido, 2020). A large-scale international study reported that 16% of respondents from developing countries reported stigmatizing attitudes compared with 8% for North America (Brown, Ing, Seeman & Tang, 2016). There has also been a significant association with supernatural causes and increased bias and social exclusion (Haddad et al., 2016). In keeping with this, Islamic participants in Cinnirella and Loewenthal's (1999) study who linked mental illness with lack of faith displayed a stronger stigmatizing attitude than other ethnic minorities.

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Treatment-seeking behaviour is related to beliefs and attitudes. Despite the existence of services in most countries, the utilization of mental health services is low (Schnittker, 2013). As many as 70% of mentally ill persons in Eastern countries are receiving no treatment (Henderson, Evans-Lacko & Thornicroft, 2013). People who attribute biomedical causes to mental illness are more likely to seek professional help, while people who make supernatural and moral explanations are more likely to avoid psychiatric treatment (Schnittker, 2013; Kishore et al., 2019). For instance, in India, societal conceptions of mental illness as being related to sexual dysfunction/disease and divine punishment produce mistrust towards psychiatrists and prevent people from going for treatment, even more so when coupled with stigma (Kishore et al., 2019). Stigma may also further spread specifically to the family members, as seen for example in Girma et al.'s (2014) study, but the gender disproportion (81.2% female participants) inhibits the generalizability of the results.

From this review, it is clear that existing literature suggests that cultural beliefs about mental illness directly influence societal attitudes, stigma and help-seeking. These culturally embedded perceptions are important to take into consideration in the development of effective mental health awareness interventions and service utilization in sociocultural contexts.

Beliefs, Attitudes, and Treatment Approaches toward Mental Illness in Pakistan

Culture significantly impacts the perception and understanding of mental illness (Shafiq, 2019). Beliefs and attitudes towards mental illness are influenced by several factors such as personal knowledge, social interactions, media portrayals, and cultural stereotypes that are embedded in the cultural context (Chaudhry et al., 2016). The scientific view on mental illness in Western countries is usually strongly biomedical. The opposition between individualistic and collectivist cultures is of particular interest because the view by Eastern societies of mental illness is more likely to be social, moral or spiritual (Papadopoulos, 2009).

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Emerging Awareness and Changing Attitudes toward Mental Illness in Pakistan

While most previous research found a prevalence of stigmatizing beliefs and supernaturalism about mental illness in Pakistan (Ahmed et al., 2018; Ali & Gul, 2018; Farooqi, 2006; Husain et

al., 2019; Javed et al., 2020; Shafiq, 2019; Taj et al., 2008), recent studies have documented an increase in awareness and improvement in attitude towards mental illness (Tariq & Mohammad, 2017). While university students largely had negative perceptions, as reported by Javed et al. (2006), some light at the end of the tunnel was reported by some respondents. In addition, Haddad and colleagues (2016) found that of medical practitioners, 98.5% believed in bio-psychosocial causes for depression, whereas only 37.2% referred to the supernatural. Waqas et al. (2014) also discovered that while participants attributed the greatest importance to religion in mental health treatment (79.3%), 63.4% felt that the most appropriate professional(s) for such treatment are psychiatrists and psychologists.In comparison to the findings from Suhail (2005), which showed that respondents of the Muslim community are prone to misguiding psychological symptoms for physical ailments, recent research shows an increasing level of literacy and scientific awareness about mental illness. For example, Husain et al. (2017) found that the most popular causes of psychosis among 3500 participants were stress and excessive worry, and not supernatural influences, an encouraging correlation with evidence-based models.

A number of institutional and media-led programs have also gone a long way in spreading awareness. Due to increasing mental health from the nation (Khalily, 2011), Pakistan Medical Council has announced psychiatry as an integral part of medical education (Javed et al., 2020). In order to remove such stigma, the Pakistan Association of Mental Health (PAMH) has intensified public education through free seminars, radio and television campaigns and outreach programs about the belief that mental illness is incurable (Javed et al., 2020; Shah, 2019).

More and more newspapers, in particular the national newspaper DAWN, have published discussions about mental health issues like depression and suicide (Aijazuddin, 2020; Ebrahim, 2020; Hasan, 2016, 2020; Mansoor, 2018; Mian, 2020; Mubbashar, 2019; Mustafa, 2018; Rehman, 2019; Rehman & Haque, 2020). Although the media has generally been condemned for perpetuating stereotypes (Srivastava et al., 2018), there is evidence that the disclosure of personal experiences with mental illness by celebrities is effective in improving public awareness and help-seeking behavior (Calhoun & Gold, 2020). In line with this worldwide trend, a number of Pakistani celebrities-whether they are actors, businessmen, politicians, or writers-including but not limited to Mahira Khan, Momina Mustehsan, Imran Abbas, Mawra Hocane, Meesha Shafi, Juggun Kazim, Hina Altaf, Mushk Kaleem have written about issues related to mental health, thus aiding in their normalization (Saleem & Kiran, 2020).

At this point, we can say that there is a growing acceptability of mental health discourse in Pakistan. Again, in light of this change in climate scholars like Shafiq (2019) suggest the need for more qualitative studies to understand the developments in beliefs and attitudes. Such research would be important for mental health professionals and policymakers so that

interventions can target the reduction of stigma as well as the improvement of culturally responsive care.

METHODS

Design

A qualitative research design with a thematic analysis approach was selected for this study. As the aim of the study was to explore the various factors influencing the participants' beliefs, perceptions and attitudes towards mental illness in Pakistan, a phenomenological approach was used (Neubauer, Witkop & Varpio, 2019). A qualitative approach is more appropriate than a quantitative approach in capturing layers of data regarding human perceptions and experiences and the meanings that the participants attach to them and yields more valuable findings (Pope & Mays, 1995). A quantitative approach would have provided superficial data at best, making it difficult to investigate what is essentially a multi-faceted issue (Field, 2018).

Participants

The population of interest was Pakistani adults who had completed at least 14 years of education and resided in urban areas of the country.

The inclusion criteria, in full, were:

1. Participants must be of Pakistani origin.
2. Participants must be 18 years or older.
3. Participants must have completed at least 14 years of education (equivalent to a Bachelor's/undergraduate degree).
4. Participants must be fluent in English.
5. Participants must belong to/reside in an urban area of Pakistan.

The exclusion criteria were:

1. Individuals of Pakistani origin who have never lived in the country.
2. Individuals who have never resided in urban areas of the country.
3. Individuals below 18 years of age.
4. Individuals who are not Pakistani nationals even if they reside in the country.
5. Individuals with less than a 14-year education/minimum Bachelor's degree criterion.
6. Individuals not fluent in the English language.
7. Practicing mental health professionals (psychologists/psychotherapists/counselors).
8. Those with a history of mental health issues and/or who are currently receiving treatment for mental health issues.

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Participants of Pakistani origin who had never resided in Pakistan were excluded as their perspectives may not fully represent the beliefs and attitudes that have been acquired from direct exposure to the country's culture and society. Since the study was based on subjects living in urban centers, those coming from rural regions were excluded from the study because of the lack of access to mental health awareness media and facilities which would not have been best suited for the specific purpose of the study.

Further, they were required to have a minimum of 14 years education (equivalent to a bachelor degree), the purpose of which was to assure adequate educational background and understanding. Because interviews were carried out mostly in English, only people who could speak fluently were selected. Mental health professionals were excluded in order to show lack of bias, since their professional perspective may vary from the population's perspective. For ethical reasons, subjects who had experienced mental illness were also excluded. Data was collected from 12 participants (6 males and 6 females) aged between 22 and 45 years. The sample size was determined using the principle of data saturation which is often found in qualitative studies using semi-structured interviews (Fusch & Ness, 2015). Previous studies confirm the view that saturation can easily be attained in a homogeneous sample of about 12 participants (Boddy, 2016; Guest, Bunce and Johnson, 2006), confirming the sufficiency of the chosen sample size.

Tools

The study utilized a semi-structured interview with 12 to 15 questions for data collection. Questions were rooted in research on the area, and the interview schedule and justifications for asking each question are in Table 1 below.

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Table 1: Interview Schedule with Rationale and References

	Questions	Rationale	References
1.	In your opinion, what are mental illnesses?	This question is aimed at ascertaining the participants' beliefs about mental illness. It is generally believed that the cultural ethos and in Pakistan's case, the religio-cultural ethos in turn influences belief systems (Farooqi, 2006). This means beliefs about mental health/illness influence people's attitudes towards individuals with mental illnesses and also play a crucial role in shaping their own treatment-seeking behavior (Schnittker, 2013). As such, it seems most pertinent to begin with this question.	Farooqi, Y., N. (2006) Traditional Healing Practices Sought by Muslim Psychiatric Patients in Lahore, Pakistan. *International Journal of Disability, Development and Education, 53*(4), 401-415. Schnittker J. (2013) Public Beliefs About Mental Illness. In: Aneshensel C.S., Phelan J.C., Bierman A. (eds) *Handbook of the Sociology of Mental Health*. Handbooks of Sociology and Social Research. Springer, Dordrecht.

2.	What do you think causes mental illness? Probe: Why do you think …. cause/s mental illness	Perceived causal factors play a considerable role in determining positive or negative attitudes towards mental illness in general as well as sufferers (Haddad et al., 2016). Beliefs in supernatural causes tend to be rife in Pakistan (Chaudhry et al., 2016; Haddad et al., 2016; Waqas et al., 2014). It has been found that this belief is very closely linked to negative attitudes like ostracism and biases against individuals with mental illness (Haddad et al., 2016; Sheikh & Furnham, 2000).	Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: a meta-synthesis. *Neuropsychiatric Disease and Treatment*, *12*, 2807. Haddad, M., Waqas, A., Qayyum, W., Shams, M., & Malik, S. (2016). The attitudes and beliefs of Pakistani medical practitioners about depression: a cross-sectional study in Lahore using the Revised Depression Attitude Questionnaire (R-DAQ). *BMC Psychiatry*, *16*(1), 349. Gureje, O., Olley, B. O., OLUSOLA, E. O., & Kola, L. (2006). Do beliefs about causation influence attitudes to mental illness?. *World Psychiatry*, *5*(2), 104. Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology*, *35*(7), 326-334.

		On the other hand, beliefs in biopsychosocial causes behind mental illnesses leads to less stigmatizing attitudes towards the mentally ill (Gureje et al., 2006). So this question really seeks to assess where the participant lies on the spectrum of attitudes towards the mentally ill.	Waqas, A., Zubair, M., Ghulam, H., Ullah, M. W., & Tariq, M. Z. (2014). Public stigma associated with mental illnesses in Pakistani university students: a cross sectional survey. *Peer Journal*, *2*, e698.
3.	Who do you think is more likely to develop a mental illness?.....Why?	This question will help to expose biases more fully as well as the extent of knowledge participants have about mental illnesses. It is generally agreed that mental illnesses have biopsychosocial causes and that mental illnesses can happen to anyone (Gureje et al., 2006; Read & Law, 1999).	Read, J., & Law, A. (1999). The Relationship of Causal Beliefs and Contact With Users of Mental Health Services To Attitudes To the "Mentally Ill." *International Journal of Social Psychiatry*, *45*(3), 216–229.

		This question ties in with the previous one about perceived causal factors and aims to see whether participants view the mentally ill to be at fault themselves as regards to their illness.	
4.	And so what do you think people can do to protect themselves from developing a mental illness? …..how can family, friends and society help?	It has been reported that family life and the nature of an individual's relationship with their family determines the state of their mental health (NIMH, 2001). This question seeks to ascertain whether the participant is aware of protective factors in the development of mental illnesses.	United States. Public Health Service. Office of the Surgeon General, Center for Mental Health Services (US), National Institute of Mental Health (US), United States. Substance Abuse, & Mental Health Services Administration. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General* (Vol. 2). Department of Health and Human Services, US Public Health Service.
5.	How would you describe someone with a mental illness? How would you be able to tell if someone is mentally ill?	This question aims to pick nuances in the participants' responses that will help to determine whether their attitudes towards mentally ill are positive/supportive or negative.	Ganasen, K. A., Parker, S., Hugo, C. J., Stein, D. J., Emsley, R. A., & Seedat, S. (2008). Mental health literacy: focus on developing countries. *African Journal of Psychiatry*, *11*(1), 23-28.

		The follow-on question will also serve this same purpose but will also expose the participants' literacy regarding mental health and their ability to identify or suspect the presence of a mental illness. This is important because mental	

		health literacy has been found to be low in most developing countries like Pakistan (Ganasen et al., 2008). Levels of mental health literacy are also linked with treatment seeking behaviors (Ganasen et al., 2008).	

6.	Following your description of mentally ill people, please tell me how you would interact with an individual you suspected had a mental illness?	This question will help to determine behaviors towards mentally ill individuals. Individuals with mental illnesses have been traditionally viewed as scary, dangerous and unpredictable and these beliefs lead to stigmatizing behavior which eventually causes social isolation, housing and job-related problems (Ozer et al., 2017).	Ozer, U., Varlik, C., Ceri, V., Ince, B., & Arslan Delice, M. (2017). Change starts with us: Stigmatizing attitudes towards mental illnesses and the use of stigmatizing language among mental health professionals. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences*, *30*(3), 224.
7.	How do you feel about individuals with mental illnesses working in important job roles?	Same as above	Ozer, U., Varlik, C., Ceri, V., Ince, B., & Arslan Delice, M. (2017). Change starts with us: Stigmatizing attitudes towards mental illnesses and the use of stigmatizing language among mental health professionals. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences*, *30*(3), 224.
8.	How would you feel if a mental health clinic was opened in your street? / What would you do if you found out your neighbour was mentally ill?	Same as above	Ozer, U., Varlik, C., Ceri, V., Ince, B., & Arslan Delice, M. (2017). Change starts with us: Stigmatizing attitudes towards mental illnesses and the use of stigmatizing language among mental health professionals. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences*, *30*(3), 224.

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9.	What do you think about the idea that people can recover from mental illnesses without professional help? Who else can provide help?	Studies have found faith healers to be one of the primary sources of help that people turn to for mental illnesses in Pakistan (Javed et al., 2020; Mubashar & Saeed, 2001). This question aims to determine whether the belief that faith healers can help cure mental illness is still rampant in the population.	Javed, A., Khan, M. N. S., Nasar, A., & Rasheed, A. (2020). Mental healthcare in Pakistan. *Taiwanese Journal of Psychiatry*, *34*(1), 6. Mubbashar, M. H., & Saeed, K. (2001). Development of mental health services in Pakistan. www.emro.who.int/ mnh/whd/TechPres-Pakistan1.pdf

10.	In your opinion, what factors or circumstances can influence a person seeking help for a mental illness? What factors can act as a barrier?	This question seeks to determine the various social, religious and cultural factors that may motivate or discourage individuals from seeking treatment for mental illnesses. Responses will help to lay bare the cultural context and the ways in which it is conducive to or prohibitive of help-seeking. The fear of being stigmatized and ostracized has been noted as being a primary inhibiting factor in help-seeking for mental illness in Pakistan (Waqas et al., 2014) and this question seeks to explore this matter further.	Waqas, A., Zubair, M., Ghulam, H., Ullah, M. W., & Tariq, M. Z. (2014). Public stigma associated with mental illnesses in Pakistani university students: a cross sectional survey. *Peer-review Journal*, *2*, e698.
11.	Where do you believe the cure to mental illness lies?	One of the key messages the Pakistan Association for Mental Health, PAMC, has been	Javed, A., Khan, M. N. S., Nasar, A., & Rasheed, A. (2020). Mental healthcare in Pakistan. *Taiwanese Journal of Psychiatry*, *34*(1), 6.

		seeking to drive home in its awareness campaigns is that mental illnesses are real and can be treated (Javed et al., 2020; Shah, 2019). As such, this question seeks to determine whether participants are aware that mental illnesses are treatable and how they can be treated. Beliefs about whether mental illnesses are curable would dictate help-seeking behaviors.	Shah, B. (2019, January 6). Mental health crisis. Retrieved from https://www.dawn.com/news/1455826

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12.	In your opinion, what are the care and strategies currently in place to help people with mental illness in Pakistan? What more do you think should be done?	Many individuals find that they are simply unaware of the available options for mental healthcare should they find themselves suffering from mental distress. This comes down to lack of awareness and virtually no information provided to people on where to seek help (Ali & Gul, 2018). As such, the question aims to assess how aware participants are of the institutions in place to provide mental health treatment and it also seeks to understand what people think should be done.	Ali, T. M., & Gul, S. (2018). Community mental health services in Pakistan: Review study from Muslim world 2000-2015. *Psychology, Community & Health, 7*(1), 57-71. doi:10.5964/pch.v7i1.224

13.	Finally, how has Pakistani media informed your views on mental health issues? Do you feel there has been any change in perspectives towards mental illness?	This question seeks to assess whether participants agree that mental health awareness in the country has increased. In very recent times, a change in the narrative around mental health awareness has been noted where it has been observed that efforts to increase mental health awareness in the country have been ramped up (Javed et al., 2020; Shah, 2019). A response in the affirmative would be taken as a positive in the attempts to spread mental literacy in the country and a response in the negative would be taken as a sign that not enough has been done. The question will also go beyond a simple yes/no answer to address how Pakistani media has portrayed mental health issues in recent years.	Javed, A., Khan, M. N. S., Nasar, A., & Rasheed, A. (2020). Mental healthcare in Pakistan. *Taiwanese Journal of Psychiatry*, *34*(1), 6. Shah, B. (2019, January 6). Mental health crisis. Retrieved from https://www.dawn.com/news/1455826

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Data Collection Procedure

Following written consent from the University of Liverpool Ethical Committee (Ethical approval), data were collected using the snowball sampling technique. Since the researcher's acquaintances, friends and family members were occupied with other tasks, a recruitment advert was electronically sent through WhatsApp and the recipients were requested to share with their contacts. Potentially selected participants were contacted by the researcher via her university email address and provided with detailed information about the study and a consent form. The first contacts that helped with distribution were not included as participants.

Participants were made aware of their rights which included confidentiality, anonymity, and voluntary participation. They were told that they could drop out of the study at any time before the transcription, that there were no costs or rewards whatsoever and that they could call the researcher for any questions.

After logging, signed consent forms were returned, and interview appointments were arranged by e-mail. Using Zoom video calls, all interviews were remote (45 minutes to one hour) and audio recorded with the permission of the participant. The recordings were transcribed by the researcher personally and all the audio files were deleted after transcription.

All transcripts were anonymized and kept securely on a password-protected computer. A debriefing document, which informed the participants about the parts of the study, thanked the participants for their participation, and included contact information for the researcher to re-contact them in the future, was mailed to the participants.

Data Analysis

Data was analyzed qualitatively using thematic analysis. Thematic analysis is a flexible approach to qualitative data analysis that helps analyze the data including latent content in depth to generate the maximum number of themes and subthemes present within the data (Braun & Clarke, 2006). As such, for the study's specific research question, which explored attitudes and beliefs towards mental illness in Pakistan, thematic analysis was an appropriate data analysis method.

The thematic analysis involved 6 significant steps (Braun & Clarke, 2006):

1. The student researcher familiarizes themselves with the research data.
2. Initial codes were generated.
3. The data was searched for themes.
4. Emerging themes were reviewed.
5. Themes were named.
6. A report on the study was compiled.

Ethics

Ethical approval was obtained from the University of Liverpool's ethics committee. No other official approval was required from any local body/ organization.

The researcher conducted the interviews electronically whilst secluded in a locked room, ensuring complete confidentiality for the participants and that no interview was conducted without the receipt of a signed consent form via email. Audio recordings and transcripts were anonymized and stored on a password-protected computer and were not shared with other individuals or organizations. The recorded interviews were deleted after the transcription, and the transcripts will be kept on a password-protected computer for 5 years after the completion of the study. Only the student researcher had access to the data and the transcripts were accessible only to the student researcher and her supervisor. Any quotations mentioned in the study cannot be traced back to any particular participant. Participants were also debriefed after the interviews and reminded that the interview questions were not diagnostic.

RESULTS

A total of 12 participants were recruited for the study; 6 were male and 6 were female, aged 22 to 45 years. All participants were of Pakistani origin, aged 18 or older, and from urban centers across the country. Table 2 shows demographic details of the participants.

Table 2: Participants and their demographics

Participant	Gender	Age	Profession/Occupation
Participant no. 1	Male	42	Journalist
Participant no. 2	Male	25	Not stated
Participant no. 3	Female	33	Housewife
Participant no. 4	Female	34	Communications Manager
Participant no. 5	Female	26	Masters Student
Participant no. 6	Female	32	Housewife
Participant no. 7	Female	41	Teacher
Participant no. 8	Male	38	PhD student
Participant no. 9	Male	22	Masters Student
Participant no. 10	Female	35	Teacher
Participant no. 11	Male	23	Masters Student
Participant no. 12	Male	28	Teacher

During the course of the interviews, the participants shared various perspectives about mental illness and its treatment in Pakistan. From the interviews, several categories were extracted, grouped into 15 sub-themes, which were further grouped into five themes. The five extracted themes are:

1. "General mental health awareness"
2. "Perceived barriers to treatment-seeking"
3. "Attitudes towards individuals with mental illness"
4. "Perceived facilitating factors in seeking mental health treatment"
5. "Perceived changes in perspectives towards mental health"

Table 3 shows how all the extracted codes were organized into themes and subthemes.

Table 3: Themes, subthemes and categories/codes

Themes	Subtheme 1	Subtheme 2	Subtheme 3	Subtheme 4
4.1. General Mental health awareness	**Perceptions on what mental illness is and its perceived signs**	**Causal beliefs and those who may be more prone to developing mental illness**	**Perceived protective factors**	**Knowledge about possible cures and mental health services in Pakistan**
Categories	Causes dysfunction	Genetic + environmental cause	Personal mental strength	Cure lies in medication
	Unlike normal people	Childhood trauma	Hobbies	Cure lies in having faith
	Issues with mood regulation	Excessive societal expectations	Remaining busy	Less knowledge of mental health services
	Unhealthy relationships	Men- high incomes	Meeting friends	Too few counselors in universities
	Sadness and worthlessness	Women-must be excellent housewives	Exercise	Superficial efforts
	Schizophrenia	Unequal opportunities	Looking after own health	Therapy Works
	Excessive sleep and talking	Negative personality traits	Adequate sleep	
	Social cues unidentifiable	Anyone can develop mental illness	Faith in God	
	Easily offended		Strong support system	

			Sharing problems	

4.2. Perceived barriers to treatment seeking	**Religio-cultural beliefs**	**Fear of being stigmatized**	**High cost of treatment and mistrust in mental health professionals**	
Categories	Parental discouragement	The 'crazy' label	High costs of treatment	
	Strict parenting	Loss of reputation	Affordable for only affluent people	
	Denial of mental health issues	Ostracism	Dismissive attitudes by therapists	
	Considered disease of the affluent	Center of gossip	Therapists ill trained	
	Lack of faith and prayer	Faithlessness	Therapists can exacerbate symptoms	
	Belief in dark forces behind mental illness	Weakness	Fear of confidentiality breach	
	Preference for faith healer	Cognitive deficiency	Fear of loss of anonymity	
	Dismissal of psychology as a field			
	Psychology a 'Western' science			
4.3. Attitudes	**Behavior towards**	**Appropriate place in society**		

towards individuals with mental illness	**mentally ill individuals**	**for individuals with mental illness- at the workplace**		
	Fear of befriending mentally ill people Cautious	Strong reservations More suited to junior roles		
Categories	Careful not to trigger individual Fear of unprovoked altercation and/or violence Unsure how to behave Kinder and gentler Sympathetic and non-judgmental Would reach out	Cannot shoulder much responsibility Negative effects on team Mentally ill handicapped Inability to focus on task Scary Okay to work if symptoms mild Okay to work if getting treatment		
4.4. Perceived facilitating factors in seeking mental health treatment	**Personal level of awareness**	**Support- role of family, friends and society**	**Only Mental health professionals are qualified to treat mental illness**	

Categories	Realizing need for treatment Knowledge of available facilities providing treatment Knowing how therapy has helped others Normalizing treatment seeking Faith in God	Loved ones spending more time with individual Listen more Acknowledge distress Refrain from opinions Motivate individual Refrain from mocking	Loved ones can help in mild distress Only mental health professionals qualified to treat mental illness Faith-healing not a cure Professional help + faith are both essential	
		Refrain from ostracizing Paid leaves for treatment Reduce workplace pressure Speak out and break taboo		
4.5. Perceived changes in perspectives towards mental health treatment	**Increased awareness**	**Perceived role of the media**	**What more can be done?**	

Categories	Increased awareness Reduction in stigmatizing behavior	Mainstream media causes mental illness	More awareness campaigns	
	Awareness mainly in the affluent	Mainstream media fuels stereotypes	Government involvement and funding	
	Possibly just a fad	Increased coverage in DAWN Newspaper	Equal opportunities	
		More discussion on social media	More mental health facilities	
		More awareness due to social media	Subsidized rates	
		Celebrities opening up on social media	More therapists at schools Need for more awareness in educational institutions	
			Increased role of teacher	
			More awareness at the workplace	

General Mental Health Awareness

Participants primarily defined mental illness as a disorder that interferes with normal functioning and emotional control and typically results in problems with having healthy relationships. For example, one participant identified it as having a negative impact on other parts of his life, family, relationships and so on; while another singled it out for its sadness, self-harm and the view that "life is something worthless" (participant 11). When naming specific disorders, schizophrenia was the most common example mentioned, while some participants had doubts about whether depression and anxiety were types of mental illness: "I don't know if it's part of what you call a mental illness" (participant 4). Many common traits of the condition were identified as symptoms, and included sleeping in, talking in, fussiness, and not following the norms of social interactions, with one participant explaining how individuals "get snappy, don't eat well and snap at you" (participant 6).

Most of the participants recognized that mental illness is a multitude of mixed biological, genetic, and environmental factors including adverse childhood experiences as a common theme. Participants associated trauma, neglect and parental indifference with psychological problems later on in life, as evidenced in this statement: "someone who has been in a very abusive household" (participant 12). Societal expectations were also seen as important issues, in particular gender stereotypes. Women were expected to be self-sacrificing caregivers, perfect housewives and silently accept abuse, while men were supposed to be stressed by economic obligations and marriageability. As participant 3 points out, "most women have very little agency." I believe they contribute on those grounds. Personality characteristics like being too sensitive, pessimistic, or impressionable were also seen to be risk factors (participant 5) although some participants thought that 'anyone' could develop mental illness regardless of background (participant 1).

In terms of prevention, participants agreed that self-awareness, emotional competence, leisure activities, physical exercise, socialization, proper rest, and expression of emotions were important for mental health. Spiritual faith was seen as an essential source of stability and moral guidance, "I think being spiritually connected gives you the right direction" (participant 7). Social and familial support also was found to be vital protective factors against psychological distress, with one participant saying, "a strong support network is essential and if you don't have it, you don't know who to reach out to when you are stressed" (participant 3). Talking about emotional problems with close friends was also viewed as helpful.

Participants had varying opinions about treatment. For example, while some believed that medication was the cure for the mental illness (participants 1, 8 and 9), others placed faith at the heart of recovery - 'I would say having faith in God' (participant 3). One participant highlighted however that faith was not enough, and said that spiritual beliefs when not used with a professional intervention could be "counterproductive," emphasizing instead that "it is important to ask for help" (participant 6). Several of the participants perceived that increasing public conversation on mental health was an essential step towards the reduction of stigma and aid-seeking behavior (participants 2 and 10).

Overall, the knowledge about available mental health services in Pakistan was low. Many respondents stated that they knew "not many" facilities (participant 1) or "not much" about facilities (participant 4). Participant 1 articulated the fact that even large universities would only have several counselors for thousands of students, and participant 3 referred to governmental mental health programs as "cosmetic." Only two respondents (2 and 7) were aware of Therapy Works, a private organization that provides mental health services in three major Pakistani cities.

Perceived Barriers to Treatment-Seeking

Participants named a number of barriers discouraging people from seeking mental health treatment, and many of these were based on religio-cultural beliefs, stigma, and practical barriers such as the cost and distrust of professionals. Stern, disparaging parental attitudes were often blamed as significant deterrents. For a number of participants, the family did not seem like an environment in which it would be okay to talk about psychological distress. Parents were often said to be too strict (participant 4) or openly hostile toward therapy (participant 3) and some parents denied their children had problems until they got too severe (participants 6, 7, and 9). There was also fear of social blame and shame as one participant was told "you should not be telling people you have a mental illness because it reflects badly on us" (participant 2).

Outside of the family, mental illness and therapy were often "denied" (participant 5) or "trivialized" (participant 4) by the wider community. Several participants observed that mental illness was seen as 'a disease of the rich' and there was a very popular belief that only those people who seem 'physically mentally' actually needed help (participant 5). Such barriers were only added by orthodox orthodoxy. At least six of them emphasized the role of religio-cultural beliefs, such as the belief that mental illness is caused by a lack of faith, insufficient praying or supernatural forces such as "jinns" and "magic" (participant 8). As a result, faith healers were

usually consulted before mental health professionals. Religious leaders were also seen to support such views by rejecting the study of psychology as being "a product of the West" (participant 11) and preaching faith as the only acceptable solution. One of the participants explained: "So when they hallucinate, they say now the jinn has come" (participant 6), and another participant warned that "if religious [scholars] have a certain attitude, that attitude will spread to the grassroots" (participant 8).

The fear of being stigmatized came forth as another major deterrent. Participants indicated that people suffering from mental illness were often labeled as "crazy" (participants 1, 5, 8, and 9) and ridiculed, and excluded from a social circle. The possible wipeout of fame, gossip, and ostracizing drove to the environment cutting in the center of targeting that dissuades medical treatment. As one participant put it, "they will/ make fun of you and not take you seriously" (participant 9). Stigma reached family members who may be blamed for the condition of their relative, or considered faithless and weak.

Financial obstacles were also significant. Participants 2, 4 and 5 mentioned mental health therapy as prohibitively expensive and participant 2 stated treatment services seemed "targeted to the affluent members of society." Concerns were also raised over the competence and ethics of certain mental health workers. Participants reported examples of ill-prepared therapists creating worse conditions for patients-"there are therapists who have actually destroyed people" (participant 7), or of dismissive attitudes among clinicians who were treating clients as if they were "exaggerating it" (participant 10). Fears about violations of confidentiality and anonymity further damaged trust and many people have shied away from professional treatment entirely.

Attitudes and Behavior towards Individuals with Mental Illness

The participants' perception of working with people with a mental illness was shown to be fearful, uncertain and empathetic. Seven participants (1, 3, 5, 8, 10, 11, and 12) confessed feeling scared and uncomfortable around such people, admitting that they worried about serving as a trigger for them or being pulled into unknowable situations. As participant 1 said, "It is only natural when people try to distance themselves," and others (3, 5, 8, 11 and 12) expressed concerns about unnecessary aggression or outbursts. These fears expressed a subconscious social uneasiness and lack of knowledge about the nature of mental illness. Several participants (3, 5, 8, and 12) also admitted confusion as to what the 'right' way to behave or talk would be which highlights the continuation of discomfort and avoidance in social situations.

Despite these reservations not all attitudes were negative. Four participants (2, 6, 7 and 9) reported that their response became more empathic on learning that someone had a mental health condition. They felt they needed to be more patient, supportive and non-judgmental, as evidenced by participant 6's statement: "I would be more sympathetic...I would just try to be there and be non-judgmental." Two participants explicitly stated that they would try to contact and help, which suggests the existence of the duality of compassionate and cautious orientations to the mentally ill.

The participants were also probed on their attitudes towards the presence of the mentally ill in the workplace in particular for work that requires responsibility or leadership. Opinions were divided. Five participants (1, 3, 4, 7 and 11) ago had strong objections that the mentally ill should take only a junior or lower position. Participant 3 used the word "handicapped" to describe such individuals and participant 7 explained that their presence in key positions is "very scary" with concerns for concentration, reliability and stability in teams being highlighted. Six participants (5, 6, 8, 9, 10, and 12) had more accepting views, saying that people who are getting treatment or show mild symptoms should be allowed to work in key positions. As participant 10 said, "As long as they are on their meds, then why would I say no?".

Overall, the data paint a complex picture of a social perception at once marked by a distance from fear, and often a cautious empathy. While there were clearly stigmatized attitudes that were rooted within the social stereotypes that are developing, there was evidence of an increasing willingness to tolerate people with a mental illness if sufficient treatment was available and people were stable.

Perceived Facilitating Factors in Seeking Mental Health Treatment

From these results, participants found a range of influencing factors supporting treatment behavior for mental distress, putting Cicero back into action and on display much of what it requested: individual awareness, social funding and professional intervention. Personal realization of the need for treatment was considered central to the process of initiating help-seeking (participants 1 and 8). Awareness of the help that is available, along with seeing the effectiveness of therapy on others was seen as an essential motivator. Participants emphasized that the normalization of treatment-seeking at the entire society level was necessary to lessen stigma and hesitation, as the "helps the barrier to go to the counselor go down" (participant 1). As participant 12 observed, "Just knowing that there are places to go and that it's okay to go there gives confidence." Additionally, faith in God and belief in predestination were also

explained as things that could bolster the resolve of individuals to seek help (participants 1 and 7).

Social and familial supports were also identified as essential enablers to treatment-seeking. Participants 1, 2, 3, 4, 6, 10 and 11 highlighted the need for empathetic and patient responses from friends and family, in particular listening to and validating the feelings of individuals, not being dismissive or judgmental. Encouragement, emotional presence, and motivation provided by close networks were seen as instrumental in helping people to accept their condition and seek treatment. Workplace accommodations like allowing paid leave for therapy as well as alleviating pressure on employees having mental health issues were also suggested (participant 1). In a broader level, participant 8 underlined the influence of societal figures in easing taboos around mental illness: "one of the things I've seen has a big impact on removing the taboo out of my head at least is when people who I respect a lot and look up to openly discuss their mental issues in the past."

Finally, there was near unanimity among participants that while family and friends can play a supportive role, it is only qualified mental health professionals who are equipped to deal effectively with mental illness. Participant 9 summarized this view stating, "I think in early stages one can recover but if it becomes moderate then I think professional help and medicines are important." Similarly, participant 10 highlighted the combined role of "prayer and faith along with professional help" of achieving recovery. Collectively, the participants identified personal awareness, social encouragement, and faith as central to successful professional care as a means of promoting delay-free and effective treatment-seeking behaviors.

Perceived Changes in Perspectives towards Mental Health

Participants clearly said that mental health awareness has gone up in Pakistan significantly in recent years. All twelve participants expressed an increasingly open and visible reduction of stigmatizing behavior toward mental illness. Participants 1, 3, 6, and 10 spoke to this shift, where conversations around mental health have become more normalized. In contrast, participant 7 spoke to an increased awareness of mental health problems as legitimate medical issues. Participant 9 showed this shift bluntly: "The change is positive and if someone makes fun of someone's mental illness on social media then that gets screenshotted and goes viral." However, there were several participants, such as 3, 9, and 11, who were cautious that this awareness was more prominent in urban and elite populations, with little trickle-down in rural or lower socioeconomic populations. Participant 7 stated that they were skeptical that the

current surge of awareness may be a temporary "fad," instead of an outside cultural transformation.

Media was identified as a powerful force for change, although boundaries formed between effects of mainstream versus social media which were maintained sharply by participants. Seven participants (1, 3, 4, 9, 10, 11, and 12) criticized television channels for contributing to negative stereotypes and even mental distress. Participants 10 and 11 stated that some entertainment programs "actually caused mental illness" and participants 1, 3 and 9 added that the media often portrayed mentally ill characters as violent or unstable, such as "the 'mad' domestic woman" (participant 3). In contrast, social media received much positive feedback from participants 2, 5, 6, 8, 10, and 11 about encouraging more discussion and challenging traditional silences around mental health. Participants 1 and 8 additionally credited DAWN newspaper for more coverage on mental health issues, suggesting a slow progression in print journalism to be more responsible in its representation.

Despite these positive developments, all the participants agreed there is still much work to be done. Saliently, they emphasized the need for long-lasting national awareness campaigns, government economic resources, and including religious scholars to integrate mental health education with the spiritual and cultural context in Pakistan (participant 8). Participant 9 emphasized the need to increase the number and subsidize treatment facilities so that services are available to all socioeconomic groups. Educational facilities were considered an essential means of early intervention. Participants 1, 2, 3, 4, 7 and 12 suggested initiatives such as psychological assessments on students (participant 1), mental health education as part of curricula (participants 2 and 3) and hiring professional counselors for every school (participant 12), pointing out that "this is the period when a person is more prone to developing mental issues." Participant 7 also suggested advancing workplace mental health programs so they could be more available to a large portion of the population.

In summary, participants felt there was a definite improvement in societal attitudes towards mental illness and they attributed much of this to social media and the increased public discourse of mental wellness. However, they also acknowledged the continuing levels of inequity in terms of access, cultural stigma (which regarding mental health can be a reason not to access health services) and structural support. The consensus highlighted that even though Pakistan has reached a new stage in mental health awareness, constant and multi-sectoral engagement between government, education, religion and media - is crucial to continuous and deepened positive change.

DISCUSSION

The objective of this study, in the context of increasing awareness among people in the community, was to examine beliefs and attitudes about mental illness and treatment in Pakistan. Findings revealed a definitive increase in mental health literacy, as expressed by participants in closeness to the American Psychological Association's definition of mental disorders APA, 2013. Most of the participants identified mental illness with dysfunction and decreased emotional regulation. However, there remained confusion about some conditions (however, schizophrenia remained readily identified) such as depression and anxiety, with depression impacting an estimated 322 million people around the world (Freidrich, 2017) compared to 20 million for schizophrenia (James et al., 2018). This is similar to Naeem et al. (2012), who found low levels of awareness about depression, which increases the need to improve mental health education.

A striking change from past research (Cinnirella & Loewenthal, 1999; Haddad et al., 2016; Imran et al., 2015; Mullick et al., 2013; Shah et al., 2019; Sheikh & Furnham, 2000) was the complete absence of supernatural attributions. Ninety % of participants supported biopsychosocial explanations of mental illness, with social stresses and gender roles playing an important role in causing mental illness. Such a shift is of importance since belief in biopsychosocial causes is correlated with reduced stigma and higher acceptance of treatment (Schittaker, 2013). Only one person had mentioned prayer as a protective factor (Ahmed et al., 2018), and others emphasized social support, physical activity, and meaningful activity as preventive activities - a very positive turn from a culture that thinks that people with mental illnesses lack religious observance (Pargament & Lomax, 2013).

In contrast to previous studies in which strong belief in spiritual healers was emphasized (Farooqi, 2006), it was found that none of the participants of this study considered the latter as ultimate curative agents. Eleven were in the view of many study participants only trained mental health professionals were qualified to treat mental illness - a view which showed the increasing trust in professional ability and the declining reliance on traditional healers (Haddad et al., 2016; Shafiq, 2019).

In spite of this progress, participants found that there still remained structural and cultural barriers. Many reported that widespread public beliefs of a link between mental illness and weak faith or supernatural causes still cause treatment delays and perpetuate stigma (Ahmed et al., 2018; Pargament & Lomax, 2013). Half of the participants cited dismissive parental attitudes as a significant barrier to psychiatric care, similar to previous studies of the role of

fear of social shame in not seeking psychiatric help (Husain et al., 2019). Participants stressed the importance of parent education because positive family and social networks were viewed as important facilitators of recovery. Additional barriers were high cost of treatment (Farooqi, 2006, Shafiq, 2019: Taj et al., 2008), fear of being labeled "weak" (Pargament & Lomax, 2013), and distrust of poorly trained or unethical therapists. Dealing with these requires both better training of professionals and increased public awareness efforts.

Despite stating more neutral stigmatizing beliefs about causes, participants showed ambivalence in their behavior toward persons with mental illness. Over 50 % said they were afraid of unpredictable behavior, and nearly 50 % said such people should not be in important job positions. These avoidance-based attitudes are indicative of enduring stigma (Schittaker, 2013) and imply that the cognitive awareness of diversity does by no means lead to inclusive social behaviour.

Comparing the results with the past Pakistani studies shows a positive trend. Whereas earlier studies (Javed et al., 2006; Suhail, 2005) have shown a lack of awareness and negative attitudes, however, in more recent studies of the past few years (Javed et al., 2020; Shafiq, 2019; Shah, 2019) and the current study, there is an increasing openness and sense of awareness, which was mainly brought about by social media engagement. Nonetheless, the persistence of treatment barriers and stigmatizing behaviors suggests that this progress might be concentrated within educated urban populations rather than being widespread.

Overall, the results indicate a new paradigm with a mixed picture: there are beneficial transformations in bio-psychosocial insight and reliance on professionals, but remaining issues are structural, cultural, and behavioral in nature and continue to obstruct the realization of fair mental health outcomes throughout Pakistani society.

Limitations and Recommendations for Future Research

The study's conclusions cannot be generalized due to its small sample size and focus on a small segment of society educated urban adults. Also, a social desirability bias cannot be ruled out whereby some participants may have been driven to provide more seemingly favorable responses to the researcher in lieu of genuine opinions (Ross & Zaidi, 2019).

More research needs to be carried out on this topic in Pakistan in order to truly ascertain levels of mental health literacy in different social groups across the country. To achieve this, it is recommended that future research focus on recruiting larger sample sizes from different strata of society in order to achieve a more holistic picture of the beliefs and attitudes towards mental

illness in the general public. This is important as there has been increased information about mental illness in the country and participants who are educated may have more access to this information than others. In doing so, a qualitative approach, as employed in the current study, may yield deeper, more actionable data (Shafiq, 2019).

CONCLUSION

The results of this study reflect an evident increase in the awareness of mental health among urban and educated adults of Pakistan. Participants showed an increased understanding of mental illness and its causes which is a significant step towards more empathy and less blame of the sufferer. This increasing awareness is expected to lead to people accessing professional help as opposed to hiding their difficulties (Simmons, Jones & Bradley, 2017). The assumption that only trained mental health professionals are qualified to deliver treatment is another sign of growing faith in professional expertise and recognition of mental illness as something to be addressed as a health issue.

Despite this good progress, there are still significant challenges. Parental lack of awareness regarding the mental health of the child, religious or super-naturalistic beliefs, the high cost of treatment, and lack of trust towards practitioners remain among the significant barriers to medical care. Addressing these issues involves focused education for the parents, consultation with religious leaders to debunk myths, and providing affordable, well-regulated mental health services with competent practitioners.

Long-term and sustained efforts are important in order to change the belief systems into inclusive, non-stigmatizing attitudes towards people suffering from mental illness. By bringing attention to emerging awareness, as well as still persistent misunderstandings, this study contains valuable insight for policymakers as well as awareness campaigners. The results can be used to inform the design of evidence-based, culturally sensitive interventions focused on promoting understanding, dispelling stigma, and encouraging help-seeking behaviors in Pakistani society.

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