Original research

ATTITUDES TOWARD MENTAL HEALTH AND PSYCHOTHERAPY IN A COLLECTIVISTIC MUSLIM CULTURE: VARIATIONS BY GENDER, AGE, EDUCATION, MARRIAGE, PROFESSION, AND INCOME

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Abstract: In some cultures, psychological problems and treatment are mostly not considered as important as medical illnesses. This is generally because of people's attitudes toward mental disorders and psychotherapeutic interventions. The current study involved 2702 Muslims from Pakistan. The study measured attitudes towards mental health through different dimensions. These mainly included attitudes toward mental health, attitudes towards mental disorders, attitudes towards medical illnesses, attitudes towards mentally disturbed, attitudes towards seeking psychological help for self, attitudes towards seeking psychological help for families, attitudes towards seeking psychological help for children, and attitudes towards seeking psychological help for friends. The understudied population had positive attitudes toward mental health and psychotherapy. A significant difference was found between people's attitudes towards medical illnesses and mental disorders. Attitudes based on gender, age, education, marriage, profession, and income were also significantly different. The findings of this study lead mental health practitioners and policymakers to modify their strategies for encouraging more clientele to the existing mental health facilities.

Keywords: Attitudes, Mental Health, Seeking Psychological Help, Psychotherapy

INTRODUCTION Attitude is "a learned predisposition to respond in a consistently positive or negative manner with respect to a given object" [1]. Attitudes are predictors of expected behavior. Research has suggested that attitudes toward mental health services are evaluative tendencies and predictors of seeking professional help. Ajzen's theory of "reasoned action" [2] suggested that behavior's intention precedes the behavior itself. He further elaborated and proposed a theory of "perceived behavior control," emphasizing that behaviors can be well perceived through attitudes. Thus, a person's intentions for behavior may directly predict his engagement in the actual behavior. Seeking psychological help means "communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience" [3]. Professional help-seeking may involve seeking help from different mental health practitioners [Clinical Psychologists and Psychiatrists], teachers, youth workers, and religious figures. Studying the attitudes toward seeking psychological help has been found extremely helpful in understanding help-seeking behavior [4]. Help-seeking for psychological problems can be formal and informal. Instead of the proven benefits of psychological counseling and psychotherapy [5], people usually prefer to take help from informal sources, e.g., family members and friends [6]. Culture plays a very significant role in developing beliefs about health and well-being. Culture also sets standards for the accepted and unaccepted means of treatment [7].

Pakistan is a developing country. The majority of its population is Muslim. People commonly follow a traditional collectivistic culture. The state of mental health literacy in the country is poor [8], and people are still reluctant to adequately focus on their psychosocial issues [9–11]. The public's attitudes towards mental health and its counterparts in Pakistani culture were not specifically studied earlier, and there was a significant knowledge gap. Only two earlier studies were conducted in Pakistan, which

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merely informed us about the general trends of Pakistanis in seeking psychological support, e.g., consulting spiritual healers [12] and taking suggestions from family members [13]. Two other studies conducted on the Pakistani community residing in the United Kingdom revealed lesser utilization of mental health services by women due to their negative attitudes towards mental health [14] and consulting irrelevant persons for mental problems, e.g., faith healers or general medical practitioners [15]. Based on the general clinical observations and informal feedback from mental health practitioners, it was perceived that Pakistanis do not give the same weightage to their mental problems as they do to other medical issues. Their attitudes towards mental health and its cure, in other words, were not as positive as their attitudes towards medical or biological symptoms. Studies from other cultures also reveal that mental health is still stigmatized in developing and developed countries [16]. A handful of earlier studies also reveal that Asians, compared to Westerners, are less likely to utilize mental health services [17,18]. Indian studies also reveal similar facts and emphasize the role of religious, supernatural, and astrological explanations in valuing mental health-related issues [19,20]. In a Muslim culture like Pakistan, mental disorders can be seen as tests or punishment from God [21] or as possessions by evil spirits [22], compelling people to understand mental problems in more religious or supernatural terms. The current study was initiated to determine Pakistanis' prevalent attitudes towards mental health, mental disorders, mental illness, and seeking psychological help. The findings of this study would lead mental health practitioners and policymakers to modify their strategies for encouraging more clientele to the existing mental health facilities.

MATERIALS AND METHODS ***Participants*** The study involved 2702 conveniently selected Pakistanis from major cities: Islamabad, Rawalpindi, Peshawar, Lahore, Pak Pattan, Sahiwal, Mansehra, and Peshawar. They included both males (*n*=1184) and females (*n*=1518). Excluding minor children, the participants of the study belonged to all the age groups: adolescents aged 13 to 19 years (*n*=539), young adults aged 20 to 29 years (*n*=1386), adults aged 30 to 59 years (*n*=729), and elderly aged 60 years and above (*n*=48). They included single (*n*=1795), married (*n*=890), divorced (*n*= 6), and widow (*n*= 11). Their educational qualifications varied as primary (*n*=63), middle (*n*=152), secondary (*n*=332), higher secondary (*n*=631), graduation (*n*=722), masters (*n*=499), MPhil (*n*=200) and PhD (*n*=51). The study also included illiterate participants (*n*=52) who the researchers assisted in responding to the instrument. The participants belonged to different professions i.e. students group (*n*= 1591), housewives group (*n*=287), army officer (*n*=2), businessman (*n*=88), doctors (*n*=15), engineer (*n*=10), government officers (*n*=28), (*n*=302) people haven't specified the nature of their jobs, labors (*n*=64), teachers (*n*=215), psychologists (*n*=7), retired from different jobs (*n*=9), (*n*=52) people were skilled workers (including electricians, plumbers, artists, painters etc.) and (*n*= 32) people were jobless. Based on their monthly income, the participants were divided into four categories: lower income class whose monthly income was lesser than Rs. 30000 per month (*n*=1045), a lower middle-income class whose monthly income was between Rs. 31000 to Rs. 60000 per month (*n*=872), an upper middle-income class whose monthly income was between Rs. 61000 to Rs. 90000 per month (*n*=336), and well-off whose monthly income was above Rs. 91000 per month (*n*=449).

Questionnaire A detailed research questionnaire in Urdu (language) having 27 items was used to gather data. Preference in selecting the appropriate psychological support was the first construct of the questionnaire, measured through two open-ended questions. The data gathered from these two questions were qualitative, dealt with a Thematic Analysis, and quantified in percentages. Statements in the Urdu language were developed for the constructs: (a) attitudes toward mental health, (b) attitudes towards mental disorders, (c) attitudes towards medical illnesses, (d) attitudes towards the mentally ill, and (e) attitudes towards seeking psychotherapy. These statements were derived from the researchers' vast clinical experience and commonly observed daily perceptions of the public. To measure the attitudes, 5 ranges were determined: extremely negative (if M = 1.0 – 1.9), slightly negative attitudes (if M = 2.0 – 2.9) Neutral (if M = 3.0 – 3.9), slightly positive attitudes (if M = 4.0 – 4.9), and extremely positive attitudes (if M = 5.0). The authors did not intend to develop a new scale that could be presented for further use by other researchers. However, the reliability and validity of the questionnaire were assessed through Cronbach's alpha and item-scale correlations. The values of KMO and BTS are also provided in Table 1 for the sufficiency of data. The questionnaire was accompanied by a Demographic Information Schedule, which consisted of the basic information of the respondents: gender, age, profession, marital status, educational qualification, and approximate monthly income.

Procedure The data collection took approximately one and a half years. The researchers frequently visited the cities

Scale	N	M	SD	α	1	2	3	4	5
Attitude towards overall mental health	12	3.84	0.56	0.75	-	0.66**	0.74**	0.71**	0.36**
Attitude towards Psychotherapy	5	4.33	0.65	0.82		-	0.16*	0.16**	0.43**
Attitude towards mental disorders	3	3.13	0.92	0.54			-	0.40**	0.19**
Attitude towards mentally ill	4	4.07	0.78	0.75				-	0.20**
Attitude towards medical illnesses	6	4.05	0.52	0.72					-

1= Attitudes towards mental health; 2= Attitudes towards psychotherapy; 3= Attitudes towards mental disorders; 4=Attitudes towards mentally ill; 5= Attitudes towards medical illnesses
N= Items; M = Mean; SD = Standard Deviation; α= Cronbach's Alpha.
**. Correlation is significant at the 0.01 level (2-tailed).
KMO=0.825; BTS=0.0001; DCM=0.047

Table 1. Reliability and Construct Validity of the questionnaire (N=2702).

mentioned above and approached the conveniently selected participants in different educational institutions, governmental and non-governmental offices, and private companies. The participants in educational institutions and different offices were seated in groups of 30 to 50 individuals. They were informed about the study's objective and obtained their consent. The questionnaires were then distributed to the groups of participants.

Statistical analysis. The data gathered was analyzed in the Statistical Package for Social Sciences. The statistical procedures involved calculating Means, Standard Deviations, and Percentages; and carrying out t-tests and ANOVA for analyzing the possible significant variations.

RESULTS *Overall Attitudes Towards Mental Health* The study showed the Overall Attitudes toward Mental Health: the respondents of the current study had slightly positive attitudes toward overall mental health (Table 2; M =3.84/5: %=76.8). Females had significantly more positive attitudes toward mental health as compared to males (Table 4 & 5; M=3.95 *vs.* 3.71; p=0.001).

No significant difference was found between single, married, widowed, and divorced on the overall scale of attitude towards mental health. (Tables 4 & 5; M=4.02 *vs*. 3.60; p=0.09). Young adults have a more positive attitude as compared to adolescents, adults, and the elderly (Table 4 & 5; M=3.89 *vs*. 3.82, 3.81 & 3.28 respectively; p=0.001). Ph. D.s had significantly more positive attitudes toward mental health as compared to people with lesser educational qualifications and uneducated (Table 4 & 5; M= 4.21 *vs.* 3.21, 3.39, 3.55, 3.73, 3.80, 3.88, 4.01 & 4.07 respectively, p=0.001). A gradual positive incline in the attitudes towards mental health was also observed with the increase in educational qualification. The upper-middle class and the well-off both had significantly more positive attitudes toward mental health as compared to

Attitudes	Items	M	SD	%	Interpretation
Overall Attitudes Towards Mental Health	12	3.84	0.56	76.8	Slightly positive
Attitudes towards Psychotherapy	5	4.33	0.65	86.6	Extremely positive
Attitudes towards Mental disorders	3	3.13	0.92	62.6	Slightly positive
Attitudes towards Mentally ill	4	4.07	0.78	81.4	Extremely positive
Attitudes towards Medical illnesses	6	4.05	0.53	81.0	Extremely positive

1-1.9=extremely negative; 2.1-2.9=slightly negative; 3.0-3.9=neutral; 4.0- 4.9=slightly positive; 5.0=extremely positive; N=2702.

Table 2. Attitudes: Means, Standard Deviations, Percentiles, and Interpretations.

	M	SD	t	p
Attitude towards Medical Illnesses	4.05	0.53		
			49.77	0.0001
Attitude towards Mental Disorders	3.13	0.91		

Table 3. Difference between attitudes towards medical illnesses and the attitudes towards mental disorders.

the lower-middle class and the lower class (Table 4 & 5; M= 4.12 *vs*. 4.07 & 4.00 respectively; p=0.001).

Attitude Towards Psychotherapy The current study's respondents had extremely positive attitudes toward psychotherapy (Table 2; M = 4.33/5: %=86.6). Females had significantly more positive attitudes toward psychotherapy as compared to males (table 4 & 5; *M*=4.40 *vs.* 4.26; p=0.001). Single people had a more positive attitude towards psychotherapy than married, widowed, and divorced people (Tables 4 & 5; M=4.31 *vs.* 4.00, 4.18 & 3.96 respectively; p=0.001). Adolescents and Adults have more positive attitude towards psychotherapy as compared to young adults and elderly (Table 4 & 5; M=4.34 & 4.43 *vs.* 4.30 & 4.23 respectively; p=0.001). People with Ph.D. had significantly more positive attitudes towards psychotherapy as compared to their counterparts (Table 4 & 5; M= 4.59 *vs.* 3.85, 4.32, 4.38, 4.39, 4.38, 4.24, 4.24 & 4.46 respectively; p=0.001). Lower middle class and upper middle class had more positive attitude as compared to lower class and well off (table 4 & 5; M= 4.36 & 4.41 vs 4.30 & 4.33 respectively; p=0.001).

Attitude Towards Mental Disorders The respondents of the current study had a slightly positive attitude toward accepting the diagnosis of mental disorders (Table 2; *M* = 3.13/5: %=62.6). Females had significantly more positive attitudes toward mental disorders as compared to males (Table 4 & 5; *M*=4.18 vs. 3.93; p=0.001). Young adults had a more positive attitude than adolescents and adults, whereas the elderly had slightly negative attitudes towards acceptance of mental disorders. (Tables 4 & 5; M= 3.23 vs. 3.09, 3.04 & 2.20 respectively; p=0.001). Divorced and single people had more positive attitude as compared to widowed and married (Table 4 & 5; M= 3.72 & 3.17 vs. 2.58 & 3.06 respectively; p=0.001). People with Ph.D. had significantly more positive attitudes towards psychotherapy as compared to their counterparts (Table 4 & 5; M= 3.65 vs. 2.56, 2.32, 2.68, 2.97, 3.03, 3.24, 3.34 & 3.40 respectively; p=0.001). The upper-middle class and the well-off both had a significantly more positive attitude than the lower and lower middle classes (Table 4 & 5; M= 3.31 & 3.35 vs. 2.94 & 3.18 respectively; p=0.001).

Attitude Towards Mentally Ill The respondents of the current study had an extremely positive attitude toward the mentally ill (Table 2; *M* = 4.07/5: %=81.4). Females had significantly more positive attitudes toward the mentally ill as compared to males (Table 4 & 5; *M*=3.27 vs. 2.95; p=0.00). Young adults and Adolescents had a more positive

			Gender		Marital Status		Age		Education		Socioeconomic Status		Profession	
Attitudes towards:	*M*	*SD*	*t*	*p*	*F*	*p*	*F*	*p*	*F*	*p*	*F*	*p*	*F*	*p*
Overall mental health	3.71	0.57	11.50	0.001	2.19	0.09	21.44	0.001	38.39	0.001	42.93	0.001	14.89	0.001
Psychotherapy	4.26	0.70	5.85	0.001	5.38	0.001	6.72	0.001	8.71	0.001	2.89	0.001	4.47	0.001
Mental Disorders	3.93	0.82	8.58	0.001	5.44	0.001	21.17	0.001	25.36	0.001	30.75	0.001	10.53	0.001
Mentally Ill	2.95	0.94	9.25	0.001	4.22	0.001	11.85	0.001	43.07	0.001	40.94	0.001	13.01	0.001
Medical Illnesses	4.01	0.54	4.20	0.001	9.30	0.001	13.20	0.001	7.70	0.001	7.88	0.001	2.82	0.001

Table 4. Attitudes with variations (t-test & ANNOVA).

attitude towards the mentally ill as compared to adults and the elderly (Table 4 & 5; M=4.15 & 4.05 vs. 3.98 & 3.42 respectively; p=0.001). Windowed had a more positive attitude as compared to single, married, and divorced (Table 4 & 5; M= 4.18 vs. 4.11, 4.00 & 3.96 respectively; p=0.001). People with Ph.D. had significantly more positive attitudes toward the mentally ill than their counterparts (Table 4 & 5; M=4.38 vs. 3.22, 3.51, 3.57, 3.83, 3.98, 4.18, 4.34 & 4.36 respectively; p=0.001). Well-off had a more positive attitude than the lower class, lower middle class, and upper middle class (Table 4 & 5; M= 4.29 vs. 3.88, 4.13 & 4.24 respectively; p=0.001).

Attitude Towards Medical Illnesses The respondents of the current study had extremely positive attitudes toward medical illnesses (Table 2; *M* = 4.05/5: %=81.0). Females had significantly more positive attitudes toward medical illnesses as compared to males (Table 4 & 5; *M*=4.09 *vs.* 4.01; p=0.001). The elderly had more positive attitudes as compared to adolescents, young adults, and adults (Table 4 & 5; M= 4.19 vs. 3.94, 4.07 & 4.12 respectively; p=0.001). Divorced had more positive attitudes as compared to single, married, and widowed (Table 4 & 5; M=4.44 *vs*. 4.02, 4.12 & 3.79 respectively; p=0.001). People with Ph.D. had significantly more positive attitudes toward medical illnesses as compared to their counterparts (Table 4 & 5; M= 4.32 *vs.* 3.93, 4.10, 3.93, 4.03, 4.02, 4.04, 4.09 & 4.25 respectively; p=0.001). The upper middle class and well-off had more positive attitudes as compared to the lower class and lower middle class (Table 4 & 5; M=4.12 & 4.12 *vs*. 4.00 & 4.07 respectively; p=0.001).

Preferences in Seeking Psychological Help The respondents were asked about their preferences in seeking psychological help through an open-ended question: Who will you prefer to consult for possible psychological problems in case you decide to consult someone? The top-ranked preference (Table 6) by the respondents was a psychologist (31%), followed by a psychiatrist (19%), religious practices (16%) (including offering prayers, reciting Quran, seeking help from God, consulting religious scholars, others), a medical doctor (12.21%), seeking help from family 8.88% (including mother, father, sister, brother, spouse, grandparents, daughter, others). Few respondents preferred friends (3.44%), hakeem / practitioner of Greek Medicine (2.29%), teacher (0.5%), spiritual practitioner (2.10%) and 2.07% respondents preferred exercises.

DISCUSSION The current study measured attitudes toward mental health through different dimensions.

These mainly include "Overall Attitudes" toward "Mental Health," attitudes toward "Mental Disorders," "Medical Illnesses," "Mentally Disturbed," "Seeking Psychological Help," "Seeking Psychological Help for Self," "Seeking Psychological Help for Family," "Seeking Psychological Help for Children," "Seeking Psychological Help for Friends." The findings revealed a trend of having positive attitudes toward the understudied variables. Women had more positive attitudes in this regard as compared to men. Education and socioeconomic status were also positively correlated with positive attitudes towards mental health and its counterparts.

Public attitudes toward mental disorders have been widely studied in different cultures and have been found to vary across cultures [23]. Mental disorders have been stigmatized in many parts of the world [24] due to lower mental health literacy [8] and lower educational qualifications [25]. People with mental disorders have been considered dangerous, violent, unpredictable, incompetent, and unlikable [26].

They have been discriminated against [27,28] and even some psychiatrists [29] and other medical practitioners [30–32] hold negative attitudes towards them. The media has played a vital role in stigmatizing people with mental disorders more negatively [33]. The prevalence of negative attitudes toward mental disorders hinders seeking psychological help [34]. Seeking psychological help has been thought the last option by even those who badly need it [35]. Seeking psychological help requires trust in the therapist and willingness to disclose distressful feelings, which seems difficult to most people. Most research has revealed that men vs. women seek lesser medical assistance [36] and lesser psychological help [37,38]. Earlier research has revealed that the divorced or separated seek psychological help more frequently than the married [39]. The earlier studies on age-based differences in seeking psychological help have revealed mixed results. People with higher education use psychological services more than those with lesser education [39]. Self-concealment [40], self-disclosure [4], belief-based barriers [41], and cultural differences [42,43] also contribute to deciding to seek professional psychological help.

CONCLUSION The current study has deeply investigated the prevalent attitudes of Pakistanis towards mental health and the related aspects. The study has uniquely provided the latest facts and figures in this regard. The findings of the study can be extremely beneficial for the stakeholders. A very important discovery of the current study is that Pakistanis, compared with other developing countries, have more positive attitudes towards mental health. This reflects their readiness to utilize mental health

services, if available properly. Mental disorders are not strange to them and generally do not stigmatize people with mental illnesses. Although they do not give mental disorders the same importance as medical illnesses, they prefer psychotherapists, psychiatrists, and general physicians over other non-scientific interventions. In light of the current study, mental health practitioners and service providers may target "married, educated women" more as their prospective clients. On the other hand, they can also target the entire society for mental health awareness raising to enhance the scope of mental health practice in Pakistan.

LIMITATION The current study was the first large-scale study in Pakistan to measure the public's attitudes towards mental health and its counterparts. The researchers could not involve a wider geographical area because it was not funded. The study did not have an equal proportion of the participants based on age and education. The majority of the participants were educated, young adults. The current study targeted major cities only, and people living in villages were not contacted. Future researchers are advised to overcome these shortcomings.

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