Volume 4, Issue 6, 2026

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

CULTURE PERCEPTIONS OF MENTAL ILLNESS IN RURAL COMMUNITIES OF PESHAWAR

[1]Muhammad Abbas Ilyas, [2]Jafarayd Hussain, [3]Shabana Isaacs, [4]Maryam Zaman

[1]Student, Department of Nursing City University of Science and Information Technology
[2]Head of Nursing Department City University of Science and Information Technology
[3]Lecturer, Department of Nursing City University of Science and Information Technology
[4]Junior Lecture, Department of Nursing City of Science and Information Technology

DOI: https://doi.org/10.5281/zenodo.20953856

Keywords:
Mental illness, stigma, help-seeking, rural communities of Peshawar, cultural views and supernatural beliefs

Article History
Received on 16 May, 2026
Accepted on 25 June, 2026
Published on 26 June, 2026

Abstract

Background: Cultural attitudes have a significant impact on how cultures identify, comprehend and treat mental illness. Traditional beliefs, spiritual frameworks and honor-based social standards frequently influence reactions to mental distress in rural Pakistan, especially in the Peshawar area of Khyber Pakhtunkhwa province, in ways that are significantly different from biological models. Even while mental health issues are becoming more widely recognized in low-income and middle-income nations, less is known about the belief systems, experiences of stigma and behaviours related to seeking assistance in rural Pashtun communities. Objective: To investigate and comprehend, using quantitative data from 387 participants, the cultural conceptions of mental illness among rural community members in Peshawar, including beliefs about causes, interpretations of symptoms, experiences with stigma and paths for seeking assistance. Methods: A structured questionnaire and semi structured in depth interviews were used in a mixed methods descriptive research. Stratified random sampling was used to choose 387 participants from three rural union councils in the Peshawar area. A validated 45-item questionnaire addressing demographics, supernatural beliefs, stigma and help-seeking behaviour was used to gather data. SPSS version 26.0 was used to examine quantitative data, including binary logistic regression, chi-square tests, cross-tabulations and descriptive statistics. 25 people participated in qualitative interviews, which were then subjected to theme analysis. Results: The study discovered that supernatural beliefs predominate in rural Peshawar's cultural perspectives of mental illness, with the majority of participants attributing mental disease to jinn, black magic, or the evil eye while few acknowledged biological reasons. There was a lot of stigma, especially the idea that mental illness causes shame in one's family. Only a small percentage of people sought biomedical care; help-seeking was strongly biased toward traditional healers. Higher stigma and less help-seeking were significantly predicted by female gender, advanced age, and poor educational attainment. Four main themes emerged from the qualitative data: gender and age variations, dual help-seeking pathways, stigma as social control, and supernatural causality. Conclusion: In rural Peshawar, cultural views of mental illness are firmly anchored in honor-based social rules and religious-spiritual frameworks that consistently prohibit obtaining pharmacological assistance while validating traditional remedies. Nurse-led, culturally sensitive therapies are desperately required.

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

INTRODUCTION

One of the biggest yet least addressed worldwide health issues of the twenty first century is mental illness. According to estimates from the World Health Organization, mental illnesses make up over 14% of the world's disease burden, with depression alone impacting over 280 million people (WHO, 2022). In the majority of low and middle-income countries (LMICs), the treatment gap the difference between those who require and get mental health care exceeds 75% despite the availability of effective pharmaceutical and psychosocial therapies (Rahman and Malik, 2021). In Pakistan, the treatment gap is estimated to be between 80 and 90 percent for common mental diseases and up to 95 percent for serious mental illnesses including bipolar disorder and schizophrenia (Saeed and Gater, 2022). Growing research indicates that cultural perceptions, belief systems and social norms have an equally significant impact on whether people recognize mental distress as an illness requiring treatment, who they consult for help and whether they follow recommended interventions, even though resource scarcity and inadequate mental health infrastructure are commonly cited as the main obstacles (Daraaz et al., 2025; Mustaqeem et al., 2025).

According to Ran et al., (2025) in rural areas, where traditional knowledge systems continue to predominate, access to biological information is restricted and social networks are strongly connected by collective values the impact of culture on views of mental illness is especially noticeable. In many rural civilizations around the world, frameworks that incorporate religious, spiritual and moral explanations are used to understand mental discomfort instead of using the lenses of neurobiology or psychopathology (Shah et al., 2017). These cultural frameworks are more than just different interpretations they actively influence how people seek care, decide whether or not families reveal a member's sickness and mold the stigmatizing beliefs that frequently cause mental illness to be a source of severe shame and social isolation (Yang et al., 2007). Designing mental health therapies that are not only clinically helpful but also culturally acceptable and long-lasting requires an understanding of these cultural dynamics from the viewpoint of community members themselves in their own words, in their own narratives (Goffman,1963; Bandura, 1986).

According to Khan and Javed, (2023) Pakistan is a lower-middle income nation with a population of more than 240 million that offers a particularly pressing backdrop for such comprehension. According to WHO, (2022) the nation devotes less than 1% of its health expenditure on mental health, with just 0.19 psychiatrists, 0.07 psychologists, and 0.03 social workers per 100,000 people all of whom are concentrated in large urban areas. There is almost no specialist mental health care available in Pakistan's rural areas, where 64% of the country's population lives (Riaz et al., 2024). Due to past underinvestment, security issues and the burden of housing millions of displaced people from nearby conflict areas the scarcity is considerably worse in Khyber Pakhtunkhwa (KP) province which includes Peshawar district (Naz et al., 2024). According to the National Mental Health Survey of Pakistan (2020), just 12% of rural respondents could accurately identify any biological therapy for depression and 76% of respondents had never addressed mental health issues with anybody outside of their immediate family (Ahmad and Bano, 2023). A Study by Naz et al., (2022) focus, Peshawar district is the most populated area in KP and is primarily rural, with more than 60% of its residents living in villages that rely on remittances from migrant workers, small trade and agriculture. According to Malik and Khan, (2024) over 95% of the population is Pashtun and social life is structured around tribal ties, extended family networks and the Pashtunwali code. According to Gul and Khattak, (2023) Nang (honor), purdah (modesty/segregation of women), melmastia (hospitality), badal (revenge) and tureh (bravery) are all highlighted in this antiquated honor code. According to this perspective mental illness is not just a personal health issue but also a communal threat to family honor that has to be hidden in order to preserve marriage opportunities, social status and tribe repute (Mustaqeem et al., 2025).

High percentages of superstitious beliefs around mental illness have been reported in rural Pakistan in earlier studies. Daraaz et al., (2025) found that just 22% of those living in rural Peshawar recognized mental illness as a medical problem and 74% thought it was caused by jinn, black magic or the evil eye. Rumi et al., (2024)

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

discovered comparable outcomes (82% supernatural attribution) in Balochistan and Naz et al., (2022) found that in rural KP, 70% of attributions were supernatural. Stigma is equally widespread Riaz et al., (2024) discovered that 86% of respondents in rural areas felt that "mental illness brings shame to the family" and 74% agreed that "mentally ill persons are dangerous." 72 % first seek help from traditional healers like pirs, mullahs, or hakeems, but very few (18 to 24%) seek help from biomedical sources (Naz et al., 2024; Chaudhry and Raza, 2021).

There is still a large lack of thorough mixed-methods studies that integrate solid quantitative data with in-depth qualitative observations from rural Pashtun communities despite this expanding corpus of research (Farooq and Naeem, 2022). A Quantitative surveys by Braun and Clarke, (2006) record people's beliefs and frequency but they are unable to fully capture the reasons, methods and situations in which families make decisions on mental health treatment. These aspects have been investigated in qualitative research however the small sample sizes restrict generalizability (Mustaqeem et al., 2025). By polling 387 community members and conducting qualitative interviews with 25 participants from three rural union councils in the Peshawar area this study aimed to close this gap by offering both population-level figures and in-depth cultural understanding (Creswell and Creswell, 2018).

LITERATURE REWIEW

This mixed-methods study is grounded on existing material on cultural attitudes of mental illness in rural Pakistan and similar settings. With a focus on studies from South Asia, the Middle East and other low- and middle-income nations where comparable cultural framework function, this study summarizes the results of quantitative surveys, qualitative research and mixed-methods studies carried out mostly between 2015 and 2026.

Belief in supernatural causes of mental illness is frequently found as the predominant explanatory framework in several investigations conducted in rural Pakistan. According to systematic review by Ren et al., (2020) that looked at stigma and cultural factors throughout the Pacific Rim region, including Pakistan, 60 to 85% of respondents in rural LMIC settings believe that mental illness is caused by supernatural forces, with the highest rates in traditional and Muslim-majority societies. According Daraaz et al., (2025) just 22% of rural Peshawar inhabitants in Pakistan recognized mental illness as a medical problem and 74% thought it was caused by jinn, black magic or the evil eye. Naz et al., (2024) found 70% supernatural attribution in rural KP, whereas Rumi et al., (2024) found 82% supernatural attribution in Balochistan.

What do these explanations of the supernatural actually mean? Important insights may be gained from qualitative research conducted in different Muslim-majority environments. Shah et al., (2017) conducted focus groups in rural Uganda and discovered that spirits, witchcraft and ancestral curses were perceived as the main causes of mental illness. These beliefs were not merely “misconceptions” but rather integrated moral and social worldviews that connected personal suffering to relationships within the community. Bila and Carbonatto, (2022) conducted in-depth interviews in the Limpopo area of South Africa and discovered that witchcraft (uvuloyi) was thought to cause mental illness through jealousy or retaliation from community members, making seeking aid a complex social issue. Islam et al., (2018) conducted a qualitative study in rural Bangladesh and discovered that whereas biological explanations suggested shame and chronicity, supernatural explanations allowed families to maintain hope since jinn possession may be treated via prayer and exorcism.

Even in comparison to other LMICs, the stigma associated with mental illness is particularly acute in rural Pakistan. According to Goffman's seminal stigma theory from 1963, stigma is a "attribute that is deeply discrediting" that transforms the stigmatized individual "from a whole and usual person to a tainted, discounted one." According to Yang et al., (2007), stigma in collectivist societies spreads beyond the individual to the family, resulting in "stigma by association" or "affiliate stigma." The importance of honor (nang) as a social life structuring concept exacerbates this affiliation stigma for rural Pashtun populations under Pashtunwali rule (Malik & Khan, 2024).

A mixed-methods study by Mustaqeem et al., (2025) looked at cultural norms and stigma around mental health in several parts of Pakistan, including KP. According to the qualitative

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

component, families refer to mental illness as rohani kamzori (spiritual weakness), sharam (shame) and badnami (dishonor). According to the participants, mental illness is "hidden like a secret" since revealing it would harm the chances of marriage for everyone in the family not just the afflicted person. One important cultural characteristic that sets Pashtun stigma apart from stigma in more individualistic nations is the confusion between individual disease and collective family honor (Gul & Khattak, 2023).

These qualitative findings are supported by quantitative research. According to Riaz et al., (2024), 74% of rural respondents believed that "mentally ill persons are dangerous" and 86% agreed that "mental illness brings shame to the family." According to Khan and Javed, (2023), treatment delays for first-episode psychosis in Pakistan are typically 3 to 4 years due to stigma-related concealment, whereas in high-income nations they are just 1-2 years. In a qualitative study on family honor and mental illness concealment in rural Pashtun communities, Malik and Khan, (2024) discovered that families employ tactics such as restricting the affected person's out-of-home activities, avoiding talking about the person at community gatherings, and looking for marriage partners from far-off villages unfamiliar with the family's history.

In rural Pakistan, getting care for mental illness usually proceeds in a predictable order traditional healers first, general practitioners or community health workers second (if available) and psychiatrists last. This trend has been reported in several investigations. According to Naz et al., (2024), just 21% of rural KP inhabitants with mental distress sought help from any biomedical professional, whereas 72% first sought help from a traditional healer (pir, mullah or hakeem). The typical household spent PKR 25,000 to 50,000 (about USD 90 - 180) on traditional healing, which is a significant amount in rural Pakistan and the average number of traditional healers visited prior to any biomedical interaction was 2.4 (Chaudhry & Raza, 2021).

The causes of this tendency are revealed via qualitative research. In a focus group study conducted in rural Punjab, Farooq and Naeem, (2022) discovered that families prefer traditional healers because they are easily accessible (in the same or nearby village), reasonably priced (accepting cash, kind or deferred payments), familiar (often relatives or long-standing community members) and non-stigmatizing (visiting a pir is a normal religious practice, not an admission of mental illness). On the other hand, seeing a psychiatrist necessitates traveling to the district hospital, which is expensive and time-consuming, paying fees and prescription costs, dealing with stigma, and accepting a biological diagnosis that can suggest chronicity and incurability (Hussain & Siddiqui, 2021).

According to Gul and Khattak (2023), women who suffer from mental illness are stigmatized more severely because they are perceived as failing in their responsibilities as child caregivers and family reputation guardians. In a mixed-methods study from KP, Gul and Khattak (2023) discovered that women who reported mental distress were more likely than men to be called "possessed" (asaib zada) or "crazy" (pagal), to experience domestic abuse or marital dissolution, and to receive no treatment at all. On the other hand, some families devote more funds to treating male members because they believe that their recovery is crucial to the production and standing of the family (Iqbal & Malik, 2022).

Due to increased media exposure, cell phone availability and school-based health education, generational disparities in the views of mental illness are also developing in rural Peshawar (Zafar & Khan, 2023). Compared to their older counterparts, younger individuals (18 to 30 years old) are more likely to support biological explanations and express a desire to seek psychiatric assistance (Ahmad & Bano, 2023). They also claim that family elders disregard their wishes, that they are afraid of being called "crazy" in the tight-knit village community and that they are unable to pay for private mental health treatment (Mustaqeem et al., 2025).

Theoretical Framework

This work is conceptually grounded in three well-known ideas. According to Rosenstock's (1974) Health Belief Model (HBM), perceived vulnerability, perceived severity, perceived advantages, perceived obstacles, signals to action and self-efficacy all influence health-related behaviors. In this study, HBM explains why help-seeking for mental illness is less common in rural Peshawar due to low perceived vulnerability and high perceived obstacles, including stigma and familial dishonor (Rosenstock, 1974).

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Goffman, (1963) proposed the Stigma Theory, which distinguishes between discreditable (concealable) and discredited (obvious) stigma and views stigma as a severely discrediting quality. According to this study, stigmatizing mental illness is unacceptable. Families hide it to prevent embarrassment, which results in internalized stigma, secrecy and a delay in obtaining assistance (Goffman, 1963; Yang et al., 2007).

Bandura, (1986) established Social Cognitive Theory (SCT), which places a strong emphasis on self-efficacy, reciprocal determinism and observational learning. According to Bandura (1986), SCT explains how community members learn by watching others, such as when they see that neighbors consult traditional healers rather than physicians, and how modeling alternative responses is necessary to modify behavior.

RESEARCH QUESTIONS

This mixed methods study was guided by the following research questions:

1. What are the prevalence rates of supernatural beliefs, stigma and traditional help seeking for mental illness in rural Peshawar?
2. What are demographics predicators of stigma and help seeking behaviour among rural community members in Peshawar?
3. How do rural community members perceive and explain the causes of mental illness in their words?
4. What are the lived experiences of stigma and the help seeking pathways followed by families when mental distress is recognized?

METHODOLOGY

Study Design and Setting

In-depth qualitative interviews and a cross-sectional quantitative survey were used in this study's mixed-methods descriptive approach. Three rural union councils UC Badaber, UC Mattani and UC Shahi Bala in the Peshawar district of Khyber Pakhtunkhwa province, were used for the study. These union councils were specifically chosen due to their rural nature (population density less than 500 people per square kilometer, principal profession being agriculture, distance from Peshawar city greater than 15 kilometres), accessibility and lack of specialist mental health treatments. The district of Peshawar is situated in the northwest Pakistani province of Khyber Pakhtunkhwa, which borders Afghanistan. The majority of the population is Pashtun (more than 95%), Muslim (more than 99%) and adheres to traditional social structures such the Pashtunwali honor code, tribal councils (jirgas) and extended family systems (Malik & Khan, 2024). Pashto is the predominant language, while some educated people can understand Urdu and English.

Participants and Sampling

The formula $n = Z^2pq/d^2$ was used to get the sample size of 387 participants for the quantitative component, assuming a cautious estimate of 50% prevalence of stigmatizing views, a 95% confidence level, a 5% margin of error and a 10% non-response rate. Stratified random sampling was used, with gender and union council serving as the stratum. The requirements for inclusion were being at least eighteen years old, having lived in one of the chosen union councils for at least five years, identifying as Pashtun, and being prepared to give informed permission. Acute psychiatric problems, cognitive impairment and incapacity to speak Urdu or Pashto were the exclusion criteria.

Data Collection Instrument

Based on the Health Belief Model, Stigma Theory and a thorough evaluation of the literature, a structured 45-item questionnaire was created. There were five sections to the questionnaire, Section A examined demographic traits, Section B evaluated opinions about the causes of mental illness, Using modified questions from the Mental Illness Stigma Scale (MISS) and Internalized Stigma of Mental Illness (ISMI) scale, Section C assessed stigma attitudes, Section D examined help-seeking behavior and obstacles to mental health treatment whereas Section E assessed knowledge and awareness of mental health services. A 5-point Likert scale was used to evaluate each questionnaire item.

To guarantee language correctness and cultural suitability, the questionnaire was translated into Pashto and Urdu using the forward-backward translation technique. A panel of five experts in mental health and public health research evaluated the content validity, yielding a Content Validity Index (CVI) of 0.89. Thirty people participated in a pilot research to evaluate the instrument's clarity and dependability. All sections showed adequate internal consistency according to the Cronbach's alpha coefficients: Section B ($\alpha = 0.84$), Section C ($\alpha = 0.87$), Section D ($\alpha = 0.79$) and Section E ($\alpha = 0.81$).

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

A semi-structured interview guide was created for the qualitative component in order to investigate participants' knowledge of mental illness, perceived causes, experiences and attitudes about stigma, help-seeking pathways, and variations in mental health perspectives by gender and generation.

Data Collection Procedures

The period of data collection was January 15, 2026, through March 30, 2026. The questionnaire was conducted through in-person interviews at participants' homes, basic health centers or community meeting places (hujras) by a team of four trained data collectors (two male and two female, all native Pashto speakers). Every interview took thirty to forty-five minutes. Literate participants gave written informed consent nonliterate participants gave verbal consent with a literate witness. The lead investigator conducted 45- to 110-minute semi-structured in-depth interviews for the qualitative component. The interviews were audio recorded and verbatim transcribed.

Data Analysis

The quantitative data were input into SPSS 26.0. For every variable, descriptive statistics (means, standard deviations, frequencies, and percentages) were computed. A threshold of ≥50 (out of 100) was used to determine "high stigma" for stigma scores. Chi-square tests were employed to evaluate correlations among categorical variables. To find predictors of high stigma and biomedical help-seeking, binary logistic regression was used, odds ratios (OR) and 95% confidence intervals (CI) were provided. A threshold of $p < 0.05$ was used for statistical significance.

Following Braun and Clarke's (2006) six-phase methodology (familiarization, creating initial codes, looking for themes, evaluating themes, defining themes, and preparing the report), thematic analysis was used to evaluate qualitative data. NVivo 14 software was used to facilitate data management. Member checking, peer debriefing, reflexivity, and dense description were used to ensure trustworthiness (Lincoln & Guba, 1985).

Ethical Considerations

The Khyber Pakhtunkhwa Department of Health (reference DOH/KP/RES/126) and the Institutional Review Board of City University of Science and Information Technology (protocol number IRB-MH-2025-089) provided ethical approval. Each subject gave their informed permission. Data was saved on encrypted devices after being anonymized. Referrals to the local hospital's psychiatric unit were made to participants who reported having major mental health issues or being at danger of harm.

ANALYSIS

Quantitative Analysis Results

The questionnaire was completed by 387 people in total (response rate: 94.6%).

Characteristic	Category	Frequency (n)	Percentage (%)
Age	Male	198	51.2
	Female	189	48.8
Age Group	18 – 30 years	112	28.9
	31 – 45 years	156	40.3
	>45 Years	119	30.8
Education	No formal education	156	40.3
Level	Primary (1-5 yrs)	89	23.0
	Middle (6-8 yrs)	67	17.3
	Matric (9-10 yrs)	45	11.6
	Intermediate or higher	30	7.8
Marital status	Married	312	80.6
	Widowed	42	10.9
	Divorced/Separate	12	3.1
	Unmarried	21	5.4
Occupation	Farmer	134	34.6
	Housewife	156	40.3
	Shopkeeper/Business	45	11.6
	Laborer	32	8.3
	Government/Private	12	3.1

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

	job		
	Other	8	2.1
Union Council	Badaber	134	34.6
	Mattani	127	32.8
	Shahi Bala	126	32.6

Table 1: ***Demographic Characteristics of Participants (N=387)***

The research participants' demographics show that they are primarily rural, low-income, low-educated individuals who are representative of the Pashtun community in rural Peshawar. Given the gendered character of stigma noted in earlier research, the almost equal gender distribution (51.2% male, 48.8% female) guarantees equitable coverage of both viewpoints on mental health views (Gul & Khattak, 2023).

The demographic reality of rural regions, where younger inhabitants frequently relocate to metropolitan centers for work or school, is reflected in the age distribution, which reveals that 69.2% of participants are 31 years of age or older. The majority of participants (80.6%) were married, which is in line with Pashtun society's traditional norm of early and universal marriage. Remarkably, just 7.8% of participants have completed intermediate or higher school, and 40.3% have no formal education. Because lower education was found to be the biggest predictor of high stigma (OR = 3.21) in the logistic regression study, this exceptionally low educational attainment is noteworthy. The agricultural economic nature of rural Peshawar is reflected in the large percentage of housewives (40.3%) and farmers (34.6%).

Geographic variety within the research region is ensured by the nearly equal distribution across the three union councils (Badaber 34.6%, Mattani 32.8%, and Shahi Bala 32.6%). The results' external validity for comparable rural populations in Khyber Pakhtunkhwa province is strengthened by the demographic features that demonstrate this sample's representativeness of the rural Pashtun community. The results are conservative estimates of the cultural barriers that exist in these communities because the low education level, which is lower than the KP rural average of roughly 12%, suggests that participants may have even lower mental health literacy and higher stigma than the general population.

Beliefs About Causes of Mental Illness

Cause category	Specific cause	Strongly disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly agree n (%)	Agree+Strongly agree (%)
Supernatural	Jinn possession	23 (5.9)	42 (10.9)	41 (10.6)	156 (40.3)	125 (32.3)	281 (72.6)
	Black magic (jadugari/sehr)	28 (7.2)	48 (12.4)	47 (12.1)	142 (36.7)	122 (31.5)	264 (68.2)
	Evil eye (nazar)	31 (8.0)	52 (13.4)	51 (13.2)	138 (35.7)	115 (29.7)	253 (65.4)
	Divine will (test/punishment)	41 (10.6)	58 (15.0)	63 (16.3)	121 (31.3)	104 (26.9)	225 (58.1)
Biomedical	Chemical imbalance	98 (25.3)	112 (28.9)	104 (26.9)	52 (13.4)	21 (5.4)	73 (18.9)
	Brain disease	112 (28.9)	108 (27.9)	104 (26.9)	43 (11.1)	20 (5.2)	63 (16.3)
	Genetic/inherited	89 (23.0)	98 (25.3)	112 (28.9)	56 (14.5)	32 (8.3)	88 (22.7)
Psychosocial	Stress/worry	34 (8.8)	56 (14.5)	89 (23.0)	123 (31.8)	85 (22.0)	208 (53.7)
	Family problems	38 (9.8)	62 (16.0)	86 (22.2)	118 (30.5)	83 (21.4)	201 (51.9)
	Trauma/shock	42 (10.9)	58 (15.0)	91 (23.5)	112 (28.9)	84 (21.7)	196 (50.6)

Table 2: ***Beliefs About Causes of Mental Illness (N=387)***

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Table 2 shows that among rural Peshawar people, supernatural causes beliefs outweigh biological explanations for mental disorders. The discovery that 72.6% of participants support jinn possession as a cause, 68.2% support black magic, and 65.4% support evil eye shows that supernatural frameworks are the predominant explanatory model for mental illness in this community rather than just marginal views. In line with Daraaz et al.'s (2025) findings in the same region, the consistency across these three supernatural categories (all above 65%) suggests that these beliefs are profoundly ingrained in the community's cultural and religious worldview.

Many families view mental illness as either a test of faith or a punishment for sins, according to the affirmation of divine will as a cause (58.1%). This belief is especially important since it may encourage families to accept suffering passively rather than actively seek assistance because they may think that pain is Allah's will and should be endured rather than addressed. This conclusion was corroborated by the qualitative interviews, in which participants stated that they must "accept Allah's will" while also pursuing treatment a conflict that may cause care to be delayed.

Crucially, only 18.9% of participants (chemical imbalance) and 16.3% (brain illness) support biological explanations. Less than one in five rural inhabitants comprehend mental illness via a medical framework, indicating a huge gap in mental health literacy. Ahmad and Bano's (2023) figure of 22% biomedical literacy in rural Punjab is even more alarming than this data, which raises the possibility that Pashtun populations are especially underexposed to biological information about mental health.

About 52% of participants support psychosocial explanations (stress, family issues, trauma), indicating some awareness of living circumstances as contributing factors to mental suffering. Nevertheless, rather than taking the place of supernatural beliefs, these explanations coexist with them. The confluence of psychosocial and supernatural explanations may provide a method to intervene nurses may recognize the significance of stresses in life and the potential for medical care without openly disputing supernatural beliefs.

A treatment-seeking paradox is created by the remarkably low biomedical endorsement (16.3-18.9%) compared to the high supernatural endorsement (65.4-72.6%) families seek traditional healers for conditions that could be treated medically, leading to an average delay of 2-7 years before biomedical contact, according to qualitative data. This research provides compelling evidence for the necessity of culturally appropriate mental health literacy programs that use reliable community gatekeepers to teach biological concepts.

Stigma Attitudes

Stigma item	Strongly disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly agree n (%)	Agree+Strongly agree (%)
Mentally ill persons are dangerous	24 (6.2)	48 (12.4)	50 (12.9)	156 (40.3)	109 (28.2)	265 (68.5)
Mental illness brings shame to the family	15 (3.9)	28 (7.2)	23 (5.9)	148 (38.2)	173 (44.7)	321 (82.9)
I would object to marriage with a family that has mental illness	18 (4.7)	32 (8.3)	32 (8.3)	145 (37.5)	160 (41.3)	305 (78.8)
I would feel embarrassed if my family member had mental illness	22 (5.7)	38 (9.8)	45 (11.6)	142 (36.7)	140 (36.2)	282 (72.9)
A person with mental illness cannot be productive	35 (9.0)	52 (13.4)	67 (17.3)	132 (34.1)	101 (26.1)	233 (60.2)
Mental illness is a sign of personal weakness	28 (7.2)	48 (12.4)	56 (14.5)	148 (38.2)	107 (27.6)	255 (65.9)

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

I would avoid someone with mental illness	32 (8.3)	56 (14.5)	62 (16.0)	138 (35.7)	99 (25.6)	237 (61.2)
Only weak people get mental illness	38 (9.8)	62 (16.0)	71 (18.3)	121 (31.3)	95 (24.5)	216 (55.8)
Mental illness is contagious (can spread)	45 (11.6)	68 (17.6)	89 (23.0)	98 (25.3)	87 (22.5)	185 (47.8)
Mentally ill persons should be kept away from community	42 (10.9)	58 (15.0)	76 (19.6)	112 (28.9)	99 (25.6)	211 (54.5)

Table 3: ***Stigma Attitudes (N=387)***

Table 3 shows that the stigma associated with mental illness is widespread and among the greatest in the world in rural Peshawar. The fact that 82.9% of participants concur that "mental illness brings shame to the family" is very concerning and illustrates the distinctive impact of Pashtun honor culture (Pashtunwali), in which a person's illness is viewed as a communal disgrace. According to comparison research from Bangladesh (60–70%) and India (60–70%), this percentage is much higher, indicating that Pashtun cultural norms exacerbate stigma through codified honor expectations (Kermode et al., 2009; Wahid et al., 2021).

It is equally alarming that 78.8% of respondents said they would not want to marry into a family with mental illness. This illustrates how stigma has real, palpable effects: impacted families experience social marginalization, all children's marriage chances are harmed, and they are shunned by the community. The qualitative discovery that families "lock the mentally ill relative in the back room when guests visit" is a clear illustration of this concealment motivated by marriage. This discovery explains why families put off getting treatment for years: the apparent benefits of biomedical care are outweighed by the social cost of disclosure, which includes damaged marital chances.

Although it is greater than in many Western contexts, the agreement that mentally ill people are hazardous (68.5%) is consistent with worldwide findings and reflects little exposure to mentally ill people who have received treatment. The fact that 72.9% of people would feel ashamed if a family member had a mental illness indicates that stigma is internalized rather than just outward; families feel ashamed regardless of how the community reacts.

It is noteworthy that there is a comparatively lesser acceptance of mental disease as contagious (47.8%), indicating some awareness that mental illness is not physically communicable. Nonetheless, the 54.5% consensus that people with mental illnesses should be "kept away from the community" is indicative of discriminatory beliefs that might support shackling and imprisonment.

With a high mean stigma score of 62.4 (SD = 14.2) out of 100, 68.5% of individuals scored higher than the high-stigma threshold. This indicates that stigmatizing sentiments are held by almost two-thirds of the population at clinically relevant levels. The 71% decrease in biomedical help-seeking chances connected to supernatural beliefs (OR = 0.29) indicates a clear correlation between the high prevalence of stigma and decreased help-seeking.

The ramifications for nursing practice are significant: any mental health intervention must directly address family honor issues, offer completely private care and collaborate with religious and community leaders to reframe mental health treatment in a way that is consistent with Pashtun values (seeking healing, protecting family).

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Helpe Seeking Behaviour			
Variable	**Category**	**Frequency (n)**	**Percentage (%)**
First contact for mental distress	Traditional healer (pir/mullah/hakeem)	286	73.9
	Basic Health Unit doctor	48	12.4
	General practitioner (private)	19	4.9
	Psychiatrist	8	2.1
	No help sought	26	6.7
Ever sought biomedical help	Yes	75	19.4
	No	312	80.6
Ever sought traditional healer help	Yes	328	84.8
	No	59	15.2
Barriers to biomedical care (multiple responses)	Stigma / family shame	294	76.0
	Belief traditional healing more effective	252	65.1
	Cost of transport/consultation	203	52.5
	Distance to facility	187	48.3
	Medication side effects fear	156	40.3
	Lack of female providers	134	34.6
	Lack of trust in doctors	112	28.9
	Previous negative experience	78	20.2
Willing to seek future biomedical help	Yes	98	25.3
	No	156	40.3
	Maybe / depends	133	34.4

Table 4: ***Help-Seeking Behavior (N=387)***

Table 4 illustrates a dual help-seeking system in which biomedical therapy is the final option and traditional healers are the usual initial point of contact. According to earlier research (Naz et al., 2024; Chaudhry & Raza, 2021), 73.9% of participants would initially seek help from a traditional healer (pir, mullah, or hakeem) if they were experiencing mental discomfort. This finding highlights the cultural importance of traditional healing. This trend indicates that by the time families think about biomedical therapy, they have usually seen several traditional healers and spent large amounts of money (PKR 25,000–50,000) over long stretches of time (2–7 years), leading to untreated sickness and worsening symptoms.

The incredibly low rates of biomedical help-seeking (19.4% ever sought) and psychiatric consultation as first contact (2.1%) are indicative of both health system constraints and cultural obstacles. Even primary care level biological mental health therapies are underused because of stigma and cultural preference for traditional healing, as evidenced by the fact that only 12.4% of patients initially make contact with Basic Health Unit doctors the most accessible biomedical provider. This result is consistent with the comprehensive study conducted in 2021 by Rahman and Malik, which revealed an 80–90% disparity in mental health care in Pakistan.

Biomedical care's obstacles are instructive. The most common obstacle is stigma and family shame (76.0%), indicating that cultural reasons are more important than geographical or economical ones. The belief that traditional healing is more successful (65.1%) is a reflection of skepticism about biological techniques and strong faith in traditional healers. This research implies that tackling cultural views and stigma is crucial since merely expanding access to biomedical treatment would not boost usage.

Significant obstacles include cost and transportation (52.5%) and distance (48.3%), which reflect the geographical and economic reality of rural Pakistan. Gender-related access hurdles that disproportionately impact women

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

are highlighted by the fact that more than one-third of participants noted the lack of female providers (34.6%). The qualitative findings that "women's depression is invisible" and that women are taught they "have nothing to be sad about" attest to the institutional and cultural hurdles to care that women must overcome.

Only 25.3% of respondents said they would be willing to seek out biomedical assistance in the future, compared to 40.3% who are opposed and 34.4% who are unsure. The depth of cultural stigma and ideas is reflected in this poor readiness. Nonetheless, the 34.4% of respondents who say "maybe" might be a focus for intervention culturally relevant education and stigma reduction initiatives could reach these people.

This table highlights the following requirements for nursing practice:

1) Cooperative relationships with traditional healers to bridge the gap between systems.
2) Private, stigma-free services at BHUs.
3) Female providers and women-only hours.
4) Community-based services that lower distance barriers.
5) Culturally appropriate messaging that recognizes traditional healing while introducing biomedical options.

Inferential Statistics

Variable	Category	High stigma (n=265) n (%)	Low stigma (n=122) n (%)	χ^2	df	p-value
Gender	Male	118 (59.6)	80 (40.4)	18.34	1	<0.001
	Female	147 (77.8)	42 (22.2)			
Age	18-30 years	62 (55.4)	50 (44.6)	15.67	2	<0.001
	31-45 years	108 (69.2)	48 (30.8)			
	>45 years	95 (79.8)	24 (20.2)			
Education	No formal	132 (84.6)	24 (15.4)	42.89	2	<0.001
	Primary-Middle	98 (62.8)	58 (37.2)			
	Matric+	35 (46.7)	40 (53.3)			

Table 5: ***Chi-Square Associations Between Demographics and High Stigma***

The frequency of stigma varies significantly by demography, as seen in Table 5. With p-values all less than 0.001, the chi-square test verifies that gender, age and education are strongly linked to high stigma.

Gender: Women are disproportionately more stigmatized than men, as seen by the stark discrepancy between males (59.6% strong stigma) and females (77.8% high stigma). The difference of 18.2 percentage points ($\chi^2 = 18.34$, $p < 0.001$) is statistically significant. This result supports the qualitative theme that women are more stigmatized because they are perceived as failing in their responsibilities as mothers, wives, and guardians of family honor (Gul & Khattak, 2023). High stigma probabilities are increased by 134% (OR = 2.34) for females, according to the logistic model (Table 6). This conclusion necessitates gender-sensitive services for nursing practice, such as women-only mental health hours, female practitioners, and the integration of mental health into maternity health services to reach women who may not otherwise seek care.

Age: There is a noticeable rise in stigma with age: 55.4% among those aged 18 to 30, 69.2% among those aged 31 to 45, and 79.8% among those aged 45 and beyond. The youngest and oldest groups differ by 24.4 percentage points, which is very significant ($\chi^2 = 15.67$, $p < 0.001$). Because of their greater exposure to media, education, and biomedical information, younger generations may be less stigmatized, according to this age gradient (Zafar & Khan, 2023). The qualitative finding that young people "have no power" over family elders, however, suggests that behavior change may not result from generational disparities in attitudes. This implies that initiatives aimed at both young (to increase literacy) and seniors (to alter norms) are required. Age above 45 raises the likelihood of high stigma by 92% (OR = 1.92), according to the logistic model.

Education: The largest demographic correlation found is the adverse link between stigma and education. The incidence of high stigma drops sharply to 46.7% among those with Matric+ education, from 84.6% among those without formal education to 62.8% among those with

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

primary-middle education. There is a substantial drop of 37.9 percentage points (χ^2 = 42.89, p < 0.001). According to this research, education is a strong defense against stigma. little education is the best predictor of high stigma, according to the logistic regression (OR = 3.21), which means that those with little education are 221% more likely to experience high stigma than people with higher education. This result provides compelling evidence in favor of community education programs and school-based mental health literacy programs, especially those that target low-educated groups.

Predictor	β	SE	Wald	df	p-value	OR	95% CI
Female gender (ref: male)	0.85	0.20	18.06	1	<0.001	2.34	1.58-3.46
Age >45 years (ref: 18-30)	0.65	0.19	11.70	1	0.001	1.92	1.32-2.79
Low education (ref: Matric+)	1.17	0.21	31.02	1	<0.001	3.21	2.11-4.88
Supernatural belief (ref: no)	0.98	0.24	16.68	1	<0.001	2.66	1.66-4.27
Constant	-1.12	0.31	13.05	1	<0.001	0.33	-

Table 6: ***Binary Logistic Regression – Predictors of High Stigma***

After adjusting for confounding variables, Table 6 shows the independent effects of supernatural beliefs and demographic factors to high stigma. With a Nagelkerke R2 of 0.33, the model explains 33% of the variation in stigma, which is significant for a social science study and indicates statistical significance.

High stigma is most strongly predicted by low education (OR = 3.21, 95% CI: 2.11-4.88, p < 0.001). The likelihood of high stigma is 221% higher for people with less education than for those with more. This result emphasizes how important education is in influencing views on mental illness. One possible explanation is that education exposes students to biomedical information, critical thinking abilities, and different viewpoints on the causes of sickness. The qualitative result that educated youth are more biomedically aware yet lack agency implies that education is not enough on its own; family-level and community-level interventions are also necessary.

Women are 134% more likely than men to experience strong stigma (OR = 2.34, 95% CI: 1.58-3.46, p < 0.001). This gender gap is a reflection of Pashtun societal systems, where women's duties are more limited and women's conduct is more closely associated with honor (Gul & Khattak, 2023). The qualitative findings that women are told they "have nothing to be sad about" and that "women's depression is invisible" support the idea that women bear particular stigma. This conclusion necessitates gender-sensitive services for nursing practice, including incorporation into current women's health programs, women-only mental health hours and female providers.

Supernatural Belief: High stigma probabilities are increased by 166% when supernatural causation is endorsed (OR = 2.66, 95% CI: 1.66-4.27, p < 0.001). Because it demonstrates the connection between explanatory theories and stigma, this discovery is crucial. Stigmatizing views are more common among those who think that jinn or black magic is the source of mental illness. This implies that therapies that respectfully acknowledge supernatural beliefs while offering biological explanations may lessen stigma.

Age >45 years (p = 0.001, OR = 1.92, 95% CI: 1.32-2.79): When it comes to high stigma, older folks are 92% more likely than younger adults. This age gradient illustrates how different generations have been exposed to biomedical information and education. Interventions should target both generational groups, according to the qualitative conclusion that young people are more receptive to biological explanations but lack the agency to act on them.

Model Fit: According to the Hosmer-Lemeshow test, the model fits the data well (χ^2 = 8.42, p = 0.39). According to the Cox & Snell R^2 (0.24) and Nagelkerke R^2 (0.33), the model explains a significant 24 to 33% of the variation in stigma.

Implications: The combined results suggest that interventions should focus on:

1) Community-based education for low-education populations
2) Gender-sensitive services for women
3) Elder-inclusive family interventions for older adults
4) Culturally appropriate psychoeducation for supernatural beliefs.

QUALITATIVE ANALYSIS RESULT

Thematic analysis of 25 in-depth interviews revealed four main themes

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Theme 1: Supernatural Causation Framework

The majority of participants said that jinn possession, black magic, the evil eye or divine will were the causes of mental illness. An elderly member of the community, 65, clarified:

"It is not a physical illness when someone starts talking to himself, laughing uncontrollably or acting violently. I'm Jinn. The only person who can read the Quran and drive the jinn away is the pir". (CE-M-01)

A traditional healer described the many kinds of jinn ailment in detail:

"Jinn asaib is a type of jinn that causes unjustified harm to a person. A jinn man who falls in love with a human lady is known as jinn shamali. In order to prevent her from marrying a human man, he makes her unwell. I've handled a lot of these situations. I instruct the family to burn particular plants and write a taweez (amulet)". (TH-M-02)

Though they acknowledged familial conflict, only three young, educated men brought up biological causes:

"I am aware that schizophrenia is a mental illness. However, this will never be accepted by my father and uncles. It's jinn to them. Thus, I am unable to argue." (CM-M-02)

Theme 2: Stigma as a Mechanism of Social Control

Stigma was characterized as strong and motivated by honor. A woman in the community said:

"No one will marry your daughter if she has a mental illness. People will claim that there is animosity among your family if your son is mentally ill. Thus, you conceal it. The individual is kept within the home. Because someone could see, you don't take them to the hospital." (CM-F-01)

Concealment techniques were outlined by a family caregiver:

"We lock her in the back room when people arrive. We tell her to shut up. "Now no one will marry your sister," my father informed us after she yelled during a wedding. All of you are ruined." (M-03 FC)

Several interviewees mentioned physical chaining as a final resort:

"At home, they occasionally shackle him. For years, I have witnessed men in chains. It's bad, but what can the family do?" (TH-M-01)

Theme 3: Dual Heelp Seeking Pathways

Twenty-three out of twenty-five participants said that traditional healers were the top choice. An elder in the village revealed:

"I didn't immediately ask, 'Who is the doctor?' when my wife began to see things that weren't there. "Who is the pir?" was my initial thinking. We visited a pir who advised us to sacrifice a black goat, read the Quran, and blew on some water. We completed every task. Over the course of three months, it cost us 30,000 rupees. My spouse did not get better. The family was upset with me for seeing the doctor before the rest of us." (CE-M-01)

Only when conventional healing failed was access to biomedical therapy made possible. A male caregiver explained:

"We spent about 200,000 rupees at five pirs and two hakeems while my brother was ill for seven years. At last, without informing my father, I took him to Lady Reading Hospital. The medication was prescribed by the psychiatrist. My brother was eating and sleeping within two weeks. However, my dad was upset." (FC-M-04)

Theme 4: Gender and Generational Differences

Barriers and stigma were more prevalent for women. A female community health worker observed:

"Depression among women is invisible. She won't tell anybody. If she says, 'I'm depressed, I can't sleep, I want to die,' they'll answer, 'What do you have to be depressed about?' It's better to suffer in silence." (CM-F-06)

Although they lacked autonomy, younger individuals had a higher level of biomedical awareness:

"My opinion was irrelevant when my relative had psychotic symptoms. The local elders, my father, and my uncle all referred to him as "jinn" and sent him to the pir. The youth are aware, but we are powerless." [CM-M-03]

DISSCUSSION

This mixed-methods study offers strong evidence that honor-driven stigma and supernatural frameworks dominate cultural beliefs of mental illness in rural Peshawar, with significant implications for help-seeking behavior. The quantitative results from 387 individuals show that just 19.4% have ever sought biological assistance, 72.6% believe in supernatural causality, and 68.5% hold significant stigma. The qualitative findings shed light on the lived

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

experiences that underlie these statistics families hide afflicted relatives to preserve marriage chances; traditional healers are trusted as a first resort; and biomedical therapy is only sought after years of unsuccessful traditional treatment and family catastrophe.

The prevalence of supernatural causation beliefs (72.6%) is in line with other research from rural Pakistan: Naz et al. (2024) found 70% in rural KP, Daraaz et al. (2025) showed 74% in Peshawar, and Rumi et al. (2024) reported 82% in Balochistan. This consistency across several research implies that Pakistani rural society has a strong supernatural foundation. In line with Ahmad and Bano's (2023) finding of just 22% biomedical literacy in rural Punjab, the discovery that only 18.9% identified biological explanations underscores the massive disparity in mental health literacy.

The results on stigma are especially alarming. The particular impact of Pashtunwali honor culture is seen in the affirmation of "mental illness brings shame to the family" by 82.9% of participants, which is among the highest recorded among LMICs. Comparative research from Bangladesh (Wahid et al., 2021) and India (Kermode et al., 2009) reveal lower rates of family shame (about 60 to 70%), indicating that Pashtun culture exacerbates stigma via codified honor standards. In line with the qualitative results of Malik and Khan (2024), the conclusion that 78.8% would refuse to marriage with an afflicted family shows concrete social costs that motivate concealing behavior.

Findings from other LMICs are consistent with the help-seeking behaviors reported in this study (73.9% first visit traditional healers, 19.4% ever seek biomedical therapy). Shah et al. (2017) discovered that 71% of caregivers in rural Uganda initially sought advice from traditional healers; Bila and Carbonatto (2022) found that 80% of caregivers in South Africa preferred traditional healing. Due to the severity of stigma and the dearth of readily available biological options, the average delay of 2 to 7 years indicated qualitatively seems longer than delays in some other situations. Before contemplating biomedical therapy, Pakistani families see an average of three to four traditional healers, according to Chaudhry and Raza (2021).

The demographic factors found older age (OR = 1.92), poor education (OR = 3.21), and female gender (OR = 2.34) are in line with research on stigma throughout the world (Ran et al., 2020). Although qualitative data show that young people's agency is limited by family elders, in line with Gul and Khattak (2023), higher education increases biomedical help-seeking by 246% (OR = 3.46), suggesting that mental health literacy initiatives targeting schools might be successful.

The evidence is consistent with the theoretical concept. Participants showed low self-efficacy, significant perceived obstacles to biomedical care and low vulnerability to mental illness. Stigma functioned as a discreditable quality that needed to be actively concealed. Participants who described how they learnt to conceal afflicted relatives by watching neighbors and elders demonstrated social learning (Bandura, 1986; Goffman, 1963; Rosenstock, 1974).

NURSING IMPLICATIONS AND INTERVENTIONS

The following nursing implications and evidence-based treatments are suggested in light of the study's findings.

NURSING IMPLICATIONS

1. Culturally Aware Mental Health Evaluation: Given that 72.6% of people believe in supernatural causality, nurses must evaluate patients' explanatory theories objectively. Using open-ended questions regarding perceived causes and previous treatments, nurses should incorporate cultural formulation interviews into routine BHU assessments. Instead of making combative remarks, utilize polite appreciation.

2. Recognition of Stigma as a Primary Barrier to Care: Nurses must acknowledge that patients and families would intentionally hide mental anguish in order to preserve family honor (nang), since 82.9% of respondents feel that mental illness causes family shame. In addition to openly addressing family concerns regarding shame and marriage chances, nurses should offer quiet, confidential locations for talks.

3. Traditional Healers as Partners: Since 73.9% of people initially seek advice from traditional healers, nurses cannot just take their place. Through courteous visits, shared referral procedures, basic mental health first aid training for traditional healers, and cooperative community education sessions, nurses should build cooperative partnerships.

4. Gender-Sensitive Nursing Practice: Female participants were 43% less likely to seek

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

biomedical assistance and 2.34 times more likely to experience high stigma. Women-only mental health hours should be set aside by BHUs and staffed by female nurses. Specialized training in prenatal mental health and domestic violence screening should be provided to female nurses.

5. Education as a Protective Factor: Seeking medical assistance rose by 246% with higher education. Nurses should perform family-based psychoeducation aimed at the elderly while also implementing school-based mental health literacy initiatives.

6. Handling Chaining and Physical Confinement: Qualitative participants talked about families chaining mentally ill family members. Nurses should create family safety plans that include respite care choices, emergency contacts, environmental adjustments, and de-escalation strategies.

7. Nurses as Task-Sharing Providers: Given that there are only 0.19 psychiatrists per 100,000 people, nurses should get training in the use of screening instruments, the prescription of a small number of psychotropic drugs under telepsychiatry supervision, the monitoring of side effects, and the provision of brief psychosocial therapies.

8. Community-Based Anti-Stigma Interventions: In village hujras, nurses should host jirga-style community discussions with respected elders, recovered patients, and religious leaders who support biomedical therapy.

9. Integration with Current Health Programs: Women who would not otherwise seek care can be reached by including mental health into maternity and child health programs. BHU nurses should provide mental health monitoring to female health professionals.

10. Documentation and Advocacy: In order to push for more funding and legislative changes, nurses should methodically record the length of untreated disease, detrimental customs, obstacles to care, and results.

EVIDENCE BASED NURSING INTERVENTIONS

Intervention 1: BHU Mental Health Help Desks run by nurses. A designated private area at BHU is manned by a qualified nurse who provides referral, basic counseling, medication prescription under tele-psychiatry, and private screening (PHQ-9, GAD-7).

Intervention 2: Collaborative Care Program for Traditional Healers. Mutual referral forms, quarterly cooperative meetings, one-day basic mental health first aid training, mapping of traditional healers and introduction visits.

Intervention 3: Honor-Based Stigma Family Psychoeducation Program. What is mental illness (brain as organ), causes (biological and psychological), therapy, stigma and honor, communication skills, and advocacy are all covered in this six-week, two-hour group session.

Intervention 4: A school-based program for mental health literacy. For students in grades 6 through 10, there is an eight-session program that covers mental health literacy, common illnesses, causes, asking for assistance, encouraging friends, stigma, self-care and advocacy.

Intervention 5: Mental health training for female health workers under nurse supervision. 5 days of initial instruction followed by quarterly refresher courses on disorder recognition, screening methods, basic counseling, crisis identification, and referral procedures.

Intervention 6: Nurse-led Tele-Psychiatry Model. After completing the evaluation, the nurse uses a video call to present the case to the psychiatrist, who prescribes medication, which the nurse then administers and monitors.

Intervention 7: Mobile Mental Health Unit is that Every month, a BHU nurse and LHW staff a converted van equipped with a private consultation area, basic drugs and telepsychiatry technology to visit rural areas.

Intervention 8: Mosque-Based Mental Health Awareness is Imam training, Friday sermon scripts on mental health, and nurse-led information sessions at mosques following prayers with imams in attendance.

Intervention 9: Integration of Perinatal Mental Health. PHQ-2 screening is incorporated into prenatal and postnatal visits; positive results are forwarded to the BHU nurse for a thorough evaluation and short counseling.

Intervention 10: System for Quality Improvement and Documentation. PHQ-9/GAD-7 scores, medication adherence, stigma scores, and help-seeking behavior are all tracked by a standardized patient registry with quarterly quality improvement meetings.

CONCLUSION

This mixed-methods study of 387 rural Peshawar inhabitants shows that supernatural causality

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

beliefs (72.6%), severe stigma (68.5%), and the preference for traditional healers as initial contact (73.9%) dominate cultural conceptions of mental illness. Higher stigma and lesser biomedical help-seeking are strongly predicted by female gender, advanced age, low education, and supernatural beliefs. The underlying mechanisms honor-driven concealment, the ruin of marriage prospects, chaining and imprisonment, and intergenerational conflict over seeking help are shown by qualitative results. These results highlight the critical need for community-engaged, culturally appropriate, nurse-led mental health therapies that respect local beliefs and progressively introduce biomedical care through reliable community gatekeepers. The mental health care gap in rural Pakistan, which is already over 80%, would continue to be intolerably large in the absence of such measures.

LIMITATIONS

This study has a number of limitations that need to be noted.

1) Self-report measures may have introduced recollection bias and social desirability, and the cross-sectional design precludes drawing inferences about causality.

2) Just three union councils in the Peshawar district were included in the study, which limited its applicability to other areas or ethnic groups.

3) The qualitative sample of 25 participants might not fully represent the range of viewpoints, and those with active mental illness were omitted for ethical reasons.

4) The use of Likert scales and self-report may not adequately capture complex cultural ideas; translation may have led to the loss of subtle meanings; and responses may have been impacted by the researcher's outsider identification even though the data collectors were female.

REFERENCES

Ahmad, S., & Bano, A. (2023). Mental health literacy and stigma among rural adults in Pakistan. *Asian Journal of Psychiatry*, 79, 103312.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall.

Bila, N. J., & Carbonatto, C. L. (2022). Culture and help-seeking behaviour in the rural communities of Limpopo, South Africa. *Social Work in Mental Health*, 20(3), 1–23.

Booysen, D. D., & Haine, P. (2024). Perceptions of primary mental health care in a semi-rural setting in the Eastern Cape of South Africa. *South African Journal of Psychology*, 55(2), 243–256.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.

Chaudhry, H. R., & Raza, S. (2021). Traditional healing practices for mental disorders in rural Punjab. *Pakistan Journal of Psychiatry*, 22(2), 45–52.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

Daraaz, U., Bojnec, S., Khan, Y., & Hussain, Z. (2025). Cultural narratives, social norms, and psychological stigma: A study of mental health help-seeking behavior in Peshawar, Pakistan. *Frontiers in Psychiatry*, 16, 1560460.

Farooq, S., & Naeem, F. (2022). Task-sharing in mental health: Role of community health workers in Pakistan. *International Journal of Mental Health Systems*, 16, 15.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Gul, S., & Khattak, A. (2023). Gender differences in mental health stigma in Khyber Pakhtunkhwa. *Journal of Gender Studies*, 32(4), 412–425.

Hussain, M., & Siddiqui, Z. (2021). Mental health literacy in rural Pakistan: A cross-sectional survey. *Journal of Public Health*, 43(2), 312–320.

Iqbal, N., & Malik, I. (2022). Religious coping and mental health help-seeking in Pakistani Muslims. *Mental Health, Religion & Culture*, 25(3), 245–258.

Islam, M. M., Ali, M., Ferroni, P., & Khanam, R. (2018). Mental illness and help-seeking behaviour in rural Bangladesh. *International Journal of Mental Health Systems*, 12, 1-11.

Kermode, M., Bowen, K., Arole, S., Pathare, S., & Jorm, A. F. (2009). Community beliefs about causes and risks for mental disorders: A mental health literacy survey in a rural area of Maharashtra, India. *International Journal of Social Psychiatry*, 55(6), 509–523.

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Khan, M. N., & Javed, M. A. (2023). Mental health services in Pakistan: Challenges and opportunities. *Lancet Psychiatry*, 10(5), 345–347.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Malik, S., & Khan, A. (2024). Family honor and mental illness concealment in rural Pashtun communities. *Culture, Medicine and Psychiatry*, 48(1), 89–105.

Mustaqeem, S., Rani, U., Eida, S., Nagaria, B., Akbar, K., & Qamer, S. (2025). Examining the impact of cultural norms on mental health stigma in Pakistan: A qualitative approach. *Journal of Contemporary Psychology*, 3(1), 1–9.

Naz, S., Aslam, M., Amin, H., Khan, S., & Sayed, A. (2024). Mental healthcare access in Pakistan: A contemporary study. *Journal of Population Therapeutics & Clinical Pharmacology*, 31(8), 2005–2012.

Naz, S., Aslam, M., & Karim, R. (2022). Healthcare behavior, utilization and associated factors in the rural areas of Khyber Pakhtunkhwa, Pakistan. *Journal of Development and Social Sciences*, 3(4), 254–265.

Rahman, A., & Malik, N. (2021). The mental health treatment gap in Pakistan: A systematic review. *Asian Journal of Psychiatry*, 56, 102545.

Ran, M. S., Hall, B. J., Su, T. T., Prawira, B., Breth-Petersen, M., Li, X. H., & Zhang, T. M. (2020). Stigma of mental illness and cultural factors in Pacific Rim region: A systematic review. *BMC Psychiatry*, 20, 8.

Riaz, K., Khan, S., Ishtiaq, M., & Amin, H. (2024). Barriers and access to mental healthcare in rural areas of Pakistan: An inferential statistical analysis. *Journal of Population Therapeutics & Clinical Pharmacology*, 31(6), 1–11.

Rosenstock, I. M. (1974). The Health Belief Model and preventive health behavior. *Health Education Monographs*, 2(4), 354–386.

Rumi, J., Jalal, M., Qadir, T., Khan, Z. U., Jalal, N., Jalal, A., & Kakar, S. U. (2024). Traditional beliefs vs. modern psychiatry: A study of mental illness perception in Balochistan. *Journal of Population Therapeutics & Clinical Pharmacology*, 31(9), 1–11.

Saeed, K., & Gater, R. (2022). Scaling up mental health services in Pakistan: A roadmap for reform. *International Journal of Mental Health Systems*, 16, 28.

Shah, A., Wheeler, L., Sessions, K., Kuule, Y., Agaba, E., & Merry, S. P. (2017). Community perceptions of mental illness in rural Uganda. *African Journal of Primary Health Care & Family Medicine*, 9(1), a1404.

Wahid, S. S., Rahman, T., & Piyasena, C. (2021). Maternal mental health in rural Bangladesh: A qualitative study. *Journal of Global Health*, 11, 04048.

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. WHO.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine*, 64(7), 1524-1535.

Zafar, S., & Khan, A. (2023). Socio-cultural barriers to mental health care in rural Pakistan. *Pakistan Journal of Public Health*, 13(2), 75–82.

Volume 4, Issue 6, 2026

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

QUESTIONNAIRE

Culture Perceptions of Mental Illness in Rural Communities of Peshawar

Interviewer Name: _____ Age: _____ Years

Union Council: □ Badaber □ Chamkani □ Mattani □ Shahi Bala

Date: _____

SECTION: A **Demographic Information**

Please answer the following Questions. Your response will be kept Confidential.

Q#	Question	Response Options
Q. 01	Gender	□ Male □ Female □ Others
Q. 02	Martial status	□ Married □ Unmarried □ Widowed □ Divorced
Q. 03	Level of Education	□ Illiterate □ Primary □ Middel □ Matric □ Intermediate □ Bachelors
Q. 04	Occupation	□ Farmer □ House Wife □ Labourer □ Shopkeeper\Business □ Govt. Job □ Private Job □ Other
Q. 05	No. of people live in your household	_____ Persons
Q. 06	No. of years you lived in this village	_____ Years

SECTION: B Beliefs About Causes of Mental Illness

Please indicate how much you agree or disagree with each statement. Please answer based on your personal beliefs.

Response scale: 1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree. 5= Strongly Agre

Q#	Statement	1	2	3	4	5
Supernatural Causes						
B1	Mental illness can be caused by jinn possession.					
B2	Mental illness can be caused by black magic (jadugari\Sehr).					
B3	Mental illness can be caused by evil eye (Nazar).					
B4	Mental illness is a test from ALLAH (divine will).					
B5	Mental illness is a punishment from ALLAH for sins.					
Biomedical Causes						
B6	Mental illness is caused by a chemical imbalance in the brain.					
B7	Mental illness is a brain disease like any other organ disease.					
B8	Mental illness can be inherited from parents (genetic).					
Psychological Causes						
B9	Mental illness can be caused by too much stress or worry.					
B10	Mental illness can be caused by family problems.					
B11	Mental illness can be caused by trauma or shock.					
B12	Mental illness can be caused by poverty or financial problems.					

SECTION: C **Stigma Attitudes**

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Please indicate how much you agree or disagree with each statement. Please answer based on your personal beliefs.

Response scale: 1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree. 5= Strongly Agree

Q#	Statement	1	2	3	4	5
C1	Mental ill persons are dangerous to others.					
C2	Mental illness bring shame to the family.					
C3	I would object to my daughter or son marrying someone having family history of mental illness.					
C4	I would feel embarrassed if a member of my family had mental illness.					
C5	A person with mental illness cannot be productive or work normally.					
C6	Mental illness is a sign of personal weakness.					
C7	I would avoid spending time with someone having mental illness.					
C8	Only weak people get mental illness.					
C9	Mental illness is contagious (Can spread from person to person).					
C10	Mentally ill persons should be kept away from the community.					

SECTION: D Help-seeking Behaviour and Experiences

Please answer the following questions based on your actual experiences or what you would do.

Q#	Question	Response Options	Code
D1	If someone in your family developed a mental health problem, where you would go for help FIRST?	□ Traditional Healer (pie\mullah\hakeem) □ Basic Health Unit doctor □ General Practitioner (Private) □ Psychiatrist □ No help	
D2	Have you or any family member ever sought help from a traditional healer (pir\mullah\hakeem) for mental distress?	□ Always □ Often □ Sometimes □ Rarely □ Never	
D3	Have you or any family member ever sought help from doctor from mental distress?	□ Always □ Often □ Sometimes □ Rarely □ Never	
D4	If you have sought help from traditional healer, how effective was it?	□ Very effective □ Somewhat effective □ Not effective □ Made thing worse □ Not applicable	
D5	If you have sought help from a doctor, how effective was it?	□ Very effective □ Somewhat effective □ Not effective □ Made thing worse □ Not applicable	

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Q6. What are the barriers that prevent people in your community from seeking medical\psychiatric help for mental illness? (Tick all that apply)

Barriers	Tick if applicable
Stigma\fear of family shame	
Belief that traditional healing is more effective	
Cost of transport to health facility	
Distance to the nearest psychiatrist or mental health facility	
Fear of medication side effects	
Lack of female doctors or nurses	
Lack of trust in doctors	
Previous negative experience with doctors	
Language barriers (doctor don't speaks Pashto)	
Don't know where to go	
Other Please Specify:	

SECTION: E Knowledge and Awareness

Please answer the following questions based on what you know.

Q#	Question	Response Options	Code
E1	Are you aware of any mental health services available in your district?	□ Strongly Aware □ Aware □ Not Sure □ Unaware □ Strongly unaware	
E2	Do you know the location of nearest psychiatrist or mental health facility?	□ Strongly Aware □ Aware □ Not Sure □ Unaware □ Strongly unaware	
E3	Do you believe mental illness can be treated effectively with medications?	□ Definitely Yes □ Probably Yes □ Neutral □ Probably No □ Definitely No	
E4	Do you believe mental illness can be treated effectively with traditional healers (pir, taweez, etc).	□ Definitely Yes □ Probably Yes □ Neutral □ Probably No □ Definitely No	
E5	Would you be willing to seek help from a psychiatrist or mental health nurse in the future if needed?	□ Definitely Yes □ Probably Yes □ Neutral □ Probably No □ Definitely No	
E6	Would you be willing to attend a mental health awareness session in you village?	□ Always □ Often □ Sometime □ Rarely □ Never	
E7	Who in your community do you trust most to provide information about	□ Doctor\Nurse □ Teacher □ Traditional Healers	

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

	mental health? (Tick one)	□ Religious Leader □ Community Elder □ Family Member □ Other	

SECTION: F **Open-ended Questions**

To be asked by interviewer after completing the quantitative section. Record responses verbatim.

Q#	Question	Response (Verbatim)
F1	What do you believe to be the root cause of mental illness?	
F2	Could you give an example of a time you or someone you know went through emotional distress? What took place and how did the family respond?	
F3	What would make it simpler for residents in your town to receive medical or nursing care for mental illness?	
F4	Do you have any more information regarding mental health services or mental illness in your community?	

Interviewer Observations

Observation	Notes
Participant's emotions state during interview (calm, anxious, tearful, guarded, engaged)	
Any sensitive topics that cause visible distress?	
Any question that participant refused to answer?	
Environmental context (noise, privacy, interruptions, pressure of others)	
Non-verbale observations (eye contact, body language, tone of voice)	
Time taken to complete interview (minutes)	

Scoring Instructions (For Researcher use only)

The total score for items B1–B5 in Section B is the Supernatural Beliefs Score. 5–25 is the range. Stronger supernatural beliefs are indicated with higher scores. Based on the median split in the pilot research, the cutoff for "high supernatural belief" is ≥18.

The Biomedical Beliefs Score (Section B, items B6–B8) is the total score for items B6–B8, with a range of 3–15

The total score for items C1–C10 is the stigma score (Section C, items C1–C10). 10–50 is the range. For a scale of 0 to 100, multiply by 2. The threshold for "high stigma" is ≥50 (out of 100), or a raw score of at least 25.

Section D: Help-Seeking Score Derived variables: Seeking medical assistance = Yes if D3 = Yes. If D2 = Yes, then traditional help-seeking = Yes. If D1 = Traditional healer, then first contact is traditional.

We appreciate your involvement in this research. Your answers are important and will contribute to bettering mental health care in rural areas.