FORMAN CHRISTIAN COLLEGE
(A CHARTERED UNIVERSITY)

Mental Illness and Stigma: A Perceptual Analysis of Prevalence and Determinants of Mental Illness in Undergraduate Students in Lahore

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Abstract

Current literature on student mental health offers ample evidence of a worldwide increase in the prevalence of mental health issues among university students. However, there is limited literature written from a social constructionist approach within Pakistan examining the student perception of mental illness, stigma, stigma management, and barriers to help-seeking. This study attempts to bridge the gap by conducting a descriptive qualitative study using the social constructionist framework to understand the perception of mental illness and its corresponding stigma in a fluid, non-canonical fashion. With a sample of 9 students from Forman Christian College (A Chartered University), semi-structured interviews are conducted to reveal the personalized meanings given to the key terms within the study. Intersectional dimensions of gender, class, and level of education are extensively explored in light of the student's perceptions. Using reflexive thematic analysis, the data has been analyzed to identify perceived determinants of mental illnesses, the perceived relationship between mental illness and stigma, stigma management strategies employed by respondents, and perceived barriers to seeking professional help. In the scope of Pakistan, where mental illness is not only prevalent but highly stigmatized, this research hopes to be a valuable addition to scholarly research on mental health and illness among young people in higher education institutes.

Keywords: mental illness, university students, social construction, stigma management strategies

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Introduction

Pedrelli et. al (2015) mention that college is a stressful time for most students. Alongside academic pressure, several internal and external factors such as gender, social class, and family structure can exacerbate the struggle. Due to such stress, students can develop mental health issues, either diagnosed or perceived.

These struggles are manifested as learning disabilities, self-injury incidents, eating disorders, substance use, and even sexual assaults. It is of significant value to note that suicide is the third leading cause of death among young adults and, therefore, leaves undergraduate students as a vulnerable population (Pedrelli et. al, 2015).

Most of the undergraduate population attends university while transitioning from teenage to adulthood. This newfound independence in intersection with one's individual struggles can be an overall overwhelming experience to the point that it can result in mental health issues. Adding on, most of these problems are left untreated and unattended (Pedrelli et. al, 2015).

Individually, mental health issues can have an impact on all elements of a student's physical, emotional, cognitive, and interpersonal functioning. Dysregulated mood, exhaustion and poor energy, disturbed sleep, and eating issues, reduced focus, memory, decision-making, motivation and self-esteem, loss of interest in typical activities, isolation and social withdrawal, and in rare cases suicidal or homicidal thoughts are common signs of depression (APA, 1994, p. 327, as cited in Kitzrow, 2009).

Academic performance, retention, and graduation rates may all suffer as a result of mental health issues. Elevated levels of psychological discomfort among college students were found to be substantially connected to academic performance. Greater degrees of psychological

distress were associated with higher levels of test anxiety, worse academic self-efficacy, and less effective time management and utilization of study resources (Kitzrow, 2009).

They were also less likely to persevere in the face of distraction or difficulties, and they were less likely to employ effective learning techniques such as requesting academic support. Individuals with high degrees of psychopathology have reduced information-processing abilities, which are a fundamental component of academic achievement and success (Kitzrow, 2009).

When looking at research among the general population, stigma in the form of stereotypes, prejudice, and discrimination, is a significant barrier faced by individuals with mental illness in achieving life goals and even seeking treatment. In fact, it is often perceived that seeking treatment or mental health services may exacerbate the stigma. Therefore, for most students, stigma is a primary factor in preventing them from seeking help or support for their mental health issues (Kosyluk et. al., 2016).

Research Objectives

The objectives of this study are as follows:

1. To explore the perceived nature and prevalence of mental illness and stigma among undergraduate students in Lahore.
2. To examine the perceived determinants of mental illness among undergraduate students in Lahore.
3. To understand the perceived stigma management strategies employed by undergraduate students.
4. To examine perceived barriers to help-seeking behavior for mental illnesses among undergraduate students in Lahore.

Research Questions

The research questions in this study are as follows:

1. What are the perceptions of undergraduate students about mental health and mental illness in Pakistan?
2. What is the perceived relationship between mental illness and stigma?
3. What are the perceived determinants of mental illness and mental illness stigma among university students?
4. How does mental illness stigma influence students' capacity to seek and continue seeking professional help?

Significance of the Study

This study is significant due to its deep link with grave mental health issues affecting the undergraduate student body. The mental health of undergraduate students is a critical issue for higher education and can impact university life drastically, as discussed earlier. Mental health issues may have a considerable influence on all elements of campus life, including the individual, interpersonal, and institutional levels (Kitzrow, 2009).

This study hopes to create a more nuanced and in-depth understanding of stigma and stigma management. The goal is to be able to better comprehend the barriers to treatment and help-seeking at large. It is only possible to address the wider issue of the prevalence of mental illness in the undergraduate population by looking at the root causes and perceptions surrounding the stigmatizing experiences of mental illness.

Theoretical Framework

When attempting to understand the relationship between mental health and stigma, the social constructionist viewpoint offers insight into the domain of health and medical sociology. There are three dimensions to social constructionism: "the cultural meaning of illness, the illness experiences as socially constructed, and medical knowledge as socially constructed" (Conrad & Barker, 2010, p. 2). This theoretical framework aims to understand how social interaction creates a shared social reality (Berger & Luckmann, 1966).

When looking at health, it is important to distinguish between disease and illness where disease is biological and illness is social (Eisenberg, 1977, as cited in Conrad & Barker, 2010). It is crucial to understand the potential issues of labeling and categorizing and how the very process of diagnosis is itself a social construction (Freidson,1970, as cited in Conrad & Barker, 2010). Linguistically, the seemingly concrete categories such as mental illness are mere abstractions defined by clusters of what we call "symptoms" (Walker, 2006). Marsella & Yamada (2010) state that it is of significant value to establish that such concrete definitions of mental disorders may themselves be shaped through conceptual biases and preferences of leaders in the field.

According to the social constructionist perspective, cultural meanings determine the experience and depiction of mental illness as well as the social response toward it. One such response considered in this paper is stigma where it is noted that nothing about the condition is inherently stigmatic. Rather, the social responses to the condition determine the stigma an individual may experience (Conrad & Barker, 2010).

Not only is the meaning of illness socially constructed but so is the experience of it. Conrad (1987, as cited in Conrad & Barker, 2010) discusses how people's everyday lives and the interplay of illness must be considered. It is helpful to note how the individual's world is socially organized and what stigma management strategies they employ to navigate through their experience. Goffman's (1963) stigma management strategies such as passing, avoidance, and acceptance are a key part of the conversation.

Furthermore, it is significant to note how medical knowledge about mental illness may reproduce social inequality (Conrad & Barker, 2010). Despite the claims of objectivity and value neutrality, the biomedical model is far from it. For example, when women's anger is framed as a symptom of PMS (Premenstrual Syndrome), it becomes a reductionist of women's experiences of gender inequality while they may be prescribed anti-depressants instead of acknowledging the circumstances which gave rise to such anger in the first place. Needless to say, such issues extend to class, race, ethnicity, religion, etc. as well and the experience of mental health becomes an intersectional one.

Furthermore, Walker (2006) states that the scientific model is reductionist in that it labels parts of the whole, treating the human body as a machine. The same applies to medical vocabulary. He further argues that the current model of mental health operates on the principles of binary opposition in that it differentiates what is "normal" from that which is "pathological." This may further alienate and stigmatize individuals by othering them.

Literature Review

According to the American Psychological Association (n.d.), a mental disorder is a condition of cognitive and emotional distress that may be caused by multiple factors ranging from genetics to environment, the details of which can be found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's International Classification of Diseases (ICD). Some examples of these disorders can include depression, anxiety, obsessive-compulsive disorder, borderline personality disorder, eating disorders, and body dysmorphia.

Stigma is often defined as a mark that discredits one's identity and moral status (Goffman, 1963). Normative expectations exist regarding social identities and the violation of such expectations leads to stigma, whereby an individual is perceived to be somewhat lesser than a usual person on account of mental illness, ethnicity, gender, race, class, etc. Public stigma occurs when the public engages in the stereotyping of mental health issues while self-stigma is the process of individuals with mental health issues applying stigma to themselves (Corrigan & Kleinlein, 2005).

When looking at the public stigma, it is crucial to know which power groups can lead to a negative life experience for individuals facing mental health issues. This could include relationships with property owners, employers, health providers, and in the context of this study, professors, and university administration. In contrast, self-stigma is more individual-centric in that it determines the impact on one's quality of life and well-being (Corrigan & Kleinlein, 2005).

Corrigan & Kleinlein (2005) study the relationship between mental illness and stigma. Stigma relies on certain "signals" that lead to discrimination. In the context of mental illness,

these signals may appear as symptoms, impairment, appearance, and even labels. Upon being given a label, an individual with a mental health issue may have to face stereotyping and prejudice which can force them into the identity of a mental patient (Goffman, 1961, as cited in Corrigan & Kleinlein, 2005).

Stigma adversely impacts those with mental struggles in countless ways. To mention a few, stigma may rob individuals of life opportunities and chances. This could look like unemployment or poor housing. Additionally, stigma causes a poor experience for the affected individuals with the judicial system as well as the general health care (Corrigan & Kleinlein, 2005).

The question then arises as to how individuals facing such labels cope with or manage the stigma. Siegel, Lune, & Meyer (1998) conducted a study on a diverse sample of 139 gay/bisexual men with HIV/AIDS to understand how they cope with stigma. Through the use of unstructured interviews, a variety of stigma management strategies were identified ranging from reactive to proactive. Siegel, Lune, & Meyer (1998) discussed stigma management strategies in terms of how the participants accepted or rejected the stigmatization. Where reactive strategies may include avoidance and acceptance, proactive strategies dismantle the underlying assumptions that construct the stigma through engaging in activism and discourse.

Goffman (1963) has considered a wide range of stigma types and notes how a stigmatized person may respond to their situation. They may: (a) correct the stigmatized attribute, (b) master areas perceived as weaknesses of those having the stigma, (c) offer a unique interpretation of one's identity, (d) stigma used for secondary means, (e) perceiving stigma to be a blessing, (f) portraying non-stigmatized people as individuals needing support, (g) opening up about the stigma by choice, (h) keeping the stigma discrete by reducing public display of failings, (i) re-

educating the non-stigmatized population, and (j) using humor to ease the situation (Goffman, 1963, as cited in Meisenbach, 2010).

In addition to the aforementioned strategies, Meisenbach (2010) categorizes stigma management communication strategies to include acceptance, avoidance, evasion, responsibility, reducing offensiveness, denial, and neglect. They further mention how individuals may choose a strategy based on "their attitude toward the stigma's public applicability to them and on their attitude toward challenging or maintaining others' perceptions of the stigma" (p. 277).

Globally, mental health issues affect 10–20% of children and adolescents (Kieling et. Al, 2011). If stress-related disorders are included, the data from the 1950s suggests that the prevalence of mental health disorders is as high as 40%, accounting for 8.1% of the global disease burden (Marten & Wilkerson, 2003)

Mental health issues are prevalent in Pakistan in both rural and urban settings. Depressive and anxiety disorders are frequently occurring mental health issues. Substance abuse and drug addiction are quite common with about four million estimated drug addicts according to a national survey. It is valid to assume that these numbers are heavily underreported due to shame and stigma (Khalily, 2011).

The rise of mental illness among college students is concerning where common issues include depression, anxiety, psychotic disorders, eating disorders, self-harm, and obsessive-compulsive disorder (OCD). 83% of students report being moderately or severely distressed and almost half the students report at least one mental health issue (Storrie et al., 2010).

In their study of mental health issues among Pakistani university students, Bibi, Blackwell & Margraf (2021) studied a sample of 355 students. When compared to German and

Chinese students, the results showed that Pakistani students had poorer mental health and limited access to mental health treatments. There was also a higher rate of recent suicidal ideation and bullying.

Methodology

Research Design

The study uses a descriptive qualitative research design with semi-structured interviews for the collection of data from respondents. Semi-structured interviews were used as a method of data collection because the study is exploratory in nature. Qualitative exploratory research allows the researcher to explore the respondent's experiences and interpretations through their own words and narratives. This leads to the greater involvement of the participants in the research process (Bryne, 2004).

To gain a deep and meaningful understanding of the perceptions of undergraduate students about the prevalence and determinants of mental illness among university students, a descriptive and exploratory qualitative approach with semi-structured interviews is used as the primary method of data collection. This method helps understand the perceptions of mental illness and stigma from the lens of the aforementioned individuals while identifying recurring themes across the interviews. This qualitative approach to research is grounded in the interpretive and phenomenological perspective whereby a researcher 'seeks to understand the world from the participants' point of view' (Gray, 2014, p.165). Moreover, its ontological position is deeply linked to the social constructionist theoretical framework of this research. Therefore, the study lends itself to the assumption that social properties and meaning are products of social interaction (Bryman, 2012).

Conceptualization

Mental Illness

As per the social constructionist view, the essence of mental illness lies in the cultural rules that define abnormal and normal. Mental illness is then considered as "labeled violations of social norms" rather than a set of symptoms (Scheff, 1966, p. 25, as cited in Horwitz, 1999).

Stigma

This research conceptualizes stigma as per Goffman's (1963) definition. Stigma is defined as a means that discredits an individual or group's identity and status on account of mental illness, ethnicity, gender, race, class, etc.

Two levels of stigma were considered stigma: public stigma and self-stigma (Corrigan & Kleinlein, 2005).

Public Stigma

Public stigma occurs when the general public engages in the stereotyping of mental health (Corrigan & Kleinlein, 2005).

Self-Stigma

Self-stigma is the process of individuals with mental health issues applying stigma to themselves (Corrigan & Kleinlein, 2005).

Stigma Management Strategies

Stigma management strategies are means of highlighting how a stigmatized person may respond to their situation in order to minimize social stigma (Goffman, 1963).

Access and Sampling

The population for this small-scale study will be undergraduate students at Forman Christian College (A Chartered University). Each participant met the following criteria in order to participate in the study:

1. The participant is currently enrolled in an undergraduate degree program.
2. The participant is a student of FCCU, Lahore.

I used "purposive sampling" (Bryman, 2012, p. 416) with the aim to conduct as many interviews as possible from the aforementioned population within a period of four months, or until theoretical saturation was achieved. I concluded the data collection with 9 interviews.

In terms of access, as an undergraduate student at Forman Christian College (FCCU/FCC), a university in Lahore, I reached the relevant population through social media, online student groups, personal contacts, and referrals. An information sheet (see Appendix A) was shared with the participants to explain the purpose of the research so participants could make an informed choice.

Tools

A 14-item survey was conducted to record the socio-demographic characteristics of the participants (see Appendix B) to help understand any intersectional relationship between socio-demographics and the stigma management strategies of the participants. This survey only served a descriptive purpose to better contextualize the findings of the semi-structured interview.

The semi-structured interview followed the fundamental themes of mental illness, the definition of stigma, the experience of stigma, stigma management strategies, and barriers to

treatment. The list of tentative questions used for the interviews can be found in the interview guide (see Appendix C).

Ethics

According to the British Sociological Association (2017), researchers must anticipate any harmful consequences for the respondents and safeguard them to the best of their ability. For this reason, only students currently enrolled at FCCU will be chosen in the sample.

Due to the sensitivity of the topic, I took an empathic approach toward the participants bearing in mind their comfort and emotional state. I used sensitive and carefully worded language to prevent chances of distress while offering timely check-ins and breaks to see the respondent's well-being and willingness to proceed (Egan, 2007). It was communicated to the participants that they can end their participation in the research or end the interview at any point.

Gray (2014) points out that researching in one's own institution can compromise the authenticity of the study as the researcher's fondness for the respondents may cause them to not answer truthfully. However, to counter this, I will be explained verbally and in writing how confidentiality will be maintained. Interviews were transcribed using aliases to protect the identity of the respondents. Moreover, a consent form (see Appendix A) written in clear and concise language was provided to the participants while making them aware of their right to withdraw from the study at any given point. I provided potential respondents with a comprehensive information sheet prior to undertaking interviews to indicate the purpose of the research and how the data will be used (see Appendix A).

In spite of the potential ethical concerns, my goal was to provide transparent research that makes the respondents the center of the study. I aimed to outweigh the harms, if any, by

providing an in-depth account of the experiences and perceptions of university students employing stigma management strategies while uncovering the sensitive and difficult experiences of stigma and mental illness. In case of any ethical concerns and grey areas during the study, I consulted my thesis supervisor for guidance on how to manage my response to the incoming data (Bryman, 2012; Gray, 2014).

Data Analysis

I used Clarke & Braun's (2013)'s reflexive thematic analysis which is a six-step process:

1. Familiarization
2. Coding
3. Generating themes
4. Reviewing themes
5. Defining and naming themes
6. Writing up

The transcript was coded in terms of Goffman's (1963) categories of stigma management strategies as mentioned in the literature review. Moreover, I proposed to offer a follow-up discussion with the participants to review the transcribed data and my understanding of it to ensure an accurate portrayal of their experiences.

To ensure that the findings of this study were high in validity, respondent validation or member validation was used. It is a process where the researcher provides the participants with an account of their findings (Bryman, 2012). This method ensured a healthy correspondence between the researcher's findings and the participant's experiences. Throughout the interview, I used summarization and paraphrasing, consistently confirming my understanding of the

responses and giving respondents the opportunity to correct me as and when needed. I provided each research participant with an account of what they have said in the interview alongside my observations of them (Bryman, 2012).

Findings

The findings of this study are based on perceived and self-reported experiences of mental illness among undergraduate university students. The study respondents included 9 undergraduate students from Forman Christian College. The sociodemographic characteristics are shown in Table 1. For facesheet information against each respondent, please see Appendix D.

The overall findings of this study suggest that there are three major themes:

1. Perceived Nature and Prevalence of Mental Illness
2. Perception of Mental Illness Stigma
3. Perceived Barriers to Help-Seeking

Table 1

Sociodemographic Characteristics of Participants

Sociodemographic Characteristic	Frequency (n)	Percentage (%)
Age		
18-20	3	33.3
21-23	5	55.6
24	1	11.1
Gender		
Female	6	66.7
Male	2	22.2
Queer	1	11.1
Year of Study		
Junior	5	55.6
Senior	3	33.3
Sophomore	1	11.1
Major		
Psychology	6	66.7
Political Science	2	22.2
Sociology	1	11.1
Computer Science	1	11.1
Monthly Income		
100k-200k	4	44.5
>200k	2	22.2
Not mentioned	3	33.3
Living Arrangement		
Nuclear Family	8	88.9
Joint Family	1	11.1
Relationship Status		
Single	5	55.6
Committed	3	33.3
Not mentioned	1	11.1
Religion		
Islam	7	77.8
Not mentioned	2	22.2
Clinically Diagnosed with Mental Health Issues		
Yes (ADD(1), Anxiety(2), Depression(1), GAD(1))	5	55.6
No	3	33.3
Not mentioned	1	11.1
Know Someone Who is Clinically Diagnosed with Mental Health Issues		
Yes (ADHD(2), GAD (1), MDD (1),	8	88.9

Anxiety (2), Depression (1), Schizophrenia (1))		
Not mentioned	1	11.1

Nature and Perception of Mental Illness

Defining Mental Illness

Most of the students recognized mental health as an important dimension of their own and others' overall health. Some of them emphasized it to be as important as their physical health. The majority of the students defined mental illness as an experience of dysfunctionality or lack of normalcy in their everyday lives. Hence, personal and social dimensions were introduced where failing to meet either a personal or societal threshold of performance could be understood as mental illness.

> "Mental illness. I would define it as any condition or a set of symptoms that have something to do with your psyche that leads to, for it to become an illness, it has to have some sort of a proper negative consequence on your life. It has to interrupt your normal daily function. So, your emotion, your behavior, all of that, any dysfunctions in that, any irregularities that lead to those negative consequences, I would define mental illness as that." (Maha, 20, Female)

Students from a background in psychology tended to use biomedical and pathological terms to discuss mental illness, resorting to a set of symptoms to define the onset of a mental health concern.

> "Alright, so, I think mental illness is a pathology. It is something that is different from normalcy and something that requires treatment. So, I think of it more in a biomedical sense. I'm very interested in the neurochemical aspect of it. I do believe in using drugs for treating mental illness, but I also have a very psychological perspective of it as well because I am a psychology student." (Alina, 24, Female)

Some students implied a mind-body dichotomy when defining mental health while others thought of mental health in more abstract and flexible terms.

> “So, if something that is not physical, is hindering you from doing that particular act, and you are not able to identify it as a physical trait, but you are able to identify something that is in your head.” (Musa, 21, Male)

> “It's like subjectively, it's a very invisible thing. You can't really see it on anyone. You can't know if somebody is mentally ill. And even if it's like something that's overtly expressive, it's not always noticeable. Someone could be spacing out and you don't necessarily know if they're just zoning out because they're in class or if they're dissociating because of a dissociative disorder. So, in that sense, it's very hidden.” (Kiran, 20, Female)

Many of them also believed that a professional diagnosis was not required but was important to validate their own or others’ experience of mental illness. The majority of students used their daily life experiences and personal examples as a way of defining mental illness.

Perceived Prevalence and Manifestation of Mental Illness

One respondent explicitly discussed the prevalence of mental illness, recognizing a growing trend when compared to previous generations.

> “I don't have a negative perception of mental illness. To me, it's a very normal thing at this point. Like I'm more surprised seeing people who, who aren't mentally ill. I'm like, how are you functioning? How does it feel to be you? Because in our generation at least, it's become such a growing thing because of previous generations as well, like intergenerational trauma and all that. And it's passed down. And at this point, it's a very normal thing for me. Not in the sense that it's good or bad, but more in the sense that it exists and we should be able to talk about it because it's there. It's there in a mass majority. It's there, it's so widespread at this point and it's hurting so many people because there's so much stigma, stereotypes and it's still so taboo to talk about, but it's so prevalent, like why are we not talking about it?” (Kiran, 20, Female)

Prevalent mental health concerns identified by the respondent’s included depression, anxiety, low self-esteem, and low self-confidence. In terms of manifestations, respondents perceived common features to be lethargy, emotional dysregulation, and the inability to perform daily tasks such as getting out of bed or brushing one’s teeth.

> “Not being able to get out of bed. Not being able to even brush your teeth or just function on a normal level.” (Abeer, 21, Queer)

> "And I would definitely also say something that was surprising for me, as well emotional dysregulation is a thing. Perhaps, it's because I struggle with it so I'm able to see. Cause if you don't know what it is, you often think it's something completely different, right? "I'm just overwhelmed. I'm exhausted." But emotional dysregulation is this entire experience of not knowing what you're feeling, not being able to respond with the right emotion at the right time, right? So, I think that's something I've noticed in quite a lot of people in classes, for example, in the people, I interact with." (Farah, 21, Female)

Academically, mental illness was perceived to manifest as low academic performance, low attendance inability to participate in class discussions, etc.

> "I don't think I've observed it as such to be able to discover a pattern, but I do think just not being able to engage as voluntarily and think that perhaps someone who is okay or appears to be okay but has not exhibited those symptoms in the long run, not being able to participate in those things. When you don't show up, for example, being absent from places where they could have taken, you know, those opportunities and then what they call acting out in forms of entrance discussions and just those things." (Maha, 20, Female)

Perceived Determinants of Mental Illness

Several determinants of mental illness were identified, and all respondents acknowledged the home environment as a key factor in causing mental health issues. The home environment, in this case, most commonly included one's family dynamics, primary socialization, and socioeconomic circumstances. This is a key finding as most respondents implied that the majority of the students enter into university with pre-existing issues and hence, the cause of mental illness is traceable to their experiences prior to entering university. Causes related to academics and campus life would then be perceived as secondary.

> "There's a lot of personal reasons students have a lot of, I think, um, I can't really pinpoint a cause that's come from the university or from within the university. I feel like people are mostly already coming in with these problems and they might be exacerbated in their university life or their, you know, tenure, this tenure." (Kiran, 20, Female)

Some respondents placed great emphasis on trauma being the cause of mental illness. They defined trauma with a degree of fluidity, not restricting it to quintessential characterizations

such as the loss of a loved one or sexual abuse. Here trauma became a broad term that was inclusive of everyday experiences such as bullying.

> "I think, uh, of course the most common cause I believe is some sort of trauma. It doesn't need to be a specifically big event in their lives. In the sense, I mean in a sense like traumas that we generally recognize is "Oh my god, this person lost, someone lost their mother in a young age, lost their father at a young age", or it's "Their father was abusive." I think trauma can come from things which we often do not pay attention to. It can come from simpler things, things which are not talked about, things which are average, placed in your day-to-day life, such as bullying for young kids." (Arif, 20, Male)

The majority of the respondents recognized patriarchy and gender dynamics to be key in causing mental health issues, further linking the idea to gender roles and expectations. Failure to meet gender expectations and the inability to successfully perform gender roles at home and on campus were seen to contribute to mental health issues and cause trauma to these students. Maintaining family honor, lack of mobility, negative body image, and the pressure of displaying attractiveness were perceived as factors causing mental illness in female students. A respondent also discussed the loneliness and vulnerability that comes with the defiance of heteronormativity.

> "For women, I feel like the primary factor that pressurizes them is two-fold. Firstly, it's their body which I feel like that's a very important part of it. Women feel like they should look and behave and act a certain way. They should feel attractive, and they should look attractive because, you know, that society thinks they are and that's how important they are. And the second would be a mutiny against their own kind in some ways where they think that they, you know, should not be confined to traditional heteronormative ways of thinking and they should, you know, stand against the box and when that rebelliousness arises, they feel like, you know, they're alone. They feel like they're very vulnerable and they feel like they are vulnerable to attack because they're not acting the way women are supposed to act." (Musa, 21, Male)

For men, concepts of independence and being the breadwinner were viewed as suffocating pressures. Failure to meet gender role expectations can be seen to force individuals into a state of low confidence and poorly impact their self-esteem and self-perception.

> "I think, for men, I think for men, the most common cause is definitely pressure in terms of how society expects them to, you know, integrate and how they expected to be better

> and how they're expected to be the breadwinners. They're expected to, you know, make money. So coming in, they get a very big reality check as soon as they hit the university, their parents are probably spending a lot in fees and spending a lot in time and now they feel like they've just grown up and now they're at the particular point where, you know, they just do not feel happy with themselves and they just do, you know, they feel very pressurized. So, that leads to anxiety. And in this particular time, most men including me have, you know, gone through that phase of- of, you know, of childhood love and high school now. And, you know, they just got into that phase and they've just realized that, you know, love is not just about, you know, it's just not just about that's about practicality and in that practicality of an important thing is to you know, make money and, you know, be successful and you know to have a career and whatever. So you know they feel pressured because that's even if you don't have you know that high school love thing, you still feel pressured because if your parents because society because of your cousins and your *rishtedaars* (relatives) and everyone else." (Musa, 21, Male)

In the context of university life, respondents mentioned the rigorous academic demands and expectations as a primary cause for anxiety and other mental health concerns. Pressures related to maintaining CGPA and co-curricular activities simultaneously were believed to cause distress. On the other hand, failure to meet these expectations was linked with existential dread and concerns for career prospects in the future.

> "Yes, of course, we are students. We have to be worried about grades. You have to be worried about your courses, right? But there's this distinct level of existential dread, every single wrong thing that happens in their, like, you know, academic career, in terms of not being able to register for a course, not getting a good grade in this case their GPA dropping, right? Co-curricular compromise is your academics. It becomes such a dreadful experience for these people that they think it's end-all-be-all. That thing happens. Now my entire career, you know, it could, academic career, it's— for lack of a better term — it's screwed, right? It's they're not going to be able to come back from that and that again links with like a depressive sort of, you know, hopelessness, helplessness as well, definitely. They're so affected by their circumstances that, you know, they, they don't think they can do anything about it either." (Farah, 21, Female)

Importantly, one student highlighted the role of student academic discipline in the appearance of mental health issues. For example, students of social sciences (e.g. psychology, sociology, political science) were believed to be more prone to mental health concerns as compared to students of hard sciences. This was due to their engagement with content that

encourages the acknowledgment and validation of trauma. This acknowledgment can add to the distress already being experienced.

> "And I feel like, because of my academic background and because of the content I read and engage with makes it worse for me and I think with students of FCC, if someone, who doesn't have to engage with this content, who doesn't have to engage with psychology majors, who doesn't read theory, and the fact that you need to validate your trauma in one form or another, it's- they don't get pulled down that easily too. So, I guess their perception of how they deal with trauma differs based on their academic background." (Abeer, 21, Queer)

Coping Strategies

When asked about the perception of coping and its definitions, respondents discussed how coping is an attempt at managing symptoms or reducing negative feelings. One respondent characterized coping as simply "powering through" life. A range of coping strategies was identified by respondents which can be categorized as both positive and negative. One respondent used the terms "constructive" and "not-so-constructive" coping strategies to distinguish between the two. Positive coping strategies can be understood as ones where one confronts the symptoms and has a more proactive approach toward the issue, e.g. talking to friends/peers, seeking professional help, mindfulness, engaging in activism such as student politics, and establishing routines.

> "Different strategies for different people. I personally cope by staying busy, so I have a proper routine in university. So I gym, I go to the library, I study, I work, um, I try to be with friends or I just try to keep myself as busy as I can so that I'm not, I don't have time to think about my um, problems." (Rafia, 22, Female)

Negative coping strategies can be understood as ones where individuals may simply seek to reduce distress and negative feelings associated with the symptoms, e.g. smoking, drug (ab)use, and cognitive distortions.

> "There are no recreational activities that students can do or spend their time or even places to study. So the only way they have to spend their time is to go outside and smoke

> or do drugs and that's the primary mode of socializing in FC too, right?" (Abeer, 21, Queer)

However, it is crucial to acknowledge that coping strategies can not be placed in binaries and some strategies can be placed in either category depending on how they are used.

> "Yeah, I mean there is a reason why there's different types of coping. Some people have constructive coping methods. Some people have some not-so-constructive coping methods. But I would also say that, the not-so-constructive coping methods can be seen as not-so-constructive, but can actually be constructive for someone. (Int: Could you tell me more about that?) This is a very personal example, but for me, buying stationery. It can be seen as like an unhealthy obsession in a way, like, I just like buying stationary to feel better, but it genuinely makes me feel better. I'm not associating, like retail therapy, they call it right? It's not constructive but if I'm feeling upset if I'm not doing so well and I come across some cute stationery and I was like I want to buy that and I buy it and it comes, I feel happy, I feel good." (Kiran, 20, Female)

Perception and Experience of Mental Illness Stigma

Defining Stigma

Respondents of the study defined mental illness in relation to stigma. Stigma was characterized as a lack of understanding of mental illness. It was perceived as a process of alienation and otherizing a person by looking down upon those labeled as mentally ill. For most respondents, stigma made discussion around mental health a taboo, thus limiting discourse and conversation.

> "I think it happens with this tendency to otherize people. It's-it happens in every sphere. So, anybody who's different-and, especially with mental illness, you see that there is a tendency to view them as unproductive and a source of their own problem, so they are seen as a burden, as an annoyance. So, we tend to otherize them because we don't want to believe that if similar symptoms are present in ourselves, we would end up in the same place that they did. We wanna believe that we did something right and to do that we have to make them a different category. We have to otherize them." (Alina, 24, Female)

Manifestations of Mental Illness Stigma

According to most respondents, some of stigma's prominent manifestations include alienation and labeling. Alienation can occur explicitly through the exclusion of mentally ill

persons from social settings. One respondent discussed the case of negative attention through pity. Additionally, labeling (e.g. using words like crazy, weak, *pagal* to refer to mentally ill persons) is observed as a prevalent manifestation of stigma whereby an individual with a mental illness is often given a label based on a stereotype.

Firstly, alienation was perceived to manifest in a multitude of ways through the rejection of symptoms by asserting that the individual is "okay" or "fine" or that there is nothing wrong with them. It can also occur through invalidation where symptoms are dismissed either because they are not supported by a diagnosis or they are not crippling enough to render the individual dysfunctional. Here we assume that there is a persona of an ideal victim against which individuals are compared, making them deserving of validation for their symptoms.

> "For sure, in terms of stigmatization of mental illness in general are presenting illness that is perceivable by the other. That is your ideal mentally ill person, most likely to get help. The person who is having a very open breakdown panic attack or something. Even like a psychotic break. They're scared of it and they don't understand it and they want to ostracize them, but that's the best way to be a victim of mental illness. That's the best way to be perceived as somebody who needs help. Internal struggles, half of it is, you know, perceived as personality, for example, "she is just anti-socialish, you know, she is just somebody who, she doesn't have alot of, like, self-esteem", stuff like that, right? They'll say, "it's internal, *uski personality esi hai* (his/her personality is like that)." And I don't know whether as (inaudible) 39:40 it goes. I'm, I'm not sure, but if it's not perceivable, it's not physically tangible almost, if the person is stating their experience and they're not like crying, weeping their eyes off your like, "Was it that bad? Are you really that mentally ill?" And then, the victim sort of label is withdrawn, because it wasn't that bad, right? (Farah, 21, Female)

Another way through which alienation was manifested for students was through dehumanized classroom interactions with instructors.

> "But you see, these faculties, these instructors, right? They're telling you what to do. You're learning from them, but there's no learning relationship between, like, it's very rare and I haven't had that sort of experience with my instructors at least. Because they're associated with the institution and they do not give you a human sort of, you know, side of them where you are able to interact. So they're very strict about deadlines and the sort of work that they expect." (Farah, 21, Female)

Labeling was perceived to occur through an exaggerated perspective surrounding mental illness where the symptoms are amplified, and the mental health condition is considered almost irredeemable. The demonization of certain mental illnesses such as schizophrenia was also noted.

> "And then again, there in the lower class, there's actually more belief on superficial things, right? (Int: Okay.) They believe in, um, that's the culture which believes in *hakeems* (herbalists). They're gonna go to a *hakeem* rather than a doctor if they have a problem, right? So when they talk about mental health, when they talk about medication, when they talk about, um, counseling, they're like, "What? Why are you gonna give money to somebody to just talk to them? Talk to me." (Int: Yeah.) Right? So, they're gonna be like, uh, "You'll get over it. It's okay. You're just going through a phase. It's just a phase. Just go, just get over it. It's not a problem." So they don't actually recognize it and they don't accept it because, um, I think it has something to do with the idea that we are already in so much more problems, like financially and economically and everything." (Hania, 23, Female)

Perpetrators of Mental Illness Stigma

When asked about the perpetrators of mental illness stigma, the majority of the respondents recognized three key features responsible for stigmatizing attitudes:

1. Considerably older than the stigmatized party
2. Comes from a lower level of education.
3. Belongs to a lower socioeconomic status.

> "It could be anyone, but it's more common, I think, um, amongst older people because younger people are more likely to, I think, especially now, learn more about mental health and do that. But even they can be stigmatizing about other things." (Alina, 24, Female)

> "Like, people I've seen that belonging to like the upper class and the middle class, they're more open to the idea of mental health and everything and awareness and everything, stuff like that. But I've seen that people from, um, like belonging to like the lower class, they're more like, "What do you mean? Are you gonna take help? You're gonna go counseling, You take medication. Why? Why do you do that? Yuh toh aap pagal ho jaoge (You'll go crazy)" and stuff like that. "So, uh, do you know what these medicines do to you?" And those irrational beliefs, "They're gonna alter your fertility. They're gonna do this. They're gonna do that"." (Hania, 23, Female)

However, some respondents went ahead and recognized stigmatizing attitudes as being prevalent among “progressive” or “woke” groups whereby stigma appeared to manifest as the romanticization of mental illness, thus, taking away from the gravity of the issue. One respondent discussed how any and everyone is susceptible to engaging in stigmatizing behaviors due to pre-existing biases. Hence, all groups are prone to over-generalizing or stereotyping mental illness symptoms in some way with particular emphasis on groups not typically expected to engage in stigmatizing behaviors such as students of psychology. Another student asserted that stigma exists among groups that are least expected to be stigmatizing, e.g. psychology students.

> “Also, I feel like especially in the university, since there's a psychology major, there's so many students are doing psychology major, um, it's just expected that they know, they know about these things, but that's not true because not all of them are critically engaging with the material that they have. So, if, for example, you were to talk to them about mental illness or sigma, you find out that so many of them hold so many harmful beliefs that they've never challenged, they just accepted them as is. So it needs to happen at the student body level, but it needs to happen in places that we wouldn't even think that, you know, need stigma eradication.” (Alina, 24, Female)

One respondent also discussed the case of queer students and the stigma they face. The stigma in this case was two-fold, the first being a general stigma regarding mental illness and the second being the stigma surrounding one’s sexuality.

Sources of Mental Illness-Related Stigma

Cultural and traditional explanations were used to trace the origin of stigma. The family structure through primary socialization was recognized as an important factor in shaping preconceived notions of mental health. Few female respondents also pointed out the perceived role of religious explanations in dismissing or invalidating mental illness.

> “People, because, religious, religion is, I'd say it's very, what's the word? It's very subjective for every individual. But then there are people in authority, some rightfully, some not rightfully, who abuse the teachings of religion. And this has gone on for centuries I believe. Like mental illnesses were seen as like someone being possessed where someone, you know, they had like, I don't know. But these religious, I feel like

> religious authorities have routinely dismissed mental health overall because you can't see it. It doesn't show up in scans and imaging. It's an abstract thing. It's not tangible. And they fail to understand that they take it, take someone's mental health struggles or mental illness equivalent to having a weak faith which isn't true. Someone could be, could have the strongest faith and still be struggling at a psychological level because your mental health struggles are not always in your control. And I feel like they've perpetuated the stigma a lot of these religious authorities because they don't understand it's a thing, they've associated with people having lack of faith or a weak of faith and to them it seems like it's, what's the word for that? Like, it just seems anti-religion to them, which is not true, obviously." (Kiran, 20, Female)

Peer groups and friends were also identified as a crucial source of stigma where one internalizes a certain set of attitudes towards mental illness through peer interaction. In addition to peers, for university students, the instructors' attitude towards mental health is also significant as they are characterized as figures of authority.

> "So, um, there was somebody in my class who, um, had a mental health issue and when they discussed with the professor, they like, you know, shed light on it and they were like, they're going through this thing. I saw that, that the professor, like in every class they were kind of, um, view that student in a different light, like in terms of their work, um, as if they weren't competent enough to do it. So I did see that happening and that kind of made me also think that if I'm going through something like this, should I be open to my professor about it or should I just like, you know, keep it concealed and just show myself as normal." (Rafia, 22, Female)

Media representations of mental illness were perceived as another contributing factor in terms of romanticizing and sensationalizing mental illness and making some disorders more desirable than others. Additionally, these representations can manifest as a lack of information or an exaggerated perception of mental illness.

> "So, the thing is, in the media that I consume, I see that certain illnesses are very sensationalized and they have ended up idealizing or glorifying certain mental illnesses to the point that people want to have them. They want to get those diagnoses. Anxiety wouldn't be one of them but I see everybody around me, especially online, embracing diagnoses like bipolar disorder or even borderline personality disorder, but depression and anxiety not so much." (Alina, 24, Female)

> "So, the, with the things that you see around yourself, so whether you're getting that from the media or from other people, definitely stigmatize something. Like for example, if you say that person has, um, suffered through let's say like ADHD okay, and you've seen that, um, before in showcasing a movie or in something like that, then you're gonna have that

very restricted mindset about ADHD. You see a person who, that they have ADHD or they've been diagnosed with it. Then this person will link everything that they know about the condition and associate all of those symptoms with this person who claims that they have ADHD even though they might not have all the symptoms there. (Int: Yeah.)" (Rafia, 22, Female)

Stigma Management Strategies

In light of Goffman's (1963) and Meisanbach's (2010) work, the following stigma management strategies were identified from the responses:

1. Concealment/Passing: Some respondents define this strategy as a means of hiding symptoms to evade stigma. One attempts to appear more 'normal' to draw less negative attention towards themselves.

   "Yes. Because so mental illnesses as funny as it might seem as like, you know, how in previous ages, had those physical diseases, which you would try to hide with gloves and arm so that you would not show everyone that you are diseased. Why? Because people had that particular stigma against you, they would think that you're extremely sick or that you were going to transmit this disease to everyone that you're doing, you know, affect people around you. It's kind of the same with mental illnesses, but in the sense *ke* (that), people do not think that you're going to be infecting everyone else. It's more like the thing that, you know, you having that particular mental illness in this case, somehow a bad thing. And it's somehow something that you should, you know, deal with on your own. It's something that should not be shown." (Musa, 21, Male)

2. Discretion: Several respondents frame discretion as an attempt to be subtle or less vocal about mental health concerns in public.

   "So mental health stigma is a very prevalent issue, even though that I've seen some development. Uh, but still people try to hide it. And that's, that's very sad because when, uh, even though families belonging to like pretty good backgrounds were like very knowledgeable and all, they're like taking their, if their kids are going to therapy, they're gonna be like, "Please don't tell anyone", right? So, I think that's the stigma. Even though if you break one barrier of it, there are ten more. How are you gonna break them?" (Hania, 23, Female)

3. Humor: Most respondents characterize humor an attempt to downplay or minimize one's mental health concerns to reject stigma. It is also a means of self-stigmatizing to counter the adverse impact of public stigma by self-infliction.

> "In this case, when people talk about their struggles, the humor definitely the dark humor concept. Where are you, It's so uncomfortable to confront and realize the fact that you are you have been through so much and you are struggling so much so it's just so much easier to put it out there and have that call for attention. But in a way that almost feels like, " if I won't let you invalidate me because I invited myself". This is the major theme in young adults in university population. They'll talk about it over a cup of tea, like it's just gossip, right? But they actually saying are signs of, you know, somebody who is on the brink of something." (Farah, 21, Female)

Barriers to Help-Seeking for Students

Gender

When understanding barriers to help-seeking, normative standards of masculinity and femininity emerged as a crucial dimension. A variety of perspectives emerged where one participant asserted the stigma surrounding men's mental health and the "alpha male" persona as a major barrier to seeking help. The fear of being viewed as effeminate or gay prevented them from being vulnerable and consequently, seeking help.

> "And men are supposed to be that person who they depend on. So, when the man himself says that I need help, then the entire system falls back. Like, who are they gonna rely on? Your entire society is built on that aspect. And men are the providers. Men will be there, but then when the man says, "I need help, I'm feeling sick", then everybody's like, "Oh my god, he.. he cannot be relied on. We can't rely on him." He was supposed to be that strong as like strong man, strong figure, everything that is holding everything together. But then again, he's not. So we actually as a society, I think that we don't even know what to do when a man says he needs help." (Hania, 23, Female)

On the contrary, another respondent perceived that women were far more marginalized than men. In fact, they asserted that men talk about their mental health in peer groups.

> "Contrary to popular opinion, in my experience where it's like, guys don't talk about these issues. Guys do talk about these issues. I'm sure girls do as well. But in my observation, I found that it has been very often that girls have had to suffer these issues and pressure from their family to do things which they do not want to do that have led to increased stress leading to increased anxiety." (Arif, 20, Male)

One respondent discussed the lack of queer-friendly help available. The fear of homophobia from a potential therapist was a prominent deterrent in help-seeking for queer students on campus.

Logistics

Several logistical barriers were identified pertaining to finance and accessibility. A primary barrier recognized by the majority of the respondents was financial. Professional services were perceived as expensive and therefore difficult to access or sustain over long periods for students of low socio-economic backgrounds. Students were recognized as a dependent group, relying on their families for allowance and having little to no income of their own. Hence, access to professional help is perceived to be severely compromised.

Additionally, physical access with reference to the on-campus counseling service was identified as a potential problem for disabled respondents. One respondent mentioned that the Campus Counseling Center is not physically equipped for disabled students due to the long walking distance and the need to climb stairs. Moreover, the distance of the Campus Counseling Center from the academic blocks also seemed to discourage non-disabled students from making the trip for a therapy session primarily due to privacy concerns.

> "Also, one thing, I don't know if this is relevant, but the counseling center, it's so out of your way that if you go to the counseling center, people know you're going to the counseling center. (Int: Mm-hmm.) I wouldn't wanna go to the counseling center because I have to tell people, you know, that's where I'm going. Even if I don't tell them and they see me, then they ask me and I don't really wanna be talking about those things." (Alina, 24, Female)

Attitudinal Factors

Additionally, some attitudinal factors were seen as a barrier to treatment and help-seeking. Firstly, stigma was seen as a major contributor where individuals may be concerned

about how others will perceive them should they choose to seek help. However, stigma is not only induced by others but also by oneself. The experience of shame while seeking help can be seen as a form of self-stigma.

> "So, even moving that to the side, if I have like, for example, an eating disorder, I would never seek help for that because that is very shameful for me. Because I tended to think of that as something, you know, guilt-inducing, as something that is caused internally, something that I should be able to stop. So, I invalidate my own experiences, my own symptoms. I brush them off for a really time because I didn't want to address them. I didn't think of them as serious." (Alina, 24, Female)

Moreover, misconceptions about professional help, such as fear of medication or viewing therapy as just "talking", also pose a barrier. For some individuals, simply a lack of relevant exposure/information can be a reason for not pursuing professional help.

Poor Experiences with Professional Mental Health Services

Additionally, some students reported having a lack of trust in the professional counseling services available to them on and off campus. For example, some students shared concerns that seeking professional help may lead to stigmatization and that discouraged them from seeking help. Some students fear that if the first experience of therapy is disappointing due to the stigmatization, students are discouraged from seeking professional help further as their perception is heavily influenced by the first impression.

> "And for lot of people, I, I think we need to understand that university counseling centers are the first try they have of professional health. A lot of us have not had the opportunity or the families understanding enough to send us to a professional therapist. So when the first face of professional therapy is that Counseling Center being dismissive, it really disheartens a person and makes them feel like "I was fine when I was just talking to my friends." (Arif, 20, Male)

Some students had concerns that their mental illness experiences would be dismissed, and invalidated by professional counselors. Many of these perceptions were based on personal and direct experiences with professional healthcare providers. Hence, this fear of potential

stigmatization from counselors was the main barrier to help-seeking among undergraduate students.

> “But also, there aren't that many ethical services in at least Pakistan. That would provide you with professional, confidential, ethical therapeutic services where you feel safe, you don’t feel judged, and you're not considered as like an outcast, or someone should be shunned from society. It's just that there are still many, we have therapists. But not all of them are good and we don't have a proper licensing system in our country for therapists. We don't have a regulatory authority that overlooks how therapeutic practices, these likes, private practices, or even the governmental ones are regulating their employees.” (Kiran, 20, Female)

Discussion

The findings of this study show that undergraduate students define mental illness mainly with respect to the ability or inability of a person to be functional in everyday life. Many students perceived that mental illness was caused by experiences in students' homes but exacerbated due to academic, social, and personal challenges faced by students in the university. Experiences of mental illness-related stigma were perceived as the main barrier to help-seeking behavior among students.

This study has offered definitions of key terms from students' perspectives whereby earlier conceptualization of mental illness and stigma was supported with the addition of extensive daily life examples and experiences specific to the student body. The perceived prevalence of mental illnesses such as depression and anxiety and is supported by literature (Storrie et al., 2010). In Pakistan, undergraduate students have also shown a high prevalence of mental illnesses with a high rate of suicidal ideation and bullying as well as limited access to mental health treatments (Bibi et al., 2021).

An important finding of this study is that undergraduate students with pre-existing mental illnesses are especially vulnerable to mental distress and exposure to stigmatization on campus. Research has also found that students with pre-existing mental illnesses can be at an increased risk of stress and depression as a result of academic pressures or other reasons. Studies at Nottingham reported anecdotal evidence that undergraduate medical students who struggle show a much higher incidence of psychological distress than those who do not struggle (Hamza et al.,

2021; Yates et al., 2008). However, very few or no studies in Pakistan have explored this link qualitatively.

In light of the perception of coping and categories of coping mechanisms, the literature supports the research findings by using terms such as adaptive and maladaptive coping (Tran & Lumley, 2019). It is noted that internalizing stigma can harm psychological well-being and may lead to greater use of maladaptive coping strategies, such as self-harm or substance abuse, to minimize distress (Goffman, 1963). Self-help strategies, particularly maladaptive ones, became "helpful" for students when access to alternative professional care was limited (Martin, 2010).

Gender emerged as a crucial dimension within the study with differences in the experiences of male, female, and queer students. Female students' adverse mental health and negative body image is a concern supported by a study on adolescent girls who felt worse about themselves and their bodies when compared to adolescent boys. In this case, mental health issues among girls manifested as symptoms of depression, a lower level of self-esteem, and less satisfaction with their bodies (Siegel et al., 1999). Furthermore, findings suggest that male students' mental health and corresponding stigma were associated with perceived pressures of gender roles and expectations. The concept of hegemonic masculinity (Ross et al., 2020) is crucial here to understand the perceived pressures of normative masculinity faced by male undergraduate students.

Moreover, since the study opted for a social constructionist theoretical framework, it does not quantify mental health using standardized tools. This can result in low reliability and replicability of the study. Despite low external validity, the study aimed to maximize internal validity by ensuring data accuracy and the 'faithfulness of interpretation' with the participants by

sharing a written or verbal summary of the analysis before completing the final research report (Gray, 2014, p.182).

Furthermore, the sample size had a limited number of male and queer students which could have introduced greater nuance to the gendered aspect of mental health. Additionally, the sample was primarily from urban Punjab with most respondents identifying with Islam as their religion. For future research, a greater regional and religious diversity can help understand a greater variety of perceived mental illness and stigma manifestations as well as additional intersectional explanations.

Recommendations

The above findings suggest a prevalent fear of stigmatization from mental healthcare providers among students. In addition to being supported by literature, this concern can be tackled by introducing an online system such as MePlusMe. It is noted that most young adults accessing mental health support are concerned about stigma. Since online interventions provide anonymity, they could diminish young people's concerns over confidentiality or stigmatization. Overall, online systems can remove several barriers to help-seeking among students due to convenient access to the assessment of one's own needs as well as an intervention solution. (Barrable et al., 2018). It is deemed necessary to improve current professional services by reinstating students' confidence and trust in pastoral support systems (Yates, James, & Aston, 2008).

Additionally, some respondents suggested the use of trauma-informed approaches on an institutional scale. Oehme et al. (2019) describe The Resilience Project as "a public-health style, web-based outreach that destigmatizes help-seeking, encourages the use of existing campus services, and teaches new skills to cope with some of the most common impediments to college student wellness" (p. 102).

Few respondents discussed the significant role of faculty members in addressing mental illness stigma by having classroom discussions and forging an empathetic connection with students. Faculty trainings were also recommended. Here, trauma-informed pedagogy can help focus on emotional wellbeing of both students and faculty by focusing on one's socio-political context within a learning environment (Pica-Smith & Scannell, 2020).

Findings of this study suggest the prevalence of financial concerns as a barrier to help-seeking. Hence, issues of accessibility and affordability of high-quality professional care must be taken into account by the academic institutions.

Moreover, needs of protected groups are a main concern. For instance, based on the findings of this study, disability emerged as a core issue. Disability-friendly counseling centers or alternatives can be considered by the campus counseling service providers.

When looking at gender dimensions, data suggests that peer support interventions tend to be effective and may be more appealing to female students (Byrom, 2018). Limited studies exist regarding the mental health of Pakistani queer students, however, deriving from the findings of this study, addressing the perceived fear of homophobia from mental health professionals may be a helpful start.

Furthermore, it is suggested that men are open to professional help if it includes an action-oriented approach, e.g., self-help strategies or physical activity. Alternative and unorthodox strategies such as using humor while holding space for mental health conversations can help (Ross et al., 2020).

Since majority of the respondents perceives awareness as a key dimension in addressing mental illness stigma, one respondent presented the idea of establishing a campus resource center which disseminates and circulates verified authentic mental health information among all students. This will be a centralized approach, targeting all student groups, including ones less likely to have exposure to such information.

Conclusion

This study expects to establish a comprehensive and in-depth understanding of stigma concerning mental, stigma management strategies, and barriers to seeking help examining undergraduate student perceptions. The social constructionist perspective is at the heart of this research, and this is reflected in the ever-changing concepts employed in the study. Mental illness and stigma are found to be fluid concepts, spanning across a range of definitions determined by personal and perceived experiences of respondents. Gender, class, disability, and several other intersectional dimensions were explored through qualitative links. Despite being small-scale, the study hopes to spark a conversation about student mental health in higher education institutes of Pakistan.

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Appendix A: Information Sheet and Consent Form

Information Sheet

Title of Research: Mental Illness and Stigma: A Perceptual Analysis of Prevalence and Determinants of Mental Illness in Undergraduate Students in Lahore

Researcher: Fatima Ghani

Institution: Forman Christian College (A Chartered University)

Researcher Contact: 231459915@formanite.fccollege.edu.pk

Supervisor: Shermeen Bano

Supervisor Contact: shermeenbano@fccollege.edu.pk

Invitation

You are being invited to take part in a research project. Before you decide to take part in the study, it is important to understand the purpose of this research and what is expected of you. Please take time to read this information sheet carefully and discuss it with the researcher or others if you wish for further clarity. Please feel free to ask if anything is not clear or if you would like more information. You may take your time to decide whether you wish to take part.

What is the project's purpose?

There has been much concern about how individuals cope with the stigma surrounding mental health issues. For the scope of this study, undergraduate university students will be studied to understand the unique ways in which students deal with understand mental illness and stigma.

This project will use interviews with university students aged between 18 and 25 about their experiences and perceptions of mental illness stigma.

Why have I been chosen?

You have been chosen because you fit the participant criteria.

Do I have to take part?

It is completely your choice. Even if you decide to participate, this information sheet and the signed copy of your consent form will be provided to you. You will also be able to withdraw from the study at any time without any reason.

What will happen if I take part?

You will only be interviewed once, and this will take between 30 minutes and an hour and a half. This interview will be recorded. A series of questions will be asked relating to your perception of mental illness, stigma, and coping strategies. You do not have to answer any questions that you do not wish to.

What are the possible benefits of taking part?

It is hoped that this work will contribute to academic and policy debates about mental health issues and stigma.

Will my information be kept confidential?

All the information will be kept strictly confidential. You will not be able to be identified in any reports or publications.

Who is organizing the research?

The research is organized by the Department of Sociology, Forman Christian College.

Who has ethically reviewed the project?

This research project has been ethically reviewed by the Internal Review Board (IRB), Forman Christian College.

Consent Form

1. I confirm that I have read and understood the information sheet explaining the purpose of the research.
2. I have had the opportunity to ask questions about the research project.
3. I understand that my participation is voluntary, and I am free to withdraw from the study at any given point without specifying any reason. I am free to decline or not respond to questions I do not wish to answer.
4. I understand that my responses will be kept strictly confidential, and my name will not be used in the research materials. I will not be identifiable in any information in the research report.
5. I give permission to the researcher to access my anonymized responses.
6. I agree that the data collected from me may be used in future studies after identifiable information has been removed.
7. I agree to take part in the above research.
8. I understand that a copy of all signed sheets including the consent form and the information sheet will be provided to me and will also be kept in the researcher's main project record.

Appendix B: Sociodemographic Survey Instrument

1)	**Age (in years):**	6)	**Provincial belonging:** () Punjab, () Sindh, () Balochistan, () Azad Kashmir, () Gilgit-Baltistan, () Khyber Pakhtunkhwa, () Islamabad Capital Territory
2)	**Gender**: () Male () Female, () Non-Binary, () Prefer not to say, () Other:	7)	**Current living arrangement**: () Joint family, () Nuclear family, () Single-person household, () Hostel, () Prefer not to say, () Other:
3)	**Year of study**: () Freshman, () Sophomore, () Junior, () Senior, () Prefer not to say	8)	**Relationship status**: () Single, () Committed, () Married, () Divorced, () Prefer not to say, () Other:
4)	**Household income (per month)**: () Below 50,000, () Between 50,000 and 100,000, () Between 100,000 and 200,000, () Above 200,000, () Prefer not to say	9)	**Religion**: () Islam, () Christianity, () Hinduism, () Atheist, () Agnostic, () Prefer not to say, () Other:
5)	**Regional belonging:** () Urban, () Rural, () Suburban, () Prefer not to say	10)	**Have you been clinically diagnosed with a mental health issue in the past one year?** () Yes, () No, () Cannot say If you answer "yes," please mention the diagnosed mental illness/es (This question is optional) _____
11)	**Do you know someone who has been clinically diagnosed with mental illness in the past one year?** () Yes, () No, () Cannot say If you answer "yes" please mention the diagnosed mental illness/es (This question is optional) _____		

Appendix C: Semi-Structured Interview Guide

Section 1: Perceptions About Mental Illnesses Among Young People

1. How is mental illness perceived by you?
2. What mental illnesses are prevalent among undergraduate students in Pakistan?
3. What are the factors that cause mental illness among university students in Pakistan?
4. What are the characteristics of students that are more likely to suffer from mental illnesses and why?

Section 2: Mental Illness Stigma

1. What do you think mental illness stigma means?
2. What does mental illness stigma look like for undergraduate students?
3. What are the causes of mental illness stigma?
4. Who is more likely to practice stigmatizing behaviors?
5. Who is more likely to be the victim of mental illness stigma?
6. What are some of the ways in which young people cope with mental illness?
7. What should be done to reduce mental illness stigma?

Section 3: Relationship with Help-Seeking

8. What kind of support is available for young people suffering from mental illness?
9. What barriers do young people face when seeking professional help or support?

Appendix D: Facesheet Information

Alias	Age	Gender	Year of Study	Major	Monthly Income	Living Arrangement	Relationship Status	Religion
Arif	20	Male	Junior	Political Science	>200k	Nuclear	-	-
Musa	21	Male	Junior	Computer Science	100k-200k	Nuclear	Committed	Islam
Alina	24	Female	Senior	Psychology	100k-200k	Nuclear	Single	Islam
Farah	21	Female	Senior	Psychology	>200k	Nuclear	Committed	Islam
Hania	23	Female	Senior	Psychology	100k-200k	Nuclear	Committed	Islam
Kiran	20	Female	Junior	Psychology	-	Nuclear	Single	Islam
Maha	20	Female	Sophomore	Psychology	100k-200k	Nuclear	Single	Islam
Rafia	22	Female	Junior	Psychology	-	Nuclear	Single	Islam
Abeer	21	Queer	Junior	Political Science, Sociology	-	Joint	Single	-

Appendix E: Thematic Analysis (Themes, Sub-Themes, and Codes)

	Main Theme	Sub-Themes	Codes
1.	Nature and Perception of Mental Illness	Manifestation of Mental Illness	Effect/Symptom-Oriented
			Cause-Oriented
			Courage/strength
			Demotivation/Disappointment
			Biomedical/Pathological
			"Letting go" of oneself (Not getting out of bed, not brushing your teeth)
			Hyperfixation
		Determinants of Mental Illness	Interpersonal (Lack of avenues to socialize on campus e.g. smoking to make friends) Relationship problems (e.g. breakups)
			Family (Socialization Home-environment)
			Academic (Performance, Grades, Class participation)
			Biological (Genetic disposition Health issues e.g. chronic illness)
		Perception of Coping	Defining Coping ● Managing symptoms ● Reducing negative feelings ● Powering through)
			Coping Strategies ● Talking to friends/peers ● Smoking/drug use ● Cognitive distortions ● Mindfulness ● Activism e.g. student politics ● Establishing routines ● Professional help
2.	Barriers to help-seeking behavior	Gender	Female: Lack of mobility/restriction, the idea of honor
			Male: Hegemonic masculinity
			Queer: Homophobia
		Financial	Little to no income
			Dependent
		Attitudinal	Shame
			Misconceptions (fear of medication, therapy = just "talking")
			Lack of relevant exposure/information
			Oversimplification of issues e.g just quit drugs
			Poor first experiences
		Disability	Physical access (distance, stairs)
3.	Perception of Stigma	Nature of Stigma	Lack of understanding
			Taboo
			Process of alienation
			Limiting discourse/conversation

			Looking down upon something
			Moral high ground
		Characteristics of Perpetrators of Stigma	Age gap
			Little to no formal education
			Lower income
		Manifestations of Stigma	Negative attention (e.g. pity)
			Exaggerated understanding (e.g demonization, amplification of symptoms)
			Othering/Alienating (e.g. exclusion)
			Rejection (e.g. not believing, asserting that the person is “okay/fine”)
			Invalidation (e.g. dismissing symptoms without a diagnosis)
			Labeling (e.g. crazy)
		Sources of Stigma	Culture/tradition
			Family
			University
			Religion
			Media
		Stigma Management Strategies	Concealment
			Discretion
			Humor

Appendix F: IRB Approval Certificate

FORMAN CHRISTIAN COLLEGE
(A CHARTERED UNIVERSITY)

INSTITUTIONAL REVIEW BOARD
APPROVAL CERTIFICATE

IRB Approval Certificate

IRB Ref: IRB-387/05-2022

Date: 18-05-2022

Project Title: Mental Illness and Stigma: A Perceptual Analysis of Prevalence and Determinants of Mental Illness in Undergraduate Students in Lahore.

Principal Investigator: Fatima Ghani.

Supervisor: Ms. Shermeen Bano.

Institutional review board has examined your project in IRB meeting held on 18-05-2022 and has approved the proposed study. If during the conduct of your research any changes occur related to participant risk, study design, confidentiality or consent or any other change then IRB must be notified immediately.

Please be sure to include IRB reference number in all correspondence.

Dr. Kauser Abdulla Malik HI. SI, TI
Chairman, IRB
HEC Distinguished National Professor (Biotechnology)
Dean Postgraduate Studies
Director, Research, Innovation & Commercialization (ORIC)
Forman Christian College (A Chartered University)
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