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Public Perceptions of Mental Health and Help-Seeking Behaviour: A Sociocultural Perspective from Pakistan

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ABSTRACT

Public perceptions influence how mental health problems are recognised, discussed, and treated. In Pakistan, improving awareness has increased public discussion of depression, anxiety, psychological distress, and suicide prevention; nevertheless, stigma, limited mental health literacy, supernatural explanations, concerns about family reputation, financial barriers, and inadequate services continue to delay professional help-seeking. This narrative review examines the relationship between public perceptions of mental illness and help-seeking behaviour, with particular attention to Pakistan's cultural, religious, familial, and healthcare context. Evidence indicates that many individuals initially rely on self-care, prayer, relatives, friends, teachers, general practitioners, or religious healers before consulting psychologists or psychiatrists. These choices should not be interpreted simply as resistance to medical treatment because they are shaped by social trust, affordability, accessibility, cultural legitimacy, and previous experiences with healthcare services. However, professional support may be delayed when mental illness is interpreted exclusively as weakness, moral failure, divine punishment, or supernatural influence. Sustainable improvement requires culturally responsive mental health education, confidential and affordable services, integration of mental healthcare into primary care, collaboration with families and religious leaders, school-based support, digital counselling, and expansion of the mental health workforce. Public attitudes can be transformed most effectively when awareness initiatives are linked with accessible, trustworthy, and rights-based services.

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Introduction:

Mental health is shaped not only by biological and psychological processes but also by the meanings that societies attach to emotional distress. Public perceptions determine whether depression is recognised as a treatable condition, whether anxiety is dismissed as ordinary weakness, whether a person feels safe disclosing psychological symptoms, and whether professional treatment is considered legitimate. The concept of mental health literacy includes the ability to recognise mental disorders, understand their possible causes, identify appropriate sources of assistance, and hold beliefs that facilitate timely intervention. Poor mental health literacy can cause symptoms to be normalised, concealed, spiritualised, or treated only after they become severe. Stigma is especially important because it operates at several levels. Public stigma includes negative stereotypes and discriminatory attitudes within society. Perceived stigma is the expectation that others will respond negatively, while self-stigma occurs when individuals internalise these social judgments. Together, these processes can reduce self-esteem, encourage secrecy, and discourage people from contacting mental health professionals. Systematic reviews have consistently identified stigma, embarrassment, poor symptom recognition, confidentiality concerns, preference for self-reliance, and uncertainty about treatment as important barriers to help-seeking. Pakistan presents a particularly important context for examining these relationships. Mental health services remain concentrated mainly in urban tertiary-care institutions, with limited integration into routine primary healthcare. Rural populations, low-income households, women with restricted mobility, and people living far from major hospitals may therefore experience both attitudinal and structural barriers. Recent reviews recommend greater public investment, workforce expansion, mental health education, primary-care integration, community-based services, and constructive engagement with traditional and religious care systems.

Public Understanding and Recognition of Mental Health Problems:

Public understanding of mental health exists on a continuum. Some people recognise depression, anxiety, trauma, psychosis, and substance-use disorders as health conditions requiring assessment and treatment. Others interpret psychological symptoms as temporary sadness, lack of discipline, weak faith, poor upbringing, attention-seeking, or an inability to tolerate ordinary life pressures. These interpretations influence whether symptoms are disclosed and what type of assistance is considered appropriate. Recognition is frequently more difficult when psychological distress is expressed through physical symptoms. Headaches, sleep disturbance, digestive problems, fatigue, chest discomfort, and unexplained pain may lead people to consult general physicians repeatedly without discussing emotional difficulties. This pattern does not mean that symptoms are imaginary; instead, it demonstrates how psychological distress may be understood and communicated through culturally acceptable physical language. The labels used for mental illness can also influence behaviour. Derogatory expressions equating mental illness with dangerousness, unpredictability, incompetence, or permanent “madness” create distance between the public and affected individuals. People experiencing relatively common conditions may avoid counselling because they fear being associated with severe psychiatric illness. Public education should consequently explain that mental health conditions vary in type and severity, that recovery is possible, and that seeking early assistance does not automatically imply hospitalisation or lifelong medication. Mental health literacy must extend beyond recognising diagnostic names. It should include knowledge of warning signs, available services, evidence-based treatment, confidentiality, crisis support, and the distinction between psychologists, psychiatrists, counsellors, social workers, and general practitioners. Greater knowledge can improve recognition, but knowledge alone may not change behaviour when services remain expensive, inaccessible, or socially unsafe.

Cultural, Religious, and Familial Influences:

Pakistani understandings of mental health are formed within family relationships, religious traditions, community expectations, socioeconomic pressures, and local explanatory models. Distress may be

attributed to interpersonal conflict, academic pressure, unemployment, poverty, bereavement, trauma, biomedical causes, spiritual weakness, the evil eye, sorcery, possession, or divine testing. These explanations are not always mutually exclusive. An individual may simultaneously believe that depression results from stressful circumstances, biological vulnerability, and spiritual disturbance. Religion can act as both a protective resource and a pathway that delays clinical treatment. Prayer, religious reflection, social belonging, hope, and guidance from trusted religious leaders may provide emotional support. Problems arise when a person is told that professional treatment demonstrates weak faith or when severe symptoms are managed exclusively through non-medical practices. A culturally responsive model should not ridicule religious beliefs. It should encourage religious leaders and healthcare professionals to recognise when spiritual support can complement psychological or psychiatric care. Family involvement is similarly complex. Families frequently provide financial assistance, transportation, emotional support, and supervision of treatment. At the same time, some individuals require family permission before consulting a professional, especially young people and economically dependent women. Families may discourage disclosure because of concerns about reputation, marriage prospects, employment, social judgment, or the belief that private problems should remain inside the household. A large Pakistani survey involving 3,500 participants identified lack of confidence in psychological treatment, religious fatalism, neglect of mental disorders, fear of social defamation, personal shame, negative perceptions of practitioners, family prohibition, and fear of treatment as barriers to psychological help-seeking. These findings demonstrate that reluctance is rarely caused by one belief; it usually results from interconnected personal, familial, cultural, and service-related concerns.

Stigma, Gender, Socioeconomic Position, and Service Barriers:

Stigma creates practical consequences beyond negative opinions. A person may conceal symptoms, delay treatment, travel to a distant clinic to avoid recognition, discontinue medication secretly, or describe a psychiatric appointment as treatment for a physical illness. Fear of being labelled can be especially strong in closely connected communities where privacy is difficult to maintain. Gender norms influence the expression of distress and access to care. Men may be expected to demonstrate emotional control and self-reliance, making counselling appear inconsistent with dominant ideas of masculinity. Women may be more willing to acknowledge emotional distress but may face restrictions involving mobility, finances, family approval, childcare, or fear that a diagnosis will be used against them. Gender-sensitive services must therefore address both men's reluctance to disclose vulnerability and women's structural constraints. Economic position also affects help-seeking. Private psychological therapy may be unaffordable for low-income households, while public facilities may have long waiting periods or may be located far from rural communities. Costs include not only consultation fees but also transportation, lost wages, childcare, medication, and repeated follow-up visits. Individuals may therefore choose familiar and locally available sources of support even when they recognise the value of professional treatment. Provider-related factors are equally important. People are less likely to seek or continue treatment when they encounter dismissive communication, inadequate privacy, brief consultations, unexplained medication, culturally insensitive advice, or uncertainty about professional qualifications. Improving public attitudes without improving service quality risks placing responsibility entirely on individuals. Trust develops when services are confidential, respectful, affordable, competent, and responsive to local languages and cultural contexts.Pakistan's mental health treatment gap is consequently both a perception problem and a health-system problem. Limited specialist availability, urban concentration of services, insufficient primary-care integration, and low public knowledge reinforce one another.

Patterns of Help-Seeking and Emerging Sources of Support:

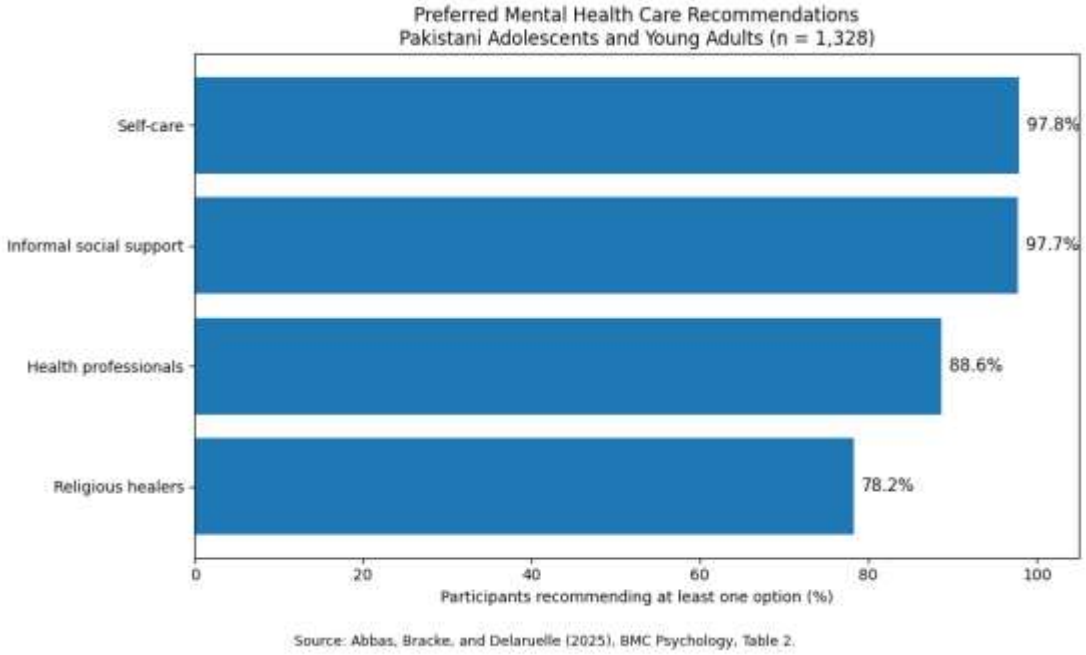
Help-seeking should be understood as a process rather than a single decision. People often begin by attempting to manage symptoms independently through rest, prayer, exercise, entertainment, changes in

sleep, or withdrawal from stressful situations. They may then speak to relatives, friends, teachers, colleagues, religious leaders, traditional healers, general physicians, counsellors, psychologists, or psychiatrists. Movement between these sources may occur repeatedly. A 2025 study of 1,328 Pakistani students aged 15–24 found that 97.8% recommended at least one form of self-care, 97.7% recommended at least one source of informal social support, 88.6% recommended at least one form of support from health professionals, and 78.2% recommended at least one form of support from religious healers. The categories were not mutually exclusive, demonstrating that respondents could support multiple pathways simultaneously. The same study found stereotypical attitudes among 51.7% of participants, while approximately one quarter underestimated the severity of the presented mental health complaints. These findings challenge the assumption that people select either traditional or professional care. Many individuals combine prayer, family assistance, medical consultation, and psychological treatment. The policy objective should therefore be to create safe referral pathways between community support and professional services. Religious leaders, teachers, general physicians, and community workers can be trained to identify warning signs and encourage timely referral without being expected to replace qualified mental health practitioners. Digital mental health services may expand access for young adults, people with mobility restrictions, and residents of underserved communities. Telephone counselling, telepsychiatry, secure video sessions, and evidence-based digital interventions can reduce travel and provide greater anonymity. However, digital services introduce challenges involving internet access, privacy at home, data security, practitioner regulation, and the risk of relying on unverified social-media advice. Digital care should supplement rather than substitute for emergency, specialist, and face-to-face services when these are clinically required.

Strategies for Improving Perceptions and Professional Help-Seeking:

Effective interventions must operate at individual, family, community, institutional, and policy levels. First, mental health education should be incorporated into schools, colleges, universities, workplaces, primary-care centres, and public media. Campaigns should use Urdu and regional languages, explain common symptoms in accessible terms, challenge myths about dangerousness and personal weakness, and clarify where confidential assistance is available. Second, awareness programmes should involve people with lived experience. Evidence suggests that contact-based interventions—where members of the public hear credible recovery experiences—can produce meaningful improvements in attitudes. Messages should present treatment realistically, acknowledging that recovery may involve medication, psychotherapy, social support, lifestyle changes, and continued follow-up rather than promising immediate cures. Third, mental healthcare should be integrated into primary healthcare. General practitioners, nurses, Lady Health Workers, teachers, and community workers can receive training in basic identification, supportive communication, referral, and follow-up. Integration can make services more accessible and reduce the visibility associated with visiting a specialist psychiatric facility. Pakistani stakeholders have previously supported primary-care integration, although implementation and workforce limitations remain significant. Fourth, engagement with families and religious leaders should be respectful and evidence-based. Training can help community leaders distinguish ordinary distress from symptoms requiring urgent clinical assessment. Referral networks can enable spiritual support and professional treatment to operate cooperatively rather than competitively. Fifth, confidentiality and service quality must be strengthened. Clear privacy policies, discreet appointment systems, professional licensing, culturally competent communication, affordable fees, and transparent treatment explanations can increase public confidence. Special attention should be given to adolescents, women, rural populations, people with disabilities, disaster-affected communities, and economically marginalised households. Finally, Pakistan requires nationally representative research on public attitudes, actual service utilisation, regional differences, gender, rural–urban inequalities, and the long-term effects of anti-stigma interventions. Cross-sectional studies describe associations but cannot establish how perceptions

change over time. Longitudinal and intervention-based studies are necessary to determine which strategies produce sustained behavioural change.



Source: Abbas, Bracke, and Delaruelle (2025), BMC Psychology, Table 2.

Summary:

Public perceptions of mental health strongly influence recognition, disclosure, social support, and treatment-seeking. In Pakistan, psychological distress is understood through overlapping biomedical, psychosocial, familial, religious, and supernatural explanations. Self-care, family support, prayer, religious guidance, and professional treatment often coexist rather than functioning as entirely separate pathways. Stigma remains an important barrier, but it should not be examined independently of cost, distance, privacy, provider behaviour, family authority, gender expectations, and service shortages. People cannot be expected to seek professional support merely because awareness has improved; appropriate services must also be available, affordable, confidential, and trustworthy. A sustainable response should combine mental health literacy programmes with primary-care integration, school and workplace services, digital access, trained community referral networks, family engagement, collaboration with responsible religious leaders, and expansion of the professional workforce. The central objective is not to replace culturally meaningful sources of support but to ensure that they do not prevent people from receiving timely evidence-based care. Transforming public perceptions and transforming mental health services must occur together.

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