



Mental health concerns and their distribution by age and gender in selected communities of Peshawar, Pakistan

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Article History	Abstract:
Received: 23-Jul-2025	This study investigated the mental health concerns of 135 people who received psychological support through community-based services in selected communities of Peshawar, Pakistan. We reviewed routine service records to understand who sought help and what problems they faced, focusing on differences by age, gender, and education. The people served were almost evenly split between men and women, mostly adults aged 20 to 50 years, and mostly from low-income households. Depression and anxiety were by far the most common concerns, together making up more than half of all cases. The type of problem was closely linked to age: young children were more often dealt with behavioral or developmental concerns, while depression was most common among teenagers and adults. Gender also mattered a great deal: women were far more likely than men to be dealing with depression (39% vs 13%), while men were more likely to report stress, behavioral issues, or personality-related concerns. A similar pattern held across education levels, where depression remained the leading concern overall, and stood out sharply among people with no formal education, who reported depression almost twice as often (48%) as other groups. These findings suggest that mental health support in these communities should be tailored by age, gender, and education rather than offered as a single, one-size-fits-all program, and they point to opportunities for Blessing Welfare and Development Organization (BWDO) to strengthen and better target its community-based mental health services, particularly for women dealing with depression and for people who never had the chance to attend school.
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1. Introduction

Mental health problems are common in Pakistan, but the support available to deal with them is very limited. It is estimated that 24 million people in Pakistan need psychiatric assistance, and mental disorders account for more than 4% of the country's total disease burden (World Health Organization Regional Office for the Eastern Mediterranean, 2023). A recent national assessment found that this need is met by a severely under-resourced system, leaving an estimated 90% of people with a mental illness untreated (Dayani et al., 2024). The first large, nationally representative survey of psychiatric illness in Pakistan found that more than a third of adults (37.9%) had experienced a psychiatric disorder in their lifetime, with mood and anxiety-related disorders the most common (Rahman et al., 2024). These figures sit within a wider regional and global picture. South Asian countries are reported to have some of the highest pooled prevalence estimates of common mental disorders in the world, with depressive symptoms and anxiety each affecting roughly a quarter of participants across pooled studies (Naveed et al., 2020). Globally, the gap between people who need mental health care and those who receive it is large in every region, and it is probably underestimated in low- and middle-income countries, where services are scarcer and community-based data are limited (Kohn et al., 2004). The Lancet Commission on global mental health and sustainable development has similarly argued that the agenda must move beyond closing the treatment gap to also address gaps in prevention and quality of care (Patel et al., 2018).

The burden of mental health problems is also not evenly spread across the population. A systematic review of studies from Pakistan estimated that about one in three people in the community had an anxiety or depressive disorder, with higher rates among women (29–66%) than men (10–33%), and with low education, financial difficulty, and relationship problems among the factors associated with these disorders (Mirza & Jenkins, 2004). Village-based surveys have similarly found depression to be more common among women than men, and among people with fewer years of education and more social adversity, including in a tribal area of north-western Pakistan (Husain et al., 2000; Husain et al., 2007). Internationally, a meta-analysis of national samples from more than 90 countries found that women had almost twice the odds of depression compared with men (odds ratio = 1.95), with the difference already evident by around age 12 (Salk et al., 2017). Age is a further consideration: worldwide, anxiety, disruptive behavior, and attention-deficit/hyperactivity disorders are among the most commonly diagnosed conditions in children and adolescents, with an overall pooled prevalence of about 13% (Polanczyk et al., 2015). Finally, socioeconomic disadvantage has been consistently linked to depression (Lorant et al., 2003), and education is among the dimensions of poverty most consistently associated with common mental disorders in low- and middle-income countries (Lund et al., 2010).

Mental health services in Pakistan are also unevenly distributed, with most specialists concentrated in major-city hospitals while smaller communities — including much of Khyber Pakhtunkhwa — have very limited access (Dayani et al., 2024). Earlier work has already called for stronger, better-resourced community mental health services in Peshawar specifically (Afridi et al., 2010), but more than a decade later, there is still very little routine reporting on the mental health concerns of people accessing community-based services in the city.

This report addresses that gap by reviewing routine service records from 135 beneficiaries who received community-based psychological support in selected communities of Peshawar. This

review looks directly at who sought help and what concerns they presented with, with a particular focus on how these concerns differ by age, gender, and education level.

2. Methodology

2.1. Study Design

A retrospective descriptive study was conducted using routinely collected data from 135 beneficiaries who received psychological services through Blessing Welfare and Development Organization. The study examined the sociodemographic characteristics and presenting mental health concerns of beneficiaries, with particular focus on patterns across age and gender and education.

2.2. Participants

The study included 135 beneficiaries who received psychological treatment through Blessing Welfare and Development Organization during the study period. All beneficiaries with a documented presenting concern in the organization's routine records during April 2025 to March 2026 were included; records with other issues including referral cases data were excluded. The participants were from selected communities of Peshawar. The sample included boys, girls, men, and women across different age groups.

2.3. Setting

The study was conducted through the psychological services provided by Blessing Welfare and Development Organization in Peshawar, Khyber Pakhtunkhwa, Pakistan. The organization provides community-based mental health and psychosocial support services to individuals from selected communities, including but not limited to Tajabad, Canal Road, Board Bazaar, and Danishabad. Psychological services were provided to children, adolescents, and adults through the organization's service delivery system.

2.4. Measures/Instruments

Psychological assessment was conducted according to the presenting concerns and individual needs of the beneficiaries. The assessment process included a Mental Status Examination (MSE) and, where clinically indicated, standardized psychological assessment tools. These included the Generalized Anxiety Disorder-7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Human Figure Drawing Test, and autism-specific assessment tools (CARS). For children, age-appropriate behavioral checklists and other standardized assessment tools were used where clinically indicated. The selection of instruments was based on the client's presenting symptoms, age, and clinical requirements.

2.5. Procedure

Beneficiaries accessed psychological services through referrals, community outreach activities, and direct access to the organization's psychological services. Following initial registration and informed consent, beneficiaries underwent a clinical assessment, including a Mental Status Examination and, where clinically indicated, standardized psychological assessments based on

their presenting concerns, age, and individual needs. A psychological formulation was developed, and an appropriate treatment plan was established. Psychological interventions were provided according to the identified needs of each beneficiary. Relevant sociodemographic, clinical, assessment, and treatment information was documented in the organization's records. Each beneficiary's presenting concern was classified by the treating clinician into a single primary category based on the concern identified during assessment; where more than one concern was present, the record was coded to reflect the dominant presenting issue. For the present study, data from 135 beneficiaries were retrospectively reviewed and analyzed to examine patterns in their sociodemographic characteristics and mental health concerns.

2.6. Data Analysis

Data were analyzed using IBM SPSS Statistics. Descriptive statistics, including frequencies and percentages, were calculated to summarize the sociodemographic characteristics and presenting mental health concerns of the beneficiaries. Cross-tabulations were used to examine the distribution of mental health concerns across age groups, gender, and education level. Where appropriate, chi-square tests were conducted to examine associations between categorical variables; because several presenting-concern categories contained small cell counts, these results should be interpreted with caution, and combining categories or using an alternative exact test would be advisable in future analyses. Cases with missing values on a given variable were excluded from the analysis of that variable, and the extent of missing data is noted alongside the relevant results. Statistical significance was set at $p < .05$.

2.7. Ethical Considerations

Informed consent was obtained from beneficiaries prior to the provision of psychological services. The purpose of the assessment and the confidentiality of the information provided were explained verbally to the beneficiaries, and written consent was obtained using a standardized consent form. Beneficiaries were informed that their personal and psychological information would be kept confidential and used only for appropriate service provision and documentation purposes. For beneficiaries below 18 years of age, the consent procedure was conducted in accordance with the organization's established protocols.

3. Results

Table 1: Sociodemographic Characteristics of the Sample

Characteristics	f	%
Gender		
Male	64	47.4
Female	71	52.6
Age		
0-10	15	11.1
11-19	39	28.9
20-50	75	55.6
50.1-80	5	3.7
Education		
No Education	25	18.5
Primary	19	14.1
Secondary	22	16.3

Higher Secondary	11	8.1
BS	16	11.9
Masters	5	3.7
MPhil	1	0.7
Madrassa (Ilm)	1	0.7
Marital Status		
Married	48	35.6
Single	86	63.7
Widow	1	0.7
Monthly Income		
No Income	10	7.4
0-50,000	77	57.0
50,001-1 Lac	35	25.9
1 Lac – 1.5 Lac	5	3.7
1.6 – 2 Lacs	6	4.4
2.1 Lacs – 2.5 Lacs	2	1.5

Note: f = frequency; % = percentage

Age data were unavailable for one beneficiary ($n = 134$ for age); education data were available for 100 of 135 beneficiaries (74.1%), and education percentages above are based on those with a recorded education level rather than the full sample.

The people we served were roughly half men and half women, mostly young adults between 20 and 50 years old. Many households were low-income, and about 1 in 5 people had no formal schooling.

Table 2: Sociodemographic Characteristics of the Sample (II)

Characteristics	f	%
Occupation		
Unemployed/No Occupation	16	11.9
Students	49	36.3
House Wife	31	23.0
Self Employed	13	9.6
Employed	20	14.8
Skilled/Manual workers	5	3.7
Retired	1	0.7
Location/Area		
Danishabad	55	40.7
Sufaid Dheri	31	23.0
Tajabad	10	7.4
Academy Town	7	5.2
Hayatabad	5	3.7
Warsak Road	4	3.0
University Town	3	2.2
Kandi Kali	3	2.2
Riksho Pull	3	2.2
Board Bazar	2	1.5
Canal Road	2	1.5
Other Areas	10	7.4

Note: f = frequency; % = percentage

Most people we served were students or had no steady job. They came mainly from Danishabad and Sufaid Dheri.

Table 3: Descriptive Statistics of Disability Status

Disability Status	<i>F</i>	%
<i>Yes</i>	<i>12</i>	<i>8.9</i>
<i>No</i>	<i>123</i>	<i>91.1</i>

Almost all of the people we served (91%) did not report a disability.

Table 4: Distribution of Presenting Mental Health Concerns Among Beneficiaries (N = 135)

Mental Health Concerns	<i>f</i>	%
Depressive concerns		
Depression + Anger and Depression	46	34.1
Anxiety and related concerns		
Anxiety+ OCD+ Phobias	28	20.7
Behavioral Concerns		
Anger + Behavioral Issues+ +Hyperactivity +Hyperactivity/Anger outburst	20	14.8
Stress and Adjustment related concerns		
Stress + Adjustment Issues	9	6.7
Interpersonal/Family Concerns		
Couple/Relationship + Couple Conflicts	8	5.9
Severe Mental Health conditions		
Personality Disorder + Psychotic Disorder + bipolar disorder	5	3.7
Neurodevelopmental Concerns		
Autism	2	1.5
Somatic Complaints	4	3.0
Substance Related Concerns		
Addiction	1	0.7
Academic Concerns		
Poor Academic Concerns	3	2.2
Other Unspecified		
Genetics + Comorbidity	9	6.7

Note: *f*= frequency; % = percentage

Depression was the most common problem people came to us with, followed by anxiety-related concerns and behavioral issues. Together, these three broad groups accounted for about 70% of all presenting concerns. Each beneficiary was classified under a single primary presenting concern; where the table combines related diagnoses (e.g., anxiety, OCD and phobias; or personality, psychotic, and bipolar disorder).

Table 5: Distribution of Presenting Mental Health Concerns Across age groups (N = 134)

Mental Health Concerns	Children (0-10)	Adolescents (11-19)	Adults (20-50)	Old Age (51 -80)
Anxiety	0 (0.0%)	6 (15.4%)	19 (25.3%)	0 (0.0%)
Depression	2 (13.3%)	12 (30.8%)	21 (28.0%)	1 (20.0%)
OCD	0 (0.0%)	1 (2.6%)	1 (1.3%)	0 (0.0%)
Anger Issues	0 (0.0%)	3 (7.7%)	3 (4.0%)	0 (0.0%)
Behavioral Issues	3 (20.0%)	3 (7.7%)	1 (1.3%)	0 (0.0%)
Stress	1 (6.7%)	2 (5.1%)	3 (4.0%)	1 (20.0%)
Couple Relationship Issues	0 (0.0%)	1 (2.6%)	2 (2.7%)	0 (0.0%)
Family Conflicts	0 (0.0%)	0 (0.0%)	4 (5.3%)	1 (20.0%)
Somatic Complaints	0 (0.0%)	1 (2.6%)	1 (1.3%)	0 (0.0%)
Autism	2 (13.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Hyperactivity	1 (6.7%)	1 (2.6%)	0 (0.0%)	0 (0.0%)
Personality Disorder	1 (6.7%)	0 (0.0%)	2 (2.7%)	0 (0.0%)
Adjustment Issues	0 (0.0%)	0 (0.0%)	2 (2.7%)	0 (0.0%)
Psychotic Disorder	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (20.0%)
Addiction	0 (0.0%)	0 (0.0%)	1 (1.3%)	0 (0.0%)
Anger + Depression	0 (0.0%)	4 (10.3%)	5 (6.7%)	1 (20.0%)
Hyperactivity + Anger Outburst	2 (13.3%)	1 (2.6%)	2 (2.7%)	0 (0.0%)
Genetics	0 (0.0%)	1 (2.6%)	2 (2.7%)	0 (0.0%)
Bipolar Disorder	0 (0.0%)	0 (0.0%)	1 (1.3%)	0 (0.0%)
Comorbidity	1 (6.7%)	1 (2.6%)	3 (4.0%)	0 (0.0%)
Medical	0 (0.0%)	0 (0.0%)	2 (2.7%)	0 (0.0%)
Mental Health Concerns	Children (0-10)	Adolescents (11-19)	Adults (20-50)	Old Age (50 -80)
Phobia	0 (0.0%)	1 (2.6%)	0 (0.0%)	0 (0.0%)
Poor Academic Performance	2 (13.3%)	1 (2.6%)	0 (0.0%)	0 (0.0%)

Note. $n = 134$ (one case excluded due to missing age data). Values represent sample counts with column percentages in parentheses. $\chi^2(66, n = 134) = 101.85, p = .003$.

The type of problem changed with age. Young children were more often dealt with behavior- or development-related concerns, while depression was more common among teenagers and adults.

We ran a statistical test (called a chi-square test) to check whether age was linked to the type of concern reported. The test showed a statistically significant link ($p = .003$); however, this table spreads 135 beneficiaries across more than 20 concern categories, so many cells contain very small or zero counts, which can make chi-square results unreliable, and the oldest age group (50–80 years) includes only five cases. These results should therefore be treated as descriptive rather than confirmatory. The test showed a clear link that was very unlikely to be due to chance ($p = .003$). For example, behavioral issues (20.0%) and autism (13.3%) were mostly seen in the youngest children (0–10 years), while depression was very common among both teenagers (30.8%) and adults aged 20–50 (28.0%).

Table 6: Distribution of Presenting Mental Health Concerns Across Educational levels (N = 87)

Educational Level	Primary	Secondary	BS	Masters	No Education
Anxiety	3 (15.8%)	1(4.5%)	4 (25.0%)	2 (40.0%)	5 (20.0%)
Depression	5 (26.3%)	5 (22.7%)	5 (31.2%)	1 (20.0%)	12 (48.0%)
OCD	0 (0.0%)	1 (4.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Anger Issues	1 (5.3%)	2 (9.1%)	1 (6.2%)	0 (0.0%)	0 (0.0%)
Behavioral Issues	2 (10.5%)	1 (4.5%)	1 (6.2%)	0 (0.0%)	0 (0.0%)
Stress	1 (5.3%)	2 (9.1%)	0 (0.0%)	0 (0.0%)	1 (4.0%)
Couple Relationship Issues	0 (0.0%)	1 (4.5%)	1 (6.2%)	0 (0.0%)	0 (0.0%)
Family Conflicts	1 (5.3%)	2 (9.1%)	0 (0.0%)	0 (0.0%)	1 (4.0%)
Somatic Complaints	1 (5.3%)	0 (0.0%)	1 (6.2%)	0 (0.0%)	0 (0.0%)
Autism	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.0%)
Hyperactivity	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Personality Disorder	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (40.0%)	0 (0.0%)
Adjustment Issues	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Psychotic Disorder	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.0%)
Addiction	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Anger + Depression	0 (0.0%)	4 (18.2%)	0 (0.0%)	0 (0.0%)	2 (8.0%)
Hyperactivity + Anger Outburst	2 (10.5%)	1 (4.5%)	1 (6.2%)	0 (0.0%)	0 (0.0%)
Genetics	0 (0.0%)	0 (0.0%)	1 (6.2%)	0 (0.0%)	1 (4.0%)
Bipolar Disorder	0 (0.0%)	0 (0.0%)	1 (6.2%)	0 (0.0%)	0 (0.0%)
Comorbidity	1 (5.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.0%)
Medical	1 (5.3%)	1 (4.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Phobia	0 (0.0%)	1 (4.5%)	0 (0.0%)	0 (0.0%)	0(0.0%)
Poor Academic Performance	1 (5.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

This table covers the 87 beneficiaries with a recorded education level of Primary, Secondary, BS, Masters, or No Education. Beneficiaries with Higher Secondary (11 people), MPhil, or Madrassa education (2 people) do have recorded education data but were not included as separate columns here, as their cell counts were too small to report meaningfully. Among the education groups currently shown depression was by far the biggest concern among people

with no formal education (48% — almost 1 in 2 people), which is much higher than any other education group. Depression was also the top concern among people with primary (26%), secondary (23%), and university-level (BS, 31%) education.

Table 7: Distribution of Presenting Mental Health Concerns by Gender (N = 135)

Mental Health Concerns	Male	Female
Anxiety	11 (17.2%)	14 (19.7%)
Depression	8 (12.5%)	28 (39.4%)
OCD	1 (1.6%)	1 (1.4%)
Anger Issues	4 (6.2%)	2 (2.8%)
Behavioral Issues	7 (10.9%)	0 (0.0%)
Stress	6 (9.4%)	1 (1.5%)
Couple Relationship Issues	1 (1.6%)	2 (2.8%)
Family Conflicts	2 (3.1%)	3 (4.2%)
Somatic Complaints	1 (1.6%)	1 (1.4%)
Autism	1 (1.6%)	1 (1.4%)
Hyperactivity	2 (3.1%)	0 (0.0%)
Personality Disorder	3 (4.7%)	0 (0.0%)
Adjustment Issues	1 (1.6%)	1 (1.4%)
Psychotic Disorder	0 (0.0%)	1 (1.4%)
Addiction	1 (1.6%)	0 (0.0%)
Anger + Depression	5 (7.8%)	5 (7.0%)
Hyperactivity + Anger Outburst	3 (4.7%)	2 (2.8%)
Genetics	3 (4.7%)	1 (1.4%)
Bipolar Disorder	0 (0.0%)	1 (1.4%)
Comorbidity	1 (1.6%)	4 (5.6%)
Medical	2 (3.1%)	0 (0.0%)
Phobia	0 (0.0%)	1 (1.4%)
Poor Academic Performance	1 (1.6%)	2 (2.8%)

Depression represented a higher proportion of presenting concerns among female beneficiaries (39.4%) than male beneficiaries (12.5%); men, on the other hand, reported comparatively more stress, behavioral, and personality-related concerns. These are descriptive patterns among BWDO service users rather than evidence of risk, and they can inform — rather than determine — gender-responsive service planning.

4. Discussion

This review looked at 135 people who received mental health support in selected communities of Peshawar. Most were adults aged 20–50, and many reported low personal incomes. Depression was the single biggest concern, making up about a third of all cases (34%), followed by anxiety-related concerns (21%) and behavioral problems (15%). Together, these three broad groups accounted for about 70% of all presenting concerns. This is a common pattern in community mental health programs, where mood and anxiety problems are usually the most frequent reason people ask for help. The predominance of depression and anxiety is also consistent with population-level evidence from Pakistan and South Asia, where these are among the most commonly reported mental health problems (Mirza & Jenkins, 2004; Naveed et al., 2020; Rahman et al., 2024), although the present figures describe who sought help rather than how common these problems are in the wider community.

The type of concern was closely linked to age, although this association should be interpreted with some caution given the large number of small and zero cell counts in the age cross-tabulation. Younger children (0–10 years) were more likely to be brought in for behavioral problems or developmental concerns such as autism. Depression, on the other hand, was more common among teenagers and adults. This suggests that staff training and services could be organized around age — for example, screening for behavioral and developmental issues in younger children, and depression- and anxiety-focused support for teenagers and adults. The prominence of behavioral concerns in childhood is in line with worldwide evidence that disruptive behavior and attention-deficit/hyperactivity disorders are among the most common conditions in children and adolescents (Polanczyk et al., 2015).

Gender also made a real difference in the concerns reported among BWDO's service users. Depression represented a higher proportion of presenting concerns among women (39.4%) than men (12.5%) — making it by far the most common concern among female beneficiaries, while male beneficiaries' concerns were spread more evenly across depression, anxiety, stress, and behavioral issues. Some concerns — such as stress, behavioral issues, personality-related concerns, addiction, and medical complaints — were reported almost only among men in this sample. These patterns, drawn from a single organization's service records, can inform gender-responsive outreach and support rather than establish that women or men are inherently more likely to experience particular conditions. The higher share of depression among women is consistent with a large body of evidence. A meta-analysis of national samples from more than 90 countries found that women had almost twice the odds of depression compared with men, and that this difference was already evident by around age 12 and largest in adolescence (Salk et al., 2017). Studies from Pakistan, including from the north-west of the country, have likewise reported higher rates of depression or depressive symptoms among women (Husain et al., 2000; Husain et al., 2007; Mirza & Jenkins, 2004; Muhammad Gadit & Mugford, 2007), and research in Peshawar has examined anxiety and depression among women, including during pregnancy (Shagufta & Shams, 2019). Pakistani studies have linked depression and anxiety to social adversity such as financial difficulty and relationship problems, alongside female sex (Mirza & Jenkins, 2004), although our data cannot test such explanations. The greater share of stress, behavioral, and personality-related concerns among men may partly reflect how distress is expressed and labeled. Some frameworks propose that depression in men can be masked by externalizing behaviors and shaped by gender norms, and so may be recorded under other headings (Addis, 2008). Our data cannot test this idea, but it is a further reason to interpret gender differences in presenting concerns cautiously.

The breakdown by education level showed one of the more notable patterns in this review, though it is also the one requiring the most caution: among the 87 beneficiaries with a recorded education level of Primary, Secondary, BS, Masters, or No Education, depression was reported by almost half of those with no formal education (48%) — higher than among people with primary (26%), secondary (23%), university-level/BS (31%), or Masters-level (20%) education. Because some education categories are missing from this analysis and several groups are small, this pattern should be read as a signal for further, more complete data collection rather than a confirmed finding; the data do not support describing this as a “heavier mental health burden.” Anxiety was also comparatively high among the small Masters group (40%, $n = 5$), though with only five people this should not be treated as a strong finding. This table does not include beneficiaries with higher-secondary schooling (11 people) or Madrassa/MPhil education (2 people) — adding these would complete the picture. A link between lower education and depression is consistent with earlier work in Pakistan. In a village

survey, people with depression were less well educated than those without, and low educational level was among the factors most closely associated with depression in multivariate analysis (Husain et al., 2000); in a tribal area of north-western Pakistan, higher depressive symptom scores were associated with fewer years of education (Husain et al., 2007). More broadly, a systematic review found education to be among the socioeconomic dimensions most consistently associated with common mental disorders in low- and middle-income countries (Lund et al., 2010), and a meta-analysis reported a dose-response relationship between education and depression (Lorant et al., 2003). Given the incomplete education data in this review, these studies are best read as context for the pattern observed here rather than as confirmation of it.

These patterns also need to be read against the wider service context. A review of community surveys found that, worldwide, a median of 56.3% of people with depression and 57.5% of those with generalized anxiety disorder received no treatment, and that the gap is probably underestimated for low- and middle-income countries (Kohn et al., 2004). Community-based delivery is one practical route to narrowing it: in a cluster-randomized trial in rural Pakistan, primary health workers trained to deliver a cognitive behavioral intervention substantially reduced major depression among mothers with perinatal depression (Rahman et al., 2008). That trial concerned perinatal depression in a rural setting, so its findings may not transfer directly to the wider client group in this review, which included men, children, and adolescents, but it supports the view that psychological care can be delivered effectively through community-based workers in Pakistan.

Taken together, these findings describe what BWDO's routine service data show: a client group that is largely working-age, often on a low personal income, and presenting mainly with depression and anxiety-related concerns, with differences by age, gender, and education that matter for how services are designed. Because this is a descriptive review of routine service data, it cannot tell us why these patterns exist, only that they appear among people who accessed BWDO's services; any explanation would need to be tested with further research. What the organization can do now is use these patterns to inform practical decisions — such as staff training priorities, outreach targeting, and which age or gender groups may benefit from additional support — consistent with longstanding calls for stronger, better-resourced community mental health services in Peshawar (Afridi et al., 2010).

5. Conclusion

This retrospective review of 135 beneficiaries receiving community-based psychological services in selected communities of Peshawar identified depression and anxiety as the most frequently reported mental health concerns, with depression being the most prominent concern overall. The findings also demonstrated meaningful differences in presenting concerns across age and gender. Behavioral and developmental concerns were more frequently observed among younger children, while depression was more common among adolescents and adults. Women reported substantially higher rates of depression than men, whereas men showed relatively higher proportions of stress, behavioral, and personality-related concerns. Depression was also particularly prominent among beneficiaries with no formal education.

Overall, the findings highlight the importance of accessible, community-based mental health services that consider the differing needs of children, adolescents, and adults and take age, gender, and educational background into account. At the same time, because the study was

based on routinely collected service data, the findings describe patterns among people who accessed these services and cannot establish the causes of the observed differences. Continued collection and systematic analysis of service data can help organizations better understand community needs and strengthen the planning and delivery of mental health services in Peshawar.

5.1. Recommendations/Implications

The findings have several implications for community-based mental health services in Peshawar. Based on the patterns identified in this study, the following recommendations are proposed:

- a) **Age-specific services:** Mental health services should consider age-specific screening and interventions, with greater attention to behavioral and developmental concerns among children and depression and anxiety among adolescents and adults.
- b) **Gender-responsive support:** Outreach and psychological services should be responsive to gender-related patterns, particularly strengthening depression-focused support and outreach for women while addressing stress and behavioral concerns among men.
- c) **Targeted community outreach:** Individuals with limited or no formal education may benefit from more accessible mental health awareness and outreach activities, particularly given the higher proportion of depression observed in this group.
- d) **Improved documentation:** Organizations providing community-based psychological services should maintain complete and consistent sociodemographic and clinical records. Regular analysis of service data can help identify changing community needs and improve service planning.
- e) **Strengthening community-based services:** Continued investment in accessible psychological and psychosocial services is recommended to improve early identification, referral, and support for individuals experiencing mental health concerns in underserved communities.

5.2. Limitations

This study has several limitations that should be considered when interpreting its findings. First, the study used a retrospective review of routinely collected service data from a single organization. Therefore, the findings reflect the characteristics and presenting concerns of beneficiaries who accessed the organization's psychological services and may not be representative of the wider population of Peshawar. The sample was also drawn from selected communities, with a substantial proportion of beneficiaries coming from Danishabad and Sufaid Dheri, which may limit the generalizability of the findings to other communities. Second, the study included a wide range of presenting concerns, and some categories contained very small numbers of beneficiaries. Comparisons involving these small groups should therefore be interpreted cautiously, as percentages based on small numbers can be unstable. Similarly, although a statistically significant association was found between age and presenting mental health concerns, the retrospective descriptive design does not allow conclusions about causality. Finally, the assessment instruments were selected according to individual presenting concerns and clinical needs rather than being administered uniformly to all beneficiaries. The findings should therefore be understood as patterns in presenting concerns documented within routine clinical services rather than as prevalence estimates of diagnosed mental health disorders in the wider community.

Declaration of conflict of interest

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