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Impact of Conventional Beliefs and Social Stigma on Attitude Towards Access to Mental Health Services in Pakistan

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Abstract

This study aims to explore the role of conventional beliefs and social stigma on attitude towards access to mental health services. From 50 caregivers data were collected by Perceived Public Stigma Scale and an in-depth semi-structured interview. The majority (86%) of patients having significant symptoms of major mental illness visited traditional healer prior to engagement with the mental health services. However a significant positive finding, related to carers predominantly perceiving that individuals with mental health difficulties were trustworthy, capable of engagement in employment and were comfortable with having them as their friends were identified.

Keywords Conventional beliefs · Social stigma · Mental health services

Introduction

Historically, it has been suggested that mental illness in Pakistan and in many other countries has been misperceived, misinterpreted and hence inappropriately managed (Zafar et al. 2008; Ahmad et al. 2016). For example, the presence of mental illnesses has been misattributed to factors such as being possessed by demons or other supernatural powers, resulting from "black magic", an "evil eye" or from the engagement in "bad deeds"

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in a previous existence (Nguyen 2003; Khalifa et al. 2011). In contrast, individuals without an active mental illness have previously been incorrectly labelled as such due to their cultural and traditional beliefs (Fabrega 1991). This misattribution of symptoms and poor management of both healthy and mentally ill individuals; has influenced people in Pakistan and elsewhere in relation to engaging with local mental health services when they or other family members show signs of a potential mental illness (Ahmad et al. 2016). The subsequent engagement in what might be perceived as less stigmatising strategies for mental health difficulties, such as traditional healing practices can however have deleterious effects including a longer period of mental ill-being and also a potential long-term poorer prognosis (Dominguez and Garralda 2016). There are several traditional healing approaches. These include strategies for the treatment of "jinn" or "jadu/tona", including "peeri/faqeeri", and "Ta'wiz". "Jinn" relates to the presence of supernatural beings which can alter an individuals' mood, behaviour and thinking processes. "Jadu/tona" refers to the claimed ability of individuals to alter events using supernatural abilities with the intention of causing harm or destruction (Dein et al. 2008). However, the extent to which beliefs about jinn and jadu/tona affect health behaviour remains contentious (Dein et al. 2008). The treatment of "jinn" or "jadu/tona" predominantly involves an indigenous spiritual faith healer removing supernatural powers which are perceived as controlling the mind of the affected individual (Al Bahrani 2004; Littlewood 2004; Choudhry et al. 2016). "Peeri/faqeeri" refers to a variety of spiritual methods utilised to treat

individuals troubled by "jinn", of which the most commonly applied method is *ruqyah* (seeking refuge with Allah by reciting certain verses from the Quran); and *Dhikr* (remembrance of Allah) (Khalifa and Hardie 2005). "Ta'wiz" involves a faith-healer giving written verses of the Quran on a paper wrapped up in cloth or skin or on a plate with washable ink, to the affected individual, who washes the cloth or plate and drinks from this (Johnsdotter et al. 2011). Additionally, a number of other healing modalities including consistent practice of supplications, exorcism, physical punishment, sham strangulation, and use of herbal remedies have been described as management strategies for probable mental health difficulties (Al-Habeeb 2003).

Even in the absence of the misattribution of symptoms as mental illness, significant social stigma relating to having a mental illness or having a family member with a mental illness exists in Pakistan (Waqas et al. 2014) resulting in reduced engagement with local mental health services. This stigma originates from multiple sources including from health care providers and popular media, which can adversely impact on mental health service engagement (Sartorius 2002; Tsao et al. 2008; Hyun et al. 2017; Zaidi and Ali 2017; Stolzenburg et al. 2018b).

Ethnically single-minded beliefs have been described as "folk thinks" or "set theories" (Lam 2010) and can be applied to common misperceptions that relate to mental illness (Choudhry et al. 2016; Stanford 2007). Thus, recognising individuals' perceptions or misperceptions of mental illness and their perceived stigma in relation to engagement with mental health services are important as they can inform both engagement in mental health services and treatment modalities considered (Haslam 2005; Svensson and Hansson 2016). Various factors have been demonstrated to influence perceptions of mental illness and stigma in different cultures including prevailing religious beliefs and a variety of socio-demographic variables including gender, age, educational attainment and socio-economic status (Dein et al. 2008; Khalifa et al. 2011). For example, beliefs regarding "jinn" are more common in individuals of lower educational and socio-economic class (Mullick et al. 2013; Afzal 2014).

In this study, in a cohort of patients attending three mental health services in Pakistan and their family members, we aimed to ascertain their perceptions of the aetiology and treatment of mental illness and ascertain the impact of stigma in relation to engagement with mental health services.

Method

Patients included 50 individuals, recruited from the psychiatry departments of the Institute of Psychiatry, the Benazir Bhutto Hospital Rawalpindi and Psychology Clinic at Integrated Health Services Hospital F-10 Islamabad, Pakistan, all of whom were inpatients at the time of recruitment. All patients required ongoing support from a care-giver. Participants were included if they were in receipt of inpatient care from one of the three inpatient units and were in attainment of the support of a principal caregiver. Patients were excluded if they did not have capacity to provide consent for their carer to participate in this study, were < 18 years of age, had an intellectual disability (intelligence quotient < 70) or suffered from dementia. Consecutive patients (n = 56) fulfilling these criteria were approached in the Benazir Bhutto Hospital Rawalpindi and Psychology Clinic at Integrated Health Services Hospital F-10 Islamabad, Pakistan, to ascertain if they would provide written informed consent to participate. Fifty (89.3%) patients agreed for their carer to be contacted. All 50 carers contacted provided written informed consent to actively participate in the study and each was involved in supporting the patient with decision making (including decisions over engagement with the mental health services). None of the caregivers themselves were in receipt of support from the mental health services or had a diagnosed mental health disorder.

Quantitative data attained included demographic and clinical data from patients including gender, age, relationship status, psychiatric diagnosis, and previous engagement with mental health services. Data attained from caregivers included demographic data and data pertaining to their relationship with the patient and their religious affiliation. Diagnoses were attained from a clinical chart review and liaison with the patients' consultant. All diagnoses were based on the International Classification of Diseases—10 diagnostic criteria.

A focus group (n = 6) was conducted in August 2014 with five mental health experts (MTK, M, IA, HA, BH) with the aid of moderator to ascertain pertinent areas to examine with patients and caregivers in relation to potential stigma associated with mental illness and potential barriers posed by stigma in relation to engagement with mental health service. The focus group was of approximately 90 min duration. An interview schedule was developed based on this focus group (Online Appendix).

Semi-structured interviews were subsequently conducted with all 50 caregivers between November 2014 and February 2015 to collect data regarding conventional beliefs held in relation to the management of major mental illness and possible reasons for such belief systems. Each interview (median duration of 30 min) was audio-recorded and subsequently transcribed.

In addition, all carers completed the Perceived Public Stigma subscale of Discrimination Devaluation Scale, which was utilised to examine stigma perceived in relation to mental illness (Link et al. 1987). This sub-scale consists of 12 items measured on a 5 point Likert scale ranging from "strongly disagree" to "strongly agree" and has good reliability indices reported (Cronbach's $\alpha = 0.89$) (Link et al. 1987). The instrument was carefully translated and conducted in Urdu. A total score was also attainable, with some questions reverse scored if question related to less perceived public stigma (see Table 1). Additionally, carers were asked to rate the intensity of their conventionally held beliefs both before and after engagement with mental

Table 1 Responses on Perceived Public Stigma Scale (n = 50)

Q#	Statements	M	SD
1[a]	Most people would willingly accept someone who has received mental health treatment as a close friend	3.20	1.31
2[a]	Most people believe that a person who has received mental health treatment is just as intelligent as the average person	3.20	1.36
3[a]	Most people believe that someone who has received mental health treatment is just as trustworthy as the average person	**3.60**	**1.22**
4[a]	Most people would accept someone who has fully recovered from a mental illness as a teacher of young children in a public school	**3.50**	**1.27**
5	Most people feel that receiving mental health treatment is a sign of personal failure	**4.20**	**1.12**
6	Most people would not hire someone who has received mental health treatment to take care of their children, even if he or she had been well for some time	3.04	1.22
7	Most people think less of a person who has received mental health treatment	**4.12**	**1.04**
8[a]	Most employers will hire someone who has received mental health treatment if he or she is qualified for the job	**3.80**	**1.21**
9	Most employers will pass over the application of someone who has received mental health treatment in favour of another applicant	2.39	0.93
10	Most people in my community would treat someone who has received mental health treatment just as they would treat anyone	**3.72**	**1.34**
11[a]	Most young adults would be reluctant to date someone who has been hospitalized for a serious mental disorder	2.76	1.36
12[a]	Once they know a person has received mental health treatment, most people will take that person's opinions less seriously	2.86	1.41

Bold values indicate most prominent findings

Findings based on Likert scale, where 1 = strongly disagree, and 5 = strongly agree

[a]Higher scores reflect greater levels of perceived social stigma

health services and preference for treatment with mental health services both at present and prior to engagement with mental health services on a 5 point Likert scale.

Descriptive statistics such as mean, standard deviation, frequency and percentages were calculated by using Statistical Package for Social Sciences 22.0 for Windows (SPSS Inc., IBM, New York, USA). However some of the representative samples of comments from interviews with carers are presented in Box 1.

Box 1: Representative samples of comments from interviews with carers

#M7 "He sees "jinn", he is controlled by one of them, and sometimes he start arguing with them. One of his older brother also has "jinn" but he is as disturbed by that "jinn". We took him to different "Peers" who tried their own methods of relieving him from "jinn" but that helped only for few days and again the patient would start seeing them around. We brought him here (Hospital) where he takes medicine and can have a rest from not seeing them. (Uncle of the patient, diagnosis of schizophrenia)

#M11 "Initially we thought she was making excuses and drama to avoid domestic chores. Later on, one of our relatives suggested taking her to a religious healer (Aalim) who recited some holy verses from the Quran over her. We took her but the patient remained the same. Then, our neighbours suggested we bring her to this hospital. The doctors and nurses are treating her and we hope she will soon get better." (Cousin of patient, diagnosis of dissocial personality disorder)

#F20 "The problems started when my son got engaged." "Some of our relatives are envious of us and engage in black magic to make others suffer from poverty and illness. They did this to my son, and made him sick and subsequently the parents of his fiancée cancelled the engagement. We approached different Peers, who stated that my relatives undertook ta'wiz on my son to cause his problems." (Mother of patient, diagnosis of major depressive disorder)

#M27 "My brother for about 7 years has lived with the problem. My parents and other relatives believe he is possessed by some powerful "jinn", as during the control by jinn it was not possible for five or six men to stop him hitting his head against the ground or against walls. Some of our relatives who did not believe "jinn" possession were also convinced when they saw his actions. This problem made it very difficult for us to arrange his marriage as people did not want their relative to marry him given these actions. We consulted different Peers who were famous for healing people possessed by Jinn, but any beneficial effects were only temporary in nature. One day the problem occurred during a marriage ceremony and people were terrified. One of our relatives suggested he be brought to hospital. The doctors and nurses are treating him for the last 2 months and his condition has improved. We hope he will attain a full recovery." (Brother of patient, diagnosis of schizophrenia)

#M30 "About 2 years ago, his behaviour changed, He stopped closing bathroom doors when washing and asked others to keep a "look-out" for him for his safety. He also started avoiding standing in the first row at prayers. One of our relatives suggested we take him to a "Peer" to give "ta'wiz" of fear, which will help him to not fear situations. This resulted in no satisfactory improvement. We recently, on the advice of his friend who studied psychology, brought him to hospital, where his condition is improving and we aim to continue on his discharge to continue bringing him for treatment with the psychiatry services." (Father of patient, diagnosis of generalised anxiety disorder)

M male, *F* female

Results

The mean age of patients was 27.8 years (SD = 11.3), with 26 (52.0%) patients male. Twenty-one participants (42%) had a primary diagnosis of a personality disorder, with dissocial personality disorder and emotionally unstable personality disorder of borderline type most prevalent diagnosed (see Table 2).

The mean age of caregivers was 36.2 years (SD = 12.1), with 32 (64.0%) caregivers male and the most common relationship with the patient being as a sibling (42.0%). Caregivers were predominantly in active employment (n = 46, 92.0%) and not in financial difficulty (see Table 3).

The most significant finding on the Perceived Public Stigma Scale related to carers believing that people view receiving mental health treatment as a sign of personal failure (Q5) (see Table 1). The other most significant responses related to carers believing that people in the community would treat someone who has received mental health treatment just as they would treat anyone (Q10), that people believe that someone who has received mental health treatment is just as trustworthy as the average person (Q3) and that people would accept someone who has fully recovered from a mental illness as a teacher of young children in a public school (Q4).

In relation to patients, no socio-demographic factor including age, gender, or marital status or level of religious affiliation had a significant effect on the intensity of conventional beliefs regarding the intensity of conventional beliefs towards mental health services (prior to or after attending). Similarly with carers, no socio-demographic factors impacted on the intensity of conventional beliefs or attitudes towards their relative attending the mental health services.

Forty-three (86.0%) patients had attended traditional healers and received traditional healing approaches prior to attending the mental health services (see Box 1) and 16 (32.0%) carers stated they would bring patients to traditional healers again in the future. The reasons for engagement with the mental health service for individuals who had initially attended traditional healers related to a number of factors including advice from others regarding in engagement additionally in the mental health services (n = 21, 42%), failure of efficacy of traditional healing treatments (n = 10, 20.0%), risk behaviours (threatening themselves, their carer or others) (n = 7, 14.0%) or a combination of these factors.

Box 1 presents some representative comments from carers relating to strongly held conventional beliefs that resulted in patients either not attending mental health services initially (#F7, #M11, # M27, #M30) or that symptoms related to the practices of black magic by others (#F20). Of note, when carers did engage with the mental health services, they noted improvements in their family members' condition (#M11, #M30) and demonstrated hope that mental health support

Table 2 Socio-demographic characteristics of patients

Variables	n (%)
Age (years)	
18–19	6 (12.0)
20–40	36 (72.0)
>40	8 (16.0)
Gender	
Male	26 (52.0)
Female	24 (48.0)
Educational attainment	
Pre-primary	10 (20.0)
Primary	17 (34.0)
Secondary	14 (28.0)
Tertiary	9 (18.0)
Relationship status	
Single	9 (18.0)
Married	41 (82.0)
Mental health disorder	
Personality disorder (PD)	
Dissocial PD	9 (18.0)
Emotionally unstable PD	9 (18.0)
Not specified	3 (6.0)
Recurrent depressive disorder	9 (18.0)
Schizophrenia	6 (12.0)
Post-traumatic stress disorder	4 (8.0)
Dissociative disorder	5 (10.0)
GAD	4 (8.0)
No ICD-10 mental disorder	1 (2.0)

GAD generalized anxiety disorder, *ICD* International Classification of Diseases, *PD* personality disorder

would construe future benefits (#F7, #M30). Of note, carers did not differentiate between personality disorders, psychotic or affective disorders in relation to the cause of the patients' symptoms being due to or requiring treatment with traditional healing practices.

Discussion

In this study, carers demonstrated intense traditional beliefs, resulting in the misattribution of symptoms as being related to mental illness with patients consequently not engaging with the mental health services at the initial presentation of overt symptoms. This finding has previously been demonstrated in other jurisdictions (Zartaloudi and Madianos 2010; Ramli et al. 2017; Stolzenburg et al. 2018a) and was demonstrated in this study from both quantitative (questionnaires) and qualitative data (semi-structured interviews). This misattribution of symptoms related to a wide variety of mental health disorders including symptomatology

Table 3 Socio-demographic characteristics of caregivers (n = 50)

Variables	n (%)
Age	
20–40	34 (68.0)
>40	16 (32.0)
Gender	
Male	32 (64.0)
Female	18 (36.0)
Marital status	
Married	31 (62.0)
Single	18 (36.0)
Widowed	1 (2.0)
Relation to patient	
Parents	13 (26.0)
Siblings	21 (42.0)
Spouse	9 (18.0)
Other relatives	7 (14.0)
Educational attainment	
Pre-primary	10 (20.0)
Primary	16 (32.0)
Secondary	9 (18.0)
Tertiary	15 (30.0)
Occupation	
Self-employed	21 (42.0)
Private employed	15 (30.0)
Government employed	10 (20.0)
Unemployed	4 (8.0)
Income level	
Below (20,000) Rs PKR	11 (22.0)
Above (20,000) Rs PKR	39 (78.0)
Stated religious affiliation with Islam	
Some affiliation	4 (8.0)
Moderate affiliation	40 (80.0)
Strong affiliation	6 (12.0)

Rs PKR Pakistani Rupee

secondary to neurotic, affective, psychotic and personality disorders. No disorder or group of disorders was more likely to be correctly interpreted as being related to a mental health disorder, albeit this study was not sufficiently powered to undertake a comparison between all the various mental health disorders diagnosed.

Engagement with the mental health services, when it did occur, was viewed in a positive regard, with carers describing benefits from such engagement, although many carers described a wish to re-engage in traditional healing processes either in addition or as a replacement of mental health service support when amelioration in the condition of their family member was attained. Engagement with the mental health services was associated with carers having a reduced intensity in their conventional beliefs and a higher preference for engagement with the mental health treatment services, a finding consistent with a number of previous studies in other jurisdictions (Dols 1987; Al-Habeeb 2003; Nguyen 2003; Abu-Ras and Abu-Bader 2008; Johnsdotter et al. 2011; Khalifa et al. 2011; Alaqeel and Sabbagh 2013; Jeon and Furnham 2017; Sottie et al. 2018). However, conventional beliefs regarding the cause of symptomatology and need for future engagement with traditional healing processes remained strongly held.

A significant positive finding, related to carers predominantly perceiving that individuals with mental health difficulties were trustworthy, capable of engagement in employment (including with children) and were comfortable with having them as their friends. This finding is more positive than that noted in a number of previous studies and may potentially reflect a less critical view of mental health difficulties in this jurisdiction (Corrigan 2004; Corrigan and Watson 2002; Corrigan and Kleinlein 2005; Corrigan et al. 2006; Tsang et al. 2003; Cinnirella and Loewenthal 1999; Gilbert et al. 2009; Haque 2004; Borneo and Pinfold 2007; Weatherhead and Daiches 2010; Youssef and Deane 2006). However, this is also potentially a biased interpretation, given the carers' relationship with the patient, and that all patients were now engaged with the mental health services. Carers did view that suffering mental health difficulties largely equated to a personal weakness and such stigma was similarly evident in the semi-structured interviews where the term "pagal" (translated approximately to "crazy") was utilised for their family member on occasion.

Conclusion

This study describes utilising both quantitative and qualitative techniques in a Pakistan cohort, how symptoms pertaining to a wide range of mental health disorders were misattributed to cultural beliefs resulting in initial engagement in traditional healing practices prior to engagement with mental health services. Engagement with mental health services was associated with a reduction in intensity of conventional beliefs for carers with an amelioration noted by carers in their relatives' mental state and a willingness by some carers for their relative to continue to engage as with community mental health services after discharge from hospital. However many carers stated they would re-engage with traditional healing approaches again in the future if their relative developed similar symptoms. This was despite the initial lack of efficacy of conventional treatments and benefit noted after treatment received from mental health services. Thus, strategies to challenge conventional beliefs that preclude treatment at least initially for individuals with mental health difficulties are required. The willingness of carers to agree to re-engage with mental health services is potentially

positive in this regard. On-going psycho-education strategies for individuals and their carers who have engaged with mental health services is suggested, given the ongoing intensity of conventional beliefs. Whilst potentially more challenging, a wider societal education strategy should also be considered given the delay patients experience in attaining evidence based treatment for mental health difficulties due to initial engagement with traditional healing approaches. Health and government authorities may be able to have a positive role in any such educational campaign.

Compliance with Ethical Standards

Conflict of interest The authors of this study certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

Ethical Approval Ethical approval was attained from the ethics committees at the International Islamic University, Islamabad, Institute of Psychiatry, Benazir Bhutto Hospital Rawalpindi and the Psychology Clinic at Integrated Health Services Hospital F-10 Islamabad. Clinical directors of each facility provided approval for the study prior to participant contact.

Informed Consent Written informed consent was attained from each participant (n = 50) to access their clinical records and to contact their primary care-giver.

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