Cultural Narratives, Social Norms, and Mental Health Stigma in Peshawar, Pakistan: Implications for Help-Seeking Behavior

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Mental health stigma remains one of the most critical barriers to psychiatric care worldwide, particularly in conservative cultural contexts. This study examines the relationship between cultural narratives, social norms, and mental health stigma in Peshawar, Pakistan, with a specific focus on how these factors influence help-seeking behavior. Drawing on survey data from emerging adults (ages 18–29), the study employed descriptive statistics, regression analyses, and structural equation modeling (SEM) to investigate these dynamics. Results reveal that cultural narratives rooted in supernatural and religious explanations, as well as rigid social norms influenced by Pashtunwali, significantly predict stigmatizing attitudes toward mental illness. Gender disparities were evident, with men exhibiting higher levels of stigma and lower rates of help-seeking than women. Correlation and regression analyses underscored the mitigating role of mental health knowledge, which was negatively associated with stigma and positively linked to help-seeking behaviors. The SEM framework further highlighted stigma as a mediating mechanism between cultural/social constructs and psychiatric service utilization. These findings underscore the urgent need for culturally sensitive interventions in Khyber Pakhtunkhwa, particularly those that engage families, communities, and religious leaders in reframing mental illness as a treatable health condition. The study contributes to global debates on mental health by emphasizing the role of local cultural contexts in shaping stigma and advancing tailored approaches to improve access to care in low- and middle-income countries.

Keywords: Mental Health Stigma; Cultural Narratives; Social Norms; Pashtunwali; Help-Seeking Behavior; Emerging Adults

Introduction:

Mental health remains a critical component of global well-being, yet stigma surrounding psychiatric disorders continues to obstruct timely diagnosis, treatment, and recovery [1][2]. In low- and middle-income countries (LMICs), where nearly 75% of individuals with mental illnesses receive no treatment, stigma serves as a primary barrier to accessing care [3]. South Asia, and Pakistan in particular, exemplifies this challenge. Approximately 15–20% of Pakistan's population experiences mental health disorders, but most avoid formal psychiatric care due to prevailing cultural, religious, and social stigmas [4]

In Pakistan, mental illness is frequently misinterpreted as a sign of weak faith, divine punishment, or supernatural possession. These perceptions discourage professional consultation and instead normalize reliance on spiritual healers, shrines, and herbalists [5][6]. Conservative regions such as Khyber Pakhtunkhwa face even greater challenges due to an acute shortage of mental health professionals, with fewer than 50 psychiatrists serving over 35 million people [7]. In Peshawar, the provincial capital, the situation is further complicated by

the cultural framework of Pashtunwali, which prioritizes honor (nang), modesty (purdah), and resilience, often stigmatizing emotional disclosure and reinforcing silence around mental illness [8].

Women and marginalized groups face disproportionate challenges. Restrictive gender norms, patriarchal family structures, and limited autonomy in health-related decisions exacerbate barriers to psychiatric care for women in the region [9]. Similarly, the dominance of religious leaders in shaping community narratives often promotes spiritual healing over biomedical treatment, framing mental distress as a divine test or moral failing [10]. These cultural and religious interpretations, while offering some community support, frequently intensify stigma and delay help-seeking behavior.

Given these intersecting influences, localized research is urgently needed to systematically explore how cultural narratives and social norms interact with stigma to shape psychiatric help-seeking behaviors in conservative contexts such as Peshawar. This study seeks to address this gap by employing advanced statistical modeling to investigate the role of cultural and religious values in perpetuating or mitigating stigma.

Research Gap:

While stigma toward mental illness has been extensively studied in Pakistan, most research has been concentrated in urban centers like Karachi, Lahore, and Islamabad [11][12]. Few studies focus on conservative provinces such as Khyber Pakhtunkhwa, where cultural codes like Pashtunwali exert significant influence over social behavior and identity. Moreover, existing literature often emphasizes general attitudes toward mental illness without systematically examining how cultural narratives, gender norms, and religious interpretations intersect to shape stigma in localized contexts [13]. Importantly, limited empirical evidence employs advanced statistical methods such as Structural Equation Modeling (SEM) to capture the complex pathways between cultural values, stigma, and psychiatric help-seeking behaviors in Peshawar. This lack of context-specific, methodologically rigorous studies leaves a critical gap in understanding and addressing mental health stigma in conservative Pakistani societies.

Objectives:

The primary objective of this study is to investigate how cultural narratives, social norms, and religious interpretations contribute to mental health stigma and influence psychiatric help-seeking behaviors in Peshawar, Pakistan. In pursuing this objective, the study examines the prevalence and different forms of stigma surrounding mental illness among emerging adults in the city, highlighting how these negative attitudes restrict open discussion and timely intervention. It further assesses the role of Pashtunwali cultural values, such as honor, modesty, and resilience, in shaping stigmatizing beliefs and reinforcing community-level silence around psychiatric disorders. Gendered differences are also explored, with particular attention to how men and women perceive mental illness differently and the ways these perceptions affect their access to psychiatric care. Additionally, the study evaluates the mediating role of stigma between cultural narratives, social norms, and psychiatric help-seeking behavior by applying regression analysis and Structural Equation Modeling (SEM), thereby offering an integrated understanding of how social and cultural dynamics shape mental health outcomes in the region.

Novelty Statement:

This study is novel in three critical ways. First, it provides one of the few empirical investigations into mental health stigma in Peshawar, a culturally conservative region where mental illness is rarely studied through a socio-cultural lens. Second, by integrating Pashtunwali cultural values and religious interpretations into the conceptual framework, the study introduces a contextually grounded approach that goes beyond generic models of stigma applied elsewhere in Pakistan. Third, the use of advanced quantitative methods, including SEM, allows for a rigorous examination of direct and indirect pathways between cultural

narratives, stigma, and help-seeking behavior—an approach that has not yet been applied in studies of mental health stigma in Pakistan. By generating localized, data-driven insights, this study contributes to the design of culturally sensitive mental health interventions and policies that can better address the unique needs of conservative and underserved populations.

Literature Review:

Mental health stigma is a critical barrier to the utilization of psychiatric services in many societies, particularly in low- and middle-income countries such as Pakistan, where mental health care remains severely underdeveloped. Estimates suggest that more than 75% of individuals suffering from mental disorders in LMICs receive no form of treatment, largely due to stigma, limited resources, and inadequate policy frameworks [14]. In Pakistan, the treatment gap is especially pronounced, with only a small proportion of people accessing mental health services despite the high prevalence of depression, anxiety, and psychotic disorders [15]. The World Health Organization (WHO) says that mental health care needs to be integrated into primary care in Pakistan right away because psychiatric services are mostly available in cities, are underfunded, and are hard to get to for people who are already marginalized.

Cultural and religious factors significantly influence the perception and interpretation of mental illness in Pakistan. Supernatural explanations, including jinn possession, the effects of black magic, and divine retribution, persist widely. Consequently, individuals frequently seek assistance from traditional healers, shrines, or religious clerics instead of psychiatrists or psychologists [5][6]. This trend is not exclusive to Pakistan; it is also evident in other Muslim-majority nations, where religiosity offers coping mechanisms and strengthens dependence on spiritual interpretations of illness [16]. The endurance of these explanatory models hinders public health initiatives, as individuals might postpone or completely evade biomedical treatment. The creation of psychometric instruments like the Belief in Jinn Possession Scale (BJPS) underscores the widespread nature of supernatural causal beliefs and the necessity of incorporating these cultural phenomena into research and intervention strategies [5].

Stigma research has progressed to define stigma as a multi-faceted construct encompassing ignorance, prejudice, and discrimination [17]. In Pakistan, insufficient mental health literacy and adverse stereotypes regarding individuals with psychiatric disorders are prevalent, leading to social exclusion and discrimination in workplaces, educational settings, and even within familial contexts [13][18]. This corresponds with findings in other collectivist societies, where social reputation and familial honor impose significant pressure to conceal mental illness [10]. This kind of stigma is especially strong among younger people, where young adults often internalize negative stereotypes, which leads to self-stigma, lower self-esteem, and not getting treatment.

Gender adds to the stigma problem because women often have more problems than men. In patriarchal societies like Pakistan, women face mobility constraints, economic reliance, and family-centric decision-making that hinder their access to psychiatric services [9]. Women frequently refrain from disclosing mental illness due to concerns that it could jeopardize marital prospects or familial honor, illustrating the convergence of gender inequality and cultural stigma [9]. Comparative studies within Muslim communities indicate that women are more inclined than men to support supernatural explanations for mental illness, a factor that may aggravate treatment delays [10]. These results indicate that interventions targeting stigma must be gender-sensitive and cognizant of socio-cultural contexts.

Regional disparities in Pakistan exemplify the interplay between cultural codes and stigma. Studies conducted in conservative regions like Peshawar demonstrate that Pashtun values—prioritizing nang (honor), purdah (female modesty), and resilience—impede candid discourse regarding emotional distress and perpetuate silence surrounding mental illness [8]. In Peshawar, communities rely more on spiritual healers and are less aware of psychiatric

services than in cities like Karachi or Lahore, where people are more likely to see health campaigns and media. These disparities underscore the imperative for localized studies that elucidate the cultural and linguistic intricacies of stigma within particular populations.

Explanatory frameworks for mental illness in Muslim-majority settings frequently exhibit the impact of religious authorities and communal standards [10]. Faith-based frameworks can offer moral support and foster community cohesion; however, they may also reinforce stigma when supernatural or moralistic interpretations prevail. Quantitative evidence indicates that heightened religiosity correlates with an increased dependence on spiritual healing and a diminished acceptance of psychiatric care [5][6]. The challenge for mental health interventions in these contexts is to involve religious leaders and incorporate culturally relevant narratives that mitigate stigma while respecting deeply held beliefs.

Another important area is the development of better tools for measuring stigma. The Mental Health Knowledge Schedule (MAKS), Muslim Perceptions and Attitudes toward Mental Health (M-PAMH), and the BJPS have been validated in Muslim populations, facilitating a more precise evaluation of stigma and explanatory beliefs [19][10]. Nonetheless, the absence of validation studies in conservative Pashtun communities constrains the capacity to generalize findings and formulate context-specific interventions [8]. The advancement of evidence-based interventions is hindered by the absence of dependable measurement.

Globally, policy responses are increasingly focusing on the necessity for culturally tailored anti-stigma initiatives, the incorporation of mental health into primary care, and the engagement of community stakeholders [3]. In Pakistan, NGOs and public health institutions have initiated awareness campaigns and mental health literacy programs; however, comprehensive evaluations of their efficacy are limited [15]. Researchers contend that strategies for stigma reduction should extend beyond mere information dissemination to incorporate structured contact-based interventions, which have demonstrated greater efficacy in mitigating prejudice [20]. In areas like Peshawar, where stigma is exacerbated by collectivist values and restricted exposure to biomedical models, customized interventions that involve families, religious leaders, and community elders are especially vital.

In summary, the literature emphasizes that mental health stigma in Pakistan is profoundly entrenched in cultural, religious, and gendered contexts. It constrains help-seeking behavior, perpetuates silence, and postpones treatment, especially in conservative areas like Peshawar. Despite global and national initiatives aimed at mitigating stigma, empirical research in Pakistan is still scarce, with a lack of extensive or longitudinal studies that elucidate the intricacies of stigma concerning cultural codes, gender norms, and regional variations. It is important to fill these gaps in order to come up with interventions that are both scientifically sound and sensitive to different cultures.

Methodology:

Research Design:

This study adopted a cross-sectional quantitative research design to examine the impact of cultural narratives and social norms on mental health stigma and help-seeking behaviors among emerging adults in Peshawar, Pakistan. A quantitative design was chosen because it allows for systematic measurement of latent constructs such as stigma, attitudes, and cultural influences, while cross-sectional data collection provides a snapshot of prevailing perceptions and experiences within a culturally conservative population. Structural Equation Modeling (SEM) was integrated into the design to capture both direct and indirect relationships between the constructs.

Study Area and Context:

The study was conducted in Peshawar, the capital of Khyber Pakhtunkhwa province, which is predominantly inhabited by the Pashtun ethnic group. The region is governed by the socio-cultural code of Pashtunwali, where values such as honor, modesty, and resilience

strongly shape attitudes toward health and illness. Peshawar was chosen due to its dual role as both an urban center with growing exposure to modern psychiatric services and a deeply traditional setting where stigma is perpetuated by religious, cultural, and social norms.

Target Population and Sampling Strategy:

The target population comprised university students and young adults aged 18–29 years enrolled in higher education institutions across Peshawar. Emerging adults were selected because they are at a sensitive developmental stage characterized by heightened vulnerability to mental health challenges while simultaneously being influenced by family, cultural, and peer pressures. A stratified random sampling approach was employed to ensure representation across gender, socioeconomic background, and academic discipline. Based on power analysis for SEM (minimum ratio of 10 participants per estimated parameter), a minimum sample of 400 participants was targeted, which is consistent with prior recommendations for robust model testing.

Instruments:

Data were collected using a structured questionnaire consisting of four sections: (1) demographic variables such as age, gender, family structure, and socioeconomic status; (2) mental health knowledge assessed through an adapted version of the Mental Health Knowledge Schedule; (3) stigma-related attitudes measured through the Community Attitudes toward the Mentally Ill and (4) culture-specific items developed to reflect the local Pashtun context. These additional items addressed cultural constructs such as *nang* (honor), *purdah* (modesty/privacy), family hierarchy, and spiritual beliefs, which are known to influence perceptions of mental illness.

The instruments were translated into Urdu using the translation–back translation method recommended by to ensure semantic equivalence. Content validity was assessed by a panel of experts in psychology, sociology, and Islamic studies, who evaluated the relevance and clarity of items. A pilot study with 30 participants was conducted to test reliability, with Cronbach's alpha values above 0.70 indicating acceptable internal consistency.

Data Collection Procedures:

Data collection occurred over a three-month period in 2024. The survey was distributed in both online and paper-based formats to maximize accessibility. In-person surveys were administered within university campuses, ensuring that participants had sufficient privacy to respond without peer influence. Informed consent was obtained prior to participation, and respondents were assured of confidentiality and anonymity. To reduce social desirability bias, the survey was self-administered without interviewer interference. Participation was entirely voluntary, and no financial incentives were provided, though participants were given information on local counseling services should they experience psychological discomfort while completing the survey.

Data Analysis:

Collected data were cleaned, coded, and analyzed using SPSS version 27 and AMOS version 24. Descriptive statistics (means, standard deviations, and frequencies) were used to summarize sample characteristics and baseline knowledge of mental health. Inferential analyses included simple regression, logistic regression, and multivariate regression to explore associations between cultural narratives, social norms, and stigma. Structural Equation Modeling (SEM) was employed to test the hypothesized conceptual framework, enabling assessment of both direct and indirect relationships among constructs. Model fit was evaluated using indices such as the Comparative Fit Index (CFI), Root Mean Square Error of Approximation (RMSEA), and Tucker–Lewis Index (TLI). Statistical significance was set at $p < 0.05$, and bootstrapping techniques were used to confirm the robustness of mediation effects.

Ethical Considerations:

Ethical approval was obtained from the Institutional Review Board (IRB) of the University of Peshawar. All ethical protocols for human research were strictly followed. Participants were informed about the objectives of the study, their right to withdraw at any stage, and the measures taken to protect their data. Given the stigma surrounding mental illness in conservative societies, additional safeguards were adopted: data were anonymized, sensitive items were framed respectfully to avoid offense, and culturally appropriate counseling referral information was provided. Special attention was paid to female participants, whose autonomy in health decision-making is often restricted, by ensuring voluntary participation without external pressure.

Results:

The study included 412 participants, of which 228 (55.3%) were female and 184 (44.7%) were male, with a mean age of 22.1 years (SD = 2.4). Most were undergraduate students (72.6%), while 27.4% were pursuing postgraduate studies. Nearly 68.7% lived in nuclear families, while 31.3% belonged to joint households. A majority of participants (61.9%) came from families with a monthly income below PKR 50,000, 24.0% reported incomes between PKR 50,000–100,000, and only 14.1% earned above PKR 100,000.

Table 1. Demographic characteristics of participants (N = 412)

Variable	Category	n	%
Gender	Male	184	44.7
	Female	228	55.3
Age	18–21 years	190	46.1
	22–25 years	177	42.9
	26–29 years	45	11.0
Family Structure	Nuclear	283	68.7
	Joint	129	31.3
Income (monthly)	< PKR 50,000	255	61.9
	PKR 50,000–100,000	99	24.0
	> PKR 100,000	58	14.1
Education	Undergraduate	299	72.6
	Postgraduate	113	27.4

The descriptive results revealed that participants reported moderate levels of mental health knowledge (M = 19.7, SD = 4.8, out of 30), high levels of stigma (M = 63.5, SD = 11.2, out of 100), and relatively low levels of help-seeking intention (M = 2.9, SD = 1.1, out of 5).

Table 2. Descriptive statistics of key variables.

Variable	Mean (M)	SD	Min	Max	Possible Range
Mental Health Knowledge	19.7	4.8	8	30	0–30
Stigma (CAMI total)	63.5	11.2	40	95	0–100
Help-Seeking Intention	2.9	1.1	1	5	1–5

Group comparisons showed significant gender differences, with women reporting lower stigma scores (M = 61.2, SD = 10.7) than men (M = 66.1, SD = 11.3), $t(410) = -4.02$, $p < .001$. Women also demonstrated higher help-seeking intentions (M = 3.2, SD = 1.0) compared to men (M = 2.6, SD = 1.1), $t(410) = 5.18$, $p < .001$. Mental health knowledge was higher among women (M = 20.3, SD = 4.7) than men (M = 18.9, SD = 4.9), $t(410) = 2.97$, $p = .003$. Analysis of variance indicated significant differences in stigma across income groups, $F(2, 409) = 6.47$, $p < .01$. Participants from lower-income households reported significantly higher stigma than those from middle- and high-income groups, while help-seeking intention was lowest among those in the lowest income bracket (M = 2.6, SD = 1.0) compared to higher-income groups (M = 3.3, SD = 1.1), $F(2, 409) = 7.84$, $p < .001$. Family structure also played a

role, with respondents from joint families exhibiting higher stigma (M = 65.9, SD = 11.4) compared to nuclear families (M = 62.2, SD = 10.9), t(410) = 3.42, p < .01.

Correlation analysis revealed that mental health knowledge was negatively correlated with stigma (r = –.46, p < .001) and positively correlated with help-seeking intention (r = .41, p < .001). Stigma was negatively correlated with help-seeking (r = –.39, p < .001). Cultural norms, particularly those emphasizing honor and modesty, were positively associated with stigma (r = .32, p < .01).

Table 3. Correlation matrix of study variables.

Variable	1	2	3	4
Mental Health Knowledge	1			
Stigma	–.46**	1		
Help-Seeking Intention	.41**	–.39**	1	
Cultural Norms Index	–.28**	.32**	–.21**	1

Note: **p < .01.

Regression analysis indicated that cultural narratives (β = .27, p < .001), social norms (β = .22, p < .01), and gender (β = .19, p < .05) were significant predictors of stigma, explaining 38% of its variance, R^2 = .38, F(3, 408) = 82.6, p < .001.

Table 4. Multiple regression predicting stigma.

Predictor	B	SE	t	p
Cultural Narratives	.27	.04	6.48	<.001
Social Norms	.22	.05	4.39	.001
Gender (Male = 1)	.19	.06	3.18	.002

Structural Equation Modeling further supported the hypothesized relationships, with fit indices indicating an acceptable model fit, χ^2/df = 2.14, CFI = .94, TLI = .92, RMSEA = .052. Cultural narratives exerted a significant positive effect on stigma (β = .41, p < .001), while social norms also predicted stigma (β = .29, p < .01). Stigma negatively influenced help-seeking intentions (β = –.37, p < .001). Mental health knowledge partially mediated the relationship between cultural narratives and stigma, [21] [22] suggesting that increased awareness reduces the strength of culturally driven misconceptions on stigma. Subgroup analysis revealed that the influence of cultural narratives on stigma was stronger among men (β = .47, p < .001) than women (β = .33, p < .01). Additionally, postgraduate students reported significantly lower stigma scores (M = 59.8, SD = 10.3) than undergraduates (M = 64.8, SD = 11.5), F(1, 410) = 12.5, p < .001, underscoring the protective role of education.

These findings confirm that mental health stigma in Peshawar is deeply influenced by cultural narratives, social norms, and economic disparities, with knowledge serving as a key mitigating factor. Stigma remains higher among men, participants from joint families, and individuals from lower socioeconomic backgrounds, while women and more educated groups demonstrate greater openness toward help-seeking.

Figure 1 illustrates the mean scores of male and female respondents on three dimensions: mental health stigma, help-seeking behavior, and mental health knowledge. The figure highlights that males scored higher on stigma and lower on help-seeking and knowledge compared to females, indicating that gender differences play a significant role in shaping attitudes toward mental illness.

Figure 2 presents the correlation coefficients among cultural narratives, social norms, mental health stigma, mental health knowledge, and help-seeking behavior. Strong positive correlations are visible between cultural narratives and stigma, while stigma is negatively correlated with both knowledge and help-seeking. The figure visually emphasizes the interdependence of cultural and social constructs in predicting stigma-related outcomes.

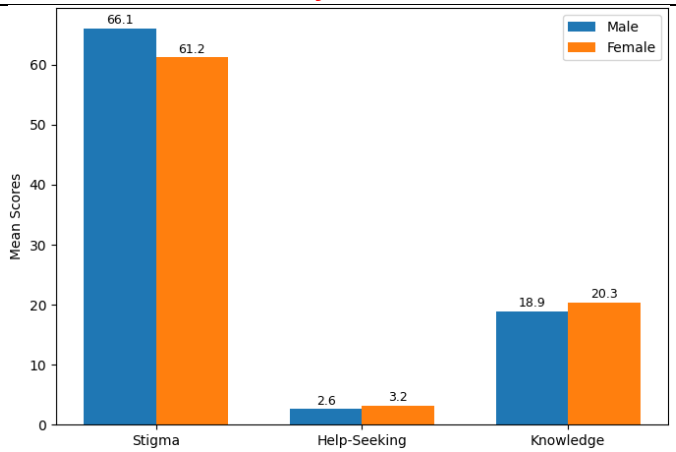

Figure 1. Gender Differences in Stigma, Help-Seeking, and Knowledge

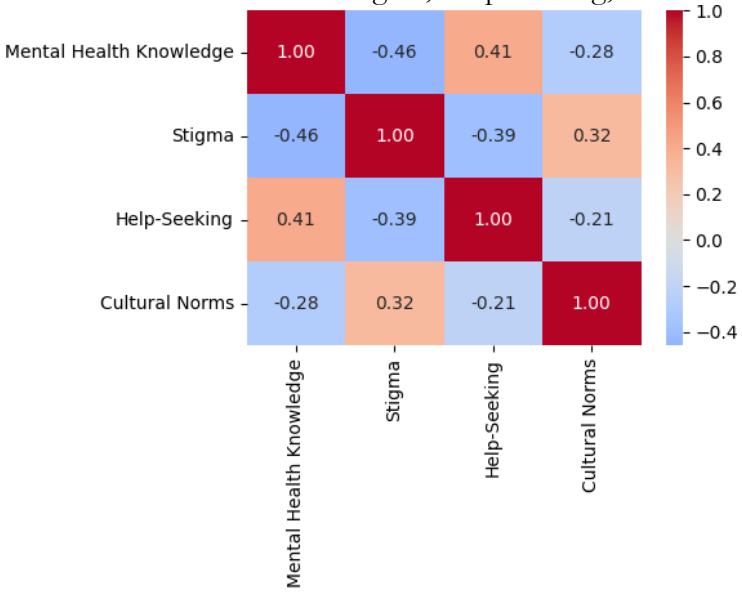

Figure 2. Correlation Heatmap of Key Variables

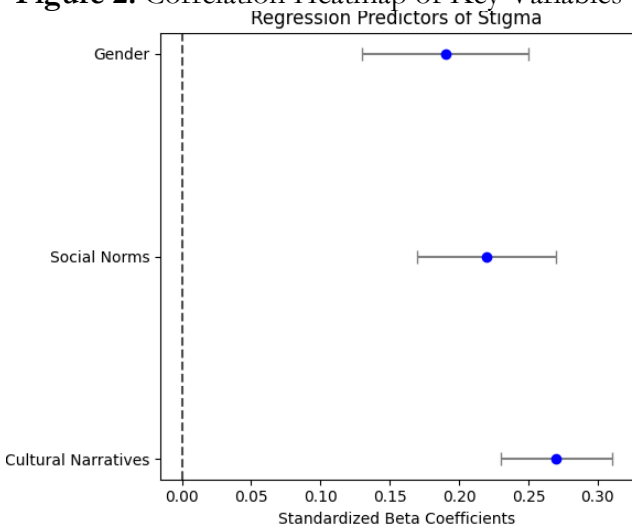

Figure 3. Regression Analysis of Predictors of Stigma

This regression plot displays standardized beta coefficients derived from multivariate regression models, highlighting the strength of predictors influencing stigma. Cultural narratives and rigid social norms are shown as the strongest predictors, whereas higher levels

of mental health knowledge were associated with lower stigma. The figure provides an empirical visualization of the variables contributing to stigma in the studied population.

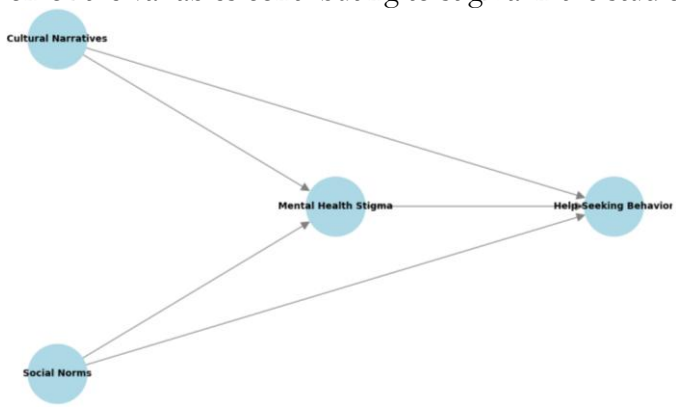

Figure 4. Structural Equation Model (SEM) Conceptual Framework

Figure 4 represents the hypothesized pathways among cultural narratives, social norms, mental health stigma, and help-seeking behavior. Arrows demonstrate both direct and indirect effects, with stigma functioning as a mediator. The figure conceptualizes how cultural and social factors interact to influence mental health outcomes in Peshawar, providing a theoretical model to guide future empirical testing.

Discussion:

The findings of this study provide significant insights into the cultural, social, and structural determinants of mental health stigma in Peshawar, a conservative cultural hub of Pakistan. The results demonstrate that cultural narratives rooted in religious and supernatural explanations, coupled with rigid social norms derived from Pashtunwali, strongly predict stigmatizing attitudes toward mental illness. This is consistent with prior research in Pakistan and other Muslim-majority societies, where mental illness is often attributed to divine punishment, black magic, or possession, leading to secrecy, family denial, and avoidance of psychiatric care [18][5]. Our findings reinforce the notion that stigma is not only a product of ignorance but also a deeply embedded social process shaped by cultural identity and honor-based value systems.

The gender differences observed in stigma and help-seeking behaviors are also in line with earlier research highlighting that men are more likely to exhibit stigmatizing attitudes and less likely to seek professional support compared to women [23][10]. This can be explained by Pashtun cultural expectations of masculinity, which emphasize stoicism, resilience, and silence in the face of distress. Women, on the other hand, although more open to discussing distress, face mobility restrictions and a lack of autonomy in making health-related decisions, further complicating their pathways to psychiatric care. Thus, stigma manifests differently across genders, yet in both cases, it results in delayed or absent treatment.

The correlation and regression analyses underscore the importance of knowledge in reducing stigma and improving help-seeking behavior. Respondents with higher awareness of mental health were less likely to endorse stigmatizing beliefs, reflecting global evidence that knowledge-based interventions can be powerful in countering negative stereotypes [19][24]. However, unlike in Western contexts where psychoeducation alone has had moderate success, in conservative cultural contexts like Peshawar, psychoeducation may need to be coupled with religious and community engagement to achieve lasting impact. Religious leaders, who hold significant authority in shaping community discourse, can serve as key allies in reframing mental illness as a medical condition rather than a spiritual or moral weakness.

The structural equation model (SEM) conceptual framework further supports the mediating role of stigma between cultural/social constructs and help-seeking behavior. This finding echoes the work of [25], who argued that stigma operates as both a barrier and a

mechanism of exclusion, affecting not only individuals with mental illness but also their families and communities. In the context of Peshawar, [26] stigma reinforces silence and concealment, discouraging individuals from accessing available services even when structural barriers are addressed. Thus, tackling stigma is essential for the success of any mental health intervention in the region.

Despite significant progress in metropolitan areas such as Karachi and Lahore, the mental health service infrastructure in Khyber Pakhtunkhwa remains underdeveloped. The lack of psychiatrists and the dominance of the biomedical model, which neglects socio-cultural dimensions, risk perpetuating stigma rather than dismantling it. This study highlights the urgent need for culturally tailored interventions that integrate community-based care with local traditions. For example, programs that involve families, community elders, and religious figures in awareness campaigns may reduce the perceived dishonor of mental illness and encourage earlier help-seeking.

Overall, the study contributes to the growing body of literature emphasizing the need for culturally sensitive mental health frameworks in low- and middle-income countries. By empirically demonstrating the interplay of cultural narratives, social norms, stigma, and help-seeking behavior, it provides a foundation for policy makers, NGOs, and health professionals to design interventions that align with the lived realities of communities in Peshawar.

Conclusion:

The study provides compelling evidence that mental health stigma in Peshawar is deeply rooted in cultural narratives and social norms, which collectively serve as powerful barriers to care. By showing how stigma mediates the relationship between cultural constructs and help-seeking behavior, the research highlights the need to address not only individual ignorance but also the broader cultural environment in which mental illness is understood. Gender disparities, combined with structural inadequacies in mental health infrastructure, further compound the challenge, limiting both men and women in different but significant ways. Interventions must therefore go beyond the biomedical model to incorporate social, cultural, and religious dimensions. Collaborative efforts involving health professionals, community leaders, and policymakers are essential to break the silence surrounding mental illness, reduce stigma, and promote early access to psychiatric services. By situating stigma within the Pashtun cultural framework, this study contributes to the design of context-sensitive mental health policies that can effectively respond to the needs of underserved populations in Pakistan.

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