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How to cite this article:
Jassim Mohammed, G. J., & Lateef Muhe-Aldeen, A. (2025). Prevalence of Myths and Cultural Misconceptions about Mental Illness among Family Caregivers: A Cross-Sectional Study. International Journal of Body, Mind and Culture, 12(9), 93-100.

Prevalence of Myths and Cultural Misconceptions about Mental Illness among Family Caregivers: A Cross-Sectional Study

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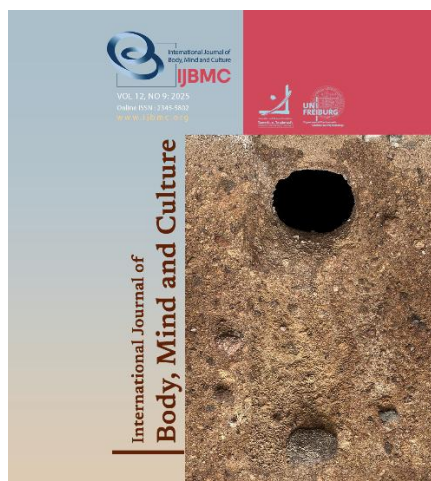
ABSTRACT

Objective: Mental illness remains stigmatized; myths and culturally rooted misconceptions may delay care. This study assessed the prevalence of such beliefs among family caregivers in Kirkuk, Iraq, and examined links with sociodemographic factors.

Methods and Materials: A descriptive cross-sectional study was conducted at the psychiatric outpatient department of Azadi Teaching Hospital, November 2024–January 2025. A convenience sample of 170 family caregivers completed a sociodemographic form and a 29-item scale (20 myths and nine misconception items). Content validity was established by expert review; Cronbach's alpha was 0.82. Data were analyzed in SPSS 26 using descriptive statistics, one-sample t-tests (test values: 60 for myths, 27 for misconceptions), and Pearson correlations with gender, education, income, and occupation.

Findings: Participants were mainly female (57.1%), married (76.5%), and urban residents. The mean myths score was 51.60 (SD = 12.54), significantly below the test value (p < 0.001), suggesting partial rejection of several stereotypes. The mean cultural misconceptions score was 28.26 (SD = 8.38), slightly above the test value (p = 0.052), indicating persistence of beliefs in supernatural causes and spiritual treatments. Education showed a significant negative correlation with misconceptions (r = −0.254, p = 0.001); no significant associations emerged for myths.

Conclusion: Myths and cultural misconceptions about mental illness remain common among Iraqi family caregivers, particularly those with lower levels of education. Culturally sensitive psychoeducation targeting caregivers is recommended to reduce stigma and support timely use of mental health services.

Keywords: Mental illness, myths, cultural misconceptions, family caregivers, stigma, Iraq.

Introduction

The definition of a mental illness is: "A syndrome that is defined by a clinically significant disruption in a person's behavior, emotion regulation, or thought processes that indicates a malfunction in the biological, developmental, or psychological processes that underlie mental functioning." Mental problems are usually associated with significant distress or impairment of social, professional, or other essential tasks. A standard or socially acceptable reaction to a typical stressor event, such as the loss of a loved one, is not a mental illness. Unless the deviance or conflict stems from a dysfunction in the individual, socially deviant behavior (such as political, religious, or sexual) and disputes that are primarily between the individual and society are not considered mental diseases (Association, 2015).

Community attitudes toward mental illness are strongly influenced by cultural beliefs, which determine how individuals interpret the causes, symptoms, and interventions of mental illness. Misconceptions and myths not only cause stigma but also prevent affected people from receiving timely psychiatric treatment (Rayan & Fawaz, 2018).

In Iraq and the Middle East, beliefs about mental illness are still governed by cultural reasoning, e.g., possession by jinn, the evil eye (hasad), or divine punishment. This kind of interpretation contributes to the stigmas, family shame, and delay in treatment. These conclusions have been drawn in other Arab settings, in which individuals may consult traditional healers rather than psychiatrists (Al-Rawashdeh et al., 2021; Rayan, 2022).

Regardless of increasing awareness, educated populations might not have the correct information about mental illness (Kuriyan et al., 2016). Psychological theories that could explain the persistence of myths include the Health Belief Model, which focuses on perceived benefits and barriers, and the Attribution Theory, which examines how cultural narratives shape blame and stigma.

The current study will determine which myths and cultural misconceptions about mental illness are most prevalent among family caregivers in Kirkuk, Iraq, and assess the associations between these myths and cultural misconceptions and specific sociodemographic variables.

Objectives

1. To determine mental illness myths and cultural misconceptions that exist among family caregivers in Kirkuk, Iraq.

2. To test the associations between the myth and the misconception scores and the sociodemographic characteristics that were chosen (gender, education level, income, and occupation).

Methods and Materials

It used a descriptive cross-sectional design. Convenience sample: The identified sample comprises 170 family members of patients diagnosed with mental illness who were seen in the psychiatric outpatient department at Azadi Teaching Hospital, Kirkuk, during November 2024 to January 2025.

Instruments: There were two tools used to collect data:

1. A socio-demographic questionnaire about age, gender, education, marital status, income, occupation, affiliation with the patient, and type of family.

2. A questionnaire that measures myths (20 items) and cultural misconceptions (9 items) about mental illness. The items were developed in accordance with the relevant literature (Kuriyan et al., 2016; Rayan, 2022) and assessed by 14 experts in psychiatric nursing. Content validity has been established, and the internal consistency reliability coefficient (Cronbach's alpha) is 0.82. Before beginning the data collection, a pilot study was conducted for the period of (1to 10 November \ 2024) at Azadi Teaching Hospital.

Data Collection: With administrative endorsements and institutional ethical clearance in place, verbal informed consent was taken from all the participants. There was anonymity and confidentiality.

Data Analysis: SPSS version 26 was used to analyze data. Descriptive statistics (frequency, percentage, mean, SD) were used to characterize the participants' characteristics. One-sample t-tests were used to assess differences in the mean myth and misconception scores. The correlations between scores and sociodemographic variables were analyzed using Pearson correlation coefficients. A significance level of $p < 0.05$ was used.

Findings and Results

Table 1 indicates that the highest age ranges among caregivers were 39-45 years (22.4%) and 32-38 years (20%). Most of the women (57.1%) were the majority, and approximately (33.5%) had only reached primary school. The majority of respondents were married (76.5%), had a monthly income just sufficient (48.8%), and were housewives (38.2%). Most of them lived in urban localities (84.7%).

Table 1

Distribution of study sample according to socio-demographic data (Age class, Gender, Educational Level, Marital status, Monthly income, Occupation, Residency)

		Frequency	Percent
Age class	(18-24)	23	13.5 %
	(25-31)	28	16.5 %
	(32-38)	34	20.0 %
	(39-45)	38	22.4 %
	(46-52)	15	8.8 %
	(53-59)	17	10.0 %
	(60-66)	8	4.7 %
	(67-73)	7	4.1 %
Gender	Male	73	42.9 %
	Female	97	57.1 %
Educational Level	Illiterate	20	11.8 %
	Primary school graduated	57	33.5 %
	High school graduation	33	19.4 %
	Institute graduated	13	7.6 %
	College graduated	40	23.5 %
	Post graduated	7	4.1 %
Marital status	Single	38	22.4 %
	Married	130	76.5 %
	Widowed	2	1.2 %
Monthly income	Sufficient	34	20.0 %
	barely sufficient	83	48.8 %
	Insufficient	53	31.2 %
Occupation	Employed	53	31.2 %
	Housewife	65	38.2 %
	Retired	11	6.5 %
	Student	27	15.9 %
	Free work	14	8.2 %
Residency	Rural	26	15.3 %
	Urban	144	84.7 %

Table 2

Distribution of study sample according to relationship with the client and Family pattern.

		Frequency	Percent
	Parents	62	36.5 %
Relationship with the client	Siblings	42	24.7 %
	Spouse	15	8.8 %
	Children	17	10.0 %
	Other	34	20.0 %
Family pattern	Nuclear	124	72.9 %
	Extended	46	27.1 %

Table 2 shows that parents and siblings were the primary caregivers (36.5% and 24.7%, respectively). It was dominated by the nuclear family structure (72.9), thereby increasing caregiving responsibilities relative to extended families.
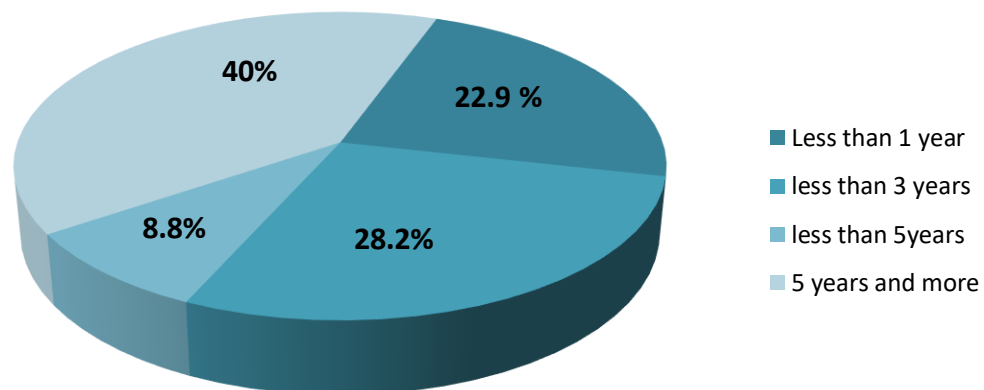
Table 3

Distribution of the study sample according to the diagnosis of the relative patient.

N	Diagnosis of mental illness	Frequency	Percent
1	Phobia	1	0.6
2	Panic attacks	2	1.2
3	Post -traumatic stress	1	0.6
4	Generalized anxiety disorder	23	13.5
5	Depression	36	21.1
6	Obsessive-compulsive disorder	15	8.8
7	Bipolar disorder	4	2.4
9	Psychosis or schizophrenia	10	5.9
10	Attention-deficit hyperactivity disorder	13	7.6
11	Autism spectrum disorder	8	4.7
12	Dementia	6	3.5
13	Alcohol or drug dependence	21	12.4
14	Any other mental, emotional, or neurological problem or condition	30	17.6
15	Total	170	100.0

Table 3 shows that the most prevalent diagnoses among relatives with mental illness were those of depression (21.1%), generalized anxiety disorder (13.5%), and substance use disorders (12.4%). Distribution of the study sample by duration of disorder for the relatives of the patient is presented in Figure 1.

Duration of disorder

Figure 1

Distribution of the study sample by duration of disorder for the relatives of the patient

Table 4

Myths about mental illness held by family caregivers for mentally ill clients

	One-Sample Statistics	Mean	Std. Deviation	t- Test	Sig. (2-tailed)
N		Mean	Std. Deviation	t- Test	Sig. (2-tailed)
1	Mental health problems are uncommon	2.54	1.351	-4.486-	.000
2	People with mental health conditions cannot work	3.12	1.413	1.085	.279
3	Mental health problems are a sign of weakness	2.95	1.440	-.479-	.632
4	Mental health problems are permanent	2.53	1.279	-4.798-	.000
5	People with mental illness are dangerous.	2.95	1.351	-.511-	.610
6	Mental health care is only for people with severe problems.	2.97	1.536	-.250-	.803
7	Children and teens don't have mental health issues.	2.41	1.517	-5.106-	.000
8	Mental health treatments don't work	2.55	1.328	-4.446-	.000
9	People with strong support networks don't need therapy.	2.61	1.333	-3.797-	.000
10	A person's mental health condition indicates that they are not very intelligent.	2.61	1.528	-3.363-	.001
11	All mentally ill patients display unusual behavior, such as using certain words and movements, and muttering to themselves	3.00	1.455	.000	1.000
12	Individuals who have a mental illness are not entitled to a spouse and children.	2.48	1.524	-4.429-	.000
13	Mental illness can be treated by a general physician who treats other diseases, such as heart disease and diabetes.	2.04	1.422	-8.845-	.000
14	Their level of sexual desire influences a person's susceptibility to mental disease.	2.23	1.212	-8.293-	.000
15	Higher education causes mental illness in certain people.	2.16	1.208	-9.077-	.000
16	A mentally ill person can spread their illness to a healthy person by coming into contact with them.	2.41	1.466	-5.232-	.000
17	Mental illness is something people should hide and be ashamed of	2.55	1.550	-3.761-	.000
18	There is no treatment in science for mental illness	2.22	1.461	-6.980-	.000
19	Mental illnesses aren't real illnesses	2.44	1.511	-4.822-	.000
20	People with a mental illness can 'pull themselves out of it.'	2.58	1.478	-3.683-	.000
	Total	**51.60**	**12.542**	**-8.733-**	**.000**

Table 4 indicates that the average myth score was significantly lower than the test value (60), at 51.60 (SD = 12.54). The myths that surround common beliefs are mental illnesses cannot be permanent, that children do not have mental illnesses, and that mental illnesses are not a condition of reality.

Table 5

Misconceptions regarding mental illness among caregivers of mentally ill clients

	One-Sample Statistics	Mean	Std. Deviation	t- Test	Sig. (2-tailed)
N		Mean	Std. Deviation	t- Test	Sig. (2-tailed)
1	The evil eye (hasad) is the source of mental illness.	3.25	1.663	1.937	.054
2	Mental illness is caused by "Seher."	3.21	1.554	1.776	.077
3	Mental illness is caused by "Jinn."	3.10	1.616	.807	.421
4	Mental illness is a punishment from "Allah."	2.61	1.625	-3.115-	.002
5	"Shehk" can treat mental illness	2.44	1.538	-4.737-	.000
6	Prayer might treat mental illness	3.82	1.486	7.173	.000
7	"Rukia" might treat mental illness	3.79	1.363	7.599	.000
8	Mental illness is a lifelong diagnosis	2.98	1.406	-.218-	.827
9	Test from Allah	2.36	1.322	-6.265-	.000

Total	**28.26**	**8.377**	**1.959**	**.052**

Table 5 shows that the mean cultural misconceptions score was 28.26 (SD = 8.38), which was slightly above the test value of 27 (p = 0.052). A significant percentage of caregivers believed in supernatural causes of mental illness, like the evil eye, seher, or jinn. It supported the use of prayer and rukia as a means of treatment. More respondents, however, did not consider that mental illness was solely a divine retribution.

Table 6

The relationships between the Myths and Misconception Score and selected socio-demographic characteristics (Gender, Educational level, Monthly income, Occupation)

		Correlations					
		Gender	Educational level	Monthly income	Occupation	Myths	Mis-conception
Gender	Pearson Correlation	1	-.166-*	.154*	-.294-**	-.067-	.010
	Sig. (2-tailed)		.030	.045	.000	.387	.899
Educational level	Pearson Correlation	-.166-*	1	-.213-**	.020	-.106-	-.254-**
	Sig. (2-tailed)	.030		.005	.791	.169	.001
Monthly income	Pearson Correlation	.154*	-.213-**	1	-.156-*	-.013-	.113
	Sig. (2-tailed)	.045	.005		.043	.867	.143
Occupation	Pearson Correlation	-.294-**	.020	-.156-*	1	.040	-.052-
	Sig. (2-tailed)	.000	.791	.043		.604	.500
Myths	Pearson Correlation	-.067-	-.106-	-.013-	.040	1	.128
	Sig. (2-tailed)	.387	.169	.867	.604		.097
Misconception	Pearson Correlation	.010	-.254-**	.113	-.052-	.128	1
	Sig. (2-tailed)	.899	.001	.143	.500	.097	

*. The two-tailed significance level for correlation is 0.05.

**. The two-tailed correlation is significant at the 0.01 level.

Table 6 showed that myth scores were not significantly correlated with gender, income, or occupation. Nonetheless, educational level was highly correlated with misconceptions (r = -0.254, p = 0.001), such that higher education was associated with fewer misconceptions.

Discussion and Conclusion

The current research investigated the socio-demographic variables, caregiving styles, mental illness diagnosis, beliefs, misconceptions, and attitudes of family caregivers towards mental illness in Kirkuk city. The sample's middle-aged, female, and urban population was unevenly distributed across educational attainment levels and was generally economically vulnerable. This pattern was similar to the corporate trends of gendered roles, urban-rural differences, and the lack of access to resources in society at large (Bawazir et al., 2023; Group, 2024; Maier, 2022; Younis, 2025). Organization (2023)

supports the caregiver demographics of this study, in which females constitute 57.1 percent of caregivers, primarily due to cultural expectations that assign caregiving duties to women. In nuclear families, where the caregiver role is most common, the emphasis on vertical family roles is lower, and extended caregiving is less frequent; consequently, caregiver roles are more likely to burden caregivers (Georgas et al., 2006; Klever, 2015).

The heterogeneity of the caregiver experience and the differing needs of the families were reflected by the clinical profile of care recipients, with a focus on depression and anxiety being the most common ones, but with a variety of other psychiatric disorders (Kaggwa et al., 2023; Younis, 2025; Ahmed et al., 2025). These morbidity statistics also point to the chronic morbidity of mental disorders in Kirkuk, where a significant number of individuals are accustomed to living with the symptoms for five years or longer, which suggests the

long-term care-giving requirements and the potential acquisition of burden (Ahmed et al., 2019; Supke et al., 2021).

Caregivers tended to deny explicit myths about the existence of mental illness. However, some beliefs, especially on dangerousness, feebleness, and ability to work remained, indicating some partiality in the maintenance of stigma and cultural misunderstanding (Ahmed et al., 2019; Ngui et al., 2010; Soo et al., 2024) Misconceptions, such as beliefs related to supernatural causes and the healing power of prayer or ruqia, were also still present and were also found in the Middle Eastern contexts (Al-Abbudi, 2019; Elshamy et al., 2023; Fekih-Romdhane et al., 2023; Younis et al., 2019).

The caregivers have a significant connection between their educational level, income, and occupation and misconceptions, which reveals the influence of socio-economic and educational variables on the formation of perceptions of mental illness (Abayneh et al., 2022; BinDhim et al., 2024; Corrigan et al., 2014; Shalaby & Agyapong, 2020). In addition, corresponding correlations between myths and misconceptions indicate that culture-based beliefs have a direct impact on the reaction of caregivers and the care they are giving, so the development of culturally sensitive psychoeducational interventions is necessary to minimize stigma, misconceptions, and create a supportive caregiving environment (Elshamy et al., 2023; Fekih-Romdhane et al., 2023; Uguz et al., 2024).

Conclusion

The myths and cultural misunderstandings of mental illnesses are still prevalent among family caregivers in Kirkuk, especially those who have lower education and income levels. Such perceptions are the source of stigma and can postpone treatment.

Recommendation

1. Community-Based Education Programs: Hold the awareness campaigns in schools, mosques, and community centers with the use of culturally relevant materials to bust the myths.

2. Integration into Health Services: Include psychoeducation of caregivers when they visit an outpatient and primary care setting.

3. Caregiver Support Resources: Provide support groups, helplines, and mobile apps with easy mental health information.

4. Future Study: Determine the effects of interventions in the long-term and trace the changes in beliefs of caregivers.

Acknowledgments

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Declaration of Helsinki, which provides guidelines for ethical research involving human participants. Ethical considerations in this study included the fact that participation was entirely optional.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

Authors' Contributions

All authors equally contribute to this study.

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