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Investigating the Relationship between Religiosity Perceived Public Stigma Related to Mental Illness and Attitude toward Seeking Professional Psychological Help among Undergraduate Students

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Abstract

The present research study examined the relationship between Religiosity, Perceived Public Stigma related to mental illness, and attitude towards seeking professional psychological help among undergraduate students in Pakistan. A survey method was used. The sample was composed of (N=271) undergraduates. The Islamic religiosity scale developed by Masood (2018), Perceived Devaluation Discrimination (PDD) (Link, 1968), and The Attitudes towards Seeking Professional Psychological Help Scale (Fischer & Farina, 1995) were used to collect information. Descriptive statistics were conducted to analyse the data, and inferential statistics were computed to test the hypothesis. Correlational analysis showed there was a positive relationship between religiosity, stigma perceptions, and attitude towards seeking professional psychological help among undergraduate students. The study's findings provide valuable information about the impact of Religiosity on Perceived Public Stigma and the attitude toward seeking professional psychological help. Undergraduate students will be the driving force behind future transformation and to shape cultural and religious initiatives to fight stigma and avoidance.

Keywords Attitude, Mental Illness, Public Stigma, Religiosity.

Introduction

King and Crowter (2004) distinguish religiosity (group-based doctrinal practices) from spirituality (personal divine connection). Despite extensive research, no consensus definition exists, creating measurement inconsistencies (Baumsteger & Chenneville, 2015). Religiosity is often measured behaviourally (e.g., worship frequency; Lewis, 2002) and varies across disciplines—theologians focus on belief (Groome & Corso, 1999), while sociologists study communal practices (Cardwell et al., 1980). In Pakistan, religiosity permeates daily life and health coping (Shafiq, 2020), aligning with global findings on religion's well-being benefits (Sherrill & Larson, 1994).

Goffman (1963) defines stigma as a social mark devaluing individuals, often leading to discrimination. For mentally ill persons, stigma manifests through stereotypes (e.g., incompetence), prejudice (negative emotions), and exclusion (denied opportunities; Major & O'Brien, 2005).

Psychological health stigma includes self-stigma (low self-esteem, reluctance to seek help), public stigma (societal prejudice due to misinformation), professional stigma (biased attitudes among healthcare providers affecting care quality), and institutional stigma (discriminatory policies reinforcing negative perceptions). These forms of stigma worsen mental health outcomes by discouraging treatment, perpetuating discrimination, and embedding inequality in systems. Addressing them requires awareness, education, and policy reforms (Subu et al., 2021).

Cultural beliefs (e.g., attributing mental illness to evil spirits; Khalifa et al., 2012) and stigma hinder help-seeking in Pakistan, where only 36% understand mental disorders (Husain, 2020). Gender differences emerge: women seek help more (Vogel et al., 2007), while men avoid it due to gender role expectations (Blazina & Watkins, 1996).

The global Muslim population, estimated at 1.6 billion, is projected to grow by 35% by 2030, with significant concentrations in Asia-Pacific, the Middle East, and Africa (Pew Research Centre, 2011). Religion plays a crucial role in shaping mental health perceptions, particularly in Muslim-majority regions like Pakistan, where mental illnesses are often attributed to divine will, spiritual tests, or supernatural causes like *jinn* possession (Shafiq, 2020). Stigma remains a major barrier to treatment, with only 35% of mentally ill individuals in developing nations seeking care (WHO, 2001).

Recent studies highlight cultural and religious influences on mental health attitudes. In Pakistan, rural populations more frequently attribute mental illness to black magic or divine punishment compared to urban groups (Waqas et al., 2014). Conversely, religiosity in Jordan and Malaysia correlates with reduced stigma, particularly among educated and medical students (Al-Natour et al., 2021; Arif & Olagoke, 2024). However, superstitious beliefs persist, with 60.6% of Pakistanis surveyed believing in *jinn* or the evil eye as causes of mental disorders (Javed et al., 2024).

Religious coping mechanisms, such as prayer and reliance on imams, are prevalent in Muslim communities (Padela et al., 2012). While some view illness as a spiritual purification process (Rasool, 2000), others associate it with moral failure, deterring professional help-seeking (Zafar et al., 2024). Cross-cultural comparisons reveal higher stigma in Pakistan than Turkey, with gender disparities exacerbating negative attitudes (Sultan, 2012).

Globally, religiosity's impact on mental health stigma varies. In Ghana, education—not religion—predicts mental health literacy (Adu et al., 2021), whereas Arab Muslims with higher religiosity show more positive help-seeking attitudes (Fekih-Romdhane et al., 2023). In China, religiosity among Hui Muslims did not significantly affect stigma, unlike in non-religious Han populations (Wang et al., 2019).

Efforts to integrate faith-based and clinical interventions are critical. Imams and religious leaders can bridge gaps in mental health awareness (Abu-Ras et al., 2008), but misconceptions persist, particularly in rural areas (Farooq, 2012). Addressing stigma requires culturally sensitive policies, public education, and collaboration with religious institutions to advance mental health literacy and bring down discrimination.

Significance of the study

There is a dearth of research in Pakistan examining the relationship between religiosity, perceived societal stigma, and openness to professional help. This study focuses on undergraduate students, as they represent future leaders who can influence societal change. Positive attitudes among them may help reduce stigma and improve access to mental health services. While prior studies have examined medical students and the general public, non-medical students' perspectives remain understudied. Pakistan's young, highly religious population faces significant mental health stigma, often viewing mental illness as divine punishment or a test. Despite this, many Muslims show compassion toward those affected. Given that 94% of Pakistanis consider religion highly important (Pew, 2018), understanding how religiosity shapes mental health attitudes is crucial. This research aims to bridge the gap by analysing how religious beliefs and public stigma influence help-seeking behaviour, ultimately promoting better mental health support and reducing treatment barriers in Pakistan.

Objectives

1. Examine the association between religiosity and stigmatizing attitudes toward individuals with mental illness in undergraduate students.
2. Investigate whether religiosity influences undergraduate students' attitudes toward seeking professional psychological help.

3. Assess the relationship between perceived public stigma and undergraduate students' willingness to seek psychological help.

Hypothesis

1. There will be an inverse association between religiosity and perceived public stigma related to mental illness among Undergraduate students.
2. An impactful positive relationship is expected between religiosity and the willingness to seek professional psychological help among undergraduate students.
3. There will be a significant negative correlation between perceived public stigma related to mental illness and willingness to seek professional psychological help among undergraduate students.

Method

Research Design

This research utilized a survey methodology, gathering data from a convenience sample of undergraduate university students.

Sample and Sampling Strategy

The research examined the association between religiosity, perceived public stigma, and willingness to seek professional psychological assistance among undergraduates (N=271) aged 18–23. Participants were selected from government graduate and postgraduate colleges in Multan and Kot Addu using simple random sampling, based on availability and willingness to participate.

Instruments

Islamic Religiosity Scale (Masood, 2018)

The Islamic attitude was examined using Masood (2018) Muslim religiosity scale, which has three dimensions: rituals, attitude, and beliefs. In this study, we will only be looking at the attitude portion, which contains 17 questions ranging from agree to disagree. The complete scale's internal consistency coefficient is 0.778, indicating strong reliability across items (Masood, 2018).

Perceived Devaluation-Discrimination Scale (Link, 1987)

This scale assesses the likelihood of discriminatory behaviour directed toward those suffering from mental illnesses or disorders. It has 12 questions, half of which are negative items. A 5-point Likert scale was employed, with response options spanning from 1 ('strongly disagree') to 5 ('strongly agree'). Scoring: Strongly Disagree (0), Disagree (1), Neither Agree nor Disagree (2), Agree (3), Strongly Agree (4). The scores for questions 1, 3, 7, 8, and 11 are reversed. The scale has good internal consistency with an alpha coefficient of .79 (Link, 1987, P. 1). The internal reliability of the PDD scales ranges from 0.72 to 0.88 among undergraduate nursing students (Abuhammad et al., 2019).

Attitude toward Seeking Professional Psychological Help Scale (Fischer & Farina, 1995)

The Attitude towards Seeking Professional Psychological Help scale (Fischer & Farina, 1995) is a 10-item measure including items such as "If I believed I was having a mental breakdown, my first inclination would be to get professional attention." It is a four-level rating measure with 1 (disagree) to 4 (agree). Higher scores reflect an optimistic mindset. For university student samples, the validity coefficient and split-half reliability coefficient were estimated to be 0.68 and 0.61, respectively.

Procedure

After obtaining ethical approval and scale permissions, participants voluntarily completed a booklet containing the three scales and a demographic form. The survey, presented in English, assessed religiosity, mental health stigma, and help-seeking attitudes. Completion took 10–15 minutes, with ensured participant confidentiality and protection from harm.

Analysis

For data analysis, we utilized version 20 of the SPSS statistical package.. Descriptive statistics (mean, variance, range) summarized key variables, while inferential statistics included Correlational analysis to examine variable relationships.

Results

The questionnaires were circulated amongst a total of 285 university students from graduate and postgraduate colleges of Kot Addu and Multan, out of 271 students who responded.

Table 1

Mean, Standard Deviation, and Range of major study variable (N=271)

			Range			
	Mean	S.D	Potential	Actual	Skewness	Kurtosis
R	56.1476	5.66408	35-79	35-44	-0.129	1.223
PPS	36.0148	6.26216	18-78	18-58	1.806	11.476
ATSPPH	27.8819	4.51837	11-38	11-27	-0.195	0.061

Note. M=Mean; S.D=Standard Deviation; R=Religiosity;
PPS= Perceived Public Stigma; ATSPPH= Attitudes Toward Seeking Professional Psychological Help.

In table 1, the average response for Religiosity is 56.1476, for Perceived Public Stigma is 36.0148, and for willingness to Seek Professional Psychological Help is 27.8819. Standard deviation measures the dispersion among data sets. The variance for Religiosity is 5.66, for Perceived Public Stigma is 6.26, and for Attitudes Toward Seeking Professional Psychological Help is 4.52. In a perfectly normal distribution, the skewness coefficient equals zero, indicating complete symmetry. Negative skewness values suggest left-tailed asymmetry, where the distribution's tail extends further toward lower values. (Religiosity = -0.129 and Attitudes toward Seeking Professional Psychological help = -0.195) indicate skewed left, and positive values (Perceived Public stigma = 1.806) for the skewness indicate skewed right. Skewness direction indicates where extreme values lie: left-skewed distributions have their atypical values on the lower end (lengthening the left tail), while right-skewed distributions show the opposite pattern with extended upper-end tails. The standard normal distribution has a kurtosis of three. Positive kurtosis (Religiosity = 1.223, and willingness to Seek Professional Psychological help = 0.061) indicates a "Light-tailed" distribution. Positive kurtosis (Perceived Public Stigma =11.476) indicates a "Heavy-tailed" (Table 1).

Table 2

Correlation Coefficient between Religiosity, Perceived Public Stigma, and Attitudes toward Seeking Professional Psychological help among undergraduate students (N=271)

Variables	R	PPS
R		
PPS	.041	
ATSPPH	.030	.184**

Note. ** p<0.01; *p<0.05 N=271.
R=Religiosity; PPS=Perceived Public Stigma; ATSPPH=Attitudes toward Seeking Professional Psychological help.

In Table 2, correlation analysis was used to check out the relationship between variables. The correlation coefficient value between religiosity and perceived public stigma is 0.41, which shows a very weak positive association between the variables. The correlation coefficient between religiosity and attitude towards seeking professional psychological help is .030, which shows a very weak positive association between the variables. The correlation coefficient value between perceived societal stigma and willingness to seek professional psychological help is 0.814**, indicating a weak positive association between the variables and the relationship is significant as the p-value is less than 0.05 (Table 2).

Discussion

This study examined the association between religiosity, perceived societal stigma of mental illness, and willingness to seek professional psychological help among Pakistani undergraduates—a topic with limited prior research in this demographic.

The findings revealed a weak positive association between religiosity and perceived public stigma, suggesting that higher religiosity may correlate with increased stigma toward mental illness. Similar trends were observed in Qatari Muslim students, who often viewed mental illness as divine punishment (Zolezzi et al., 2017). Conversely, Muslims in the U.S. exhibited more positive attitudes (Ciftci et al., 2013), highlighting cultural variations. Laurin et al. (2012) noted that religious beliefs could promote moral behaviours, potentially reducing stigma.

A slight positive link was found between religiosity and help-seeking attitudes, indicating that more religious students were marginally more open to professional support. This aligns with Fekih-Romdhane's (2023) study in Arab Muslim communities but contrasts with Abu-Ras's (2003) findings on Muslim women avoiding counselling due to marital concerns.

Additionally, a weak positive correlation emerged between perceived societal stigma and willingness to seek help.. Sultan's (2012) cross-cultural study noted that Pakistani students exhibited stronger negative associations between stigma and help-seeking compared to Turkish students.

Limitations

The present study has limited generalizability due to a convenience sample, though findings may apply to similar age groups. The findings of the research could be more valid if the sample size were increased, but due to practical limitations, researchers could not increase the sample size. Another limitation is that if culturally developed tools designed especially for Pakistan were used, then it could lead to better measurements. Lack of internal validity—confounding variables (e.g., mental health literacy) were not controlled. Narrow stigma assessment—self-stigma (Vogel et al., 2006) and personal attitudes were excluded. Religious homogeneity—only Muslim students were studied; future research should include other faiths.

Recommendations

There are the following recommendations for further research, as programs are required to increase public awareness to expose mental health myths (Fischer & Farina, 1995). Force the media to broadcast accurate mental health information. Replicate studies across diverse cultures and age groups. Address gaps in mental health research among Muslim populations to improve interventions.

Conclusion

This study identified positive relationships among undergraduate students between religiosity, stigma, and help-seeking attitudes. Higher religiosity correlated with both increased stigma and slightly more favourable help-seeking attitudes. Future research should expand sample diversity and examine self-stigma's role. Culturally sensitive religious initiatives could help reduce stigma and encourage help-seeking behaviours.

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Author's Biography and Photos

I am Pakeeza Firdos, an MPhil Scholar with a strong passion for research. Throughout my academic journey, I have gained expertise in quantitative research, with a focus on designing and conducting studies, analysing data, and interpreting results. Beyond academics, I am an avid book reader and take great joy in helping others. These personal interests not only bring me fulfilment but also broaden my perspective and inspire me to make a positive impact. Through my research and writings, I aim to contribute meaningfully to my field and inspire others to pursue their passions. I am excited to share my work and ideas with the academic community.

I am Dr. Hira Anwar, a lecturer with a passion for teaching and research. Holding a Ph.D., I possess expertise in designing and delivering engaging courses, guiding students to achieve their academic goals. As an active researcher, I contribute to advancing knowledge in my field through publications and presentations. Throughout my academic journey, I've been driven by a passion for learning and a desire to positively impact students' lives. I'm proud of my accomplishments and look forward to continuing to inspire and educate future generations. I am committed to excellence in education and strive to make a lasting impact on the academic community.

My name is Maliha Farooq, a research scholar in the Department of Applied Psychology at Women University Multan. I am deeply committed to exploring the complex interplay between self-esteem, body image, and social media use among young women in Pakistan. My research is driven by a strong belief in the power of culturally informed mental health advocacy. I aim to challenge stigma, promote awareness, and contribute to the development of effective, evidence-based strategies that support psychological well-being in underrepresented communities. With a passion for academic inquiry and social impact, I strive to bridge the gap between research and real-world mental health solutions.

I am Shazia Mustafa, an MPhil Scholar of Applied Psychology. As a dedicated learner, I have a deep passion for both research and teaching, and I aspire to pursue a career in academia. My journey is guided by sincerity, a strong work ethic, and a genuine desire to help others grow both personally and professionally. My current research focuses on the influence of family Support on Career Decision Self-Efficacy (CDSE) and Occupational Exploration (OE), reflecting my interest in how social and psychological factors impact individual development. I am committed to producing research that is both meaningful and applicable, particularly in supporting students and youth in their career paths. With a strong desire to teach in the future, I aim to create an inspiring and supportive learning environment where knowledge, empathy, and growth go hand in hand.

I am Eisha-Tur-Razia, an MPhil Scholar in Applied Psychology, The Women University Multan with a strong passion for research. Throughout my academic journey, I have gained expertise in quantitative and Quasi –Experimental research, with a focus on designing and conducting studies, analysing data, and interpreting results. Her research explores the potential of AI-driven mindfulness and meditation in reducing anxiety symptoms and enhancing academic resilience among college students. Through her work, Eisha tur Razia aims to contribute to the development of innovative, evidence-based interventions that promote mental health and academic success