QUALITATIVE RESEARCH JOURNAL FOR SOCIAL STUDIES
ISSN Online: 3006-4686, ISSN Print: 3006-4678
Volume No: 03 Issue No: 01 (2026)

HOW YOUNG ADULTS IN PAKISTAN EXPERIENCE MENTAL HEALTH STIGMA AND DECIDE TO SEEK HELP: A QUALITATIVE STUDY

Pulwasha Anwar[1], Yumna Siddiqui[2], Nimra Abbas[3], Shah Fahad[4], Irzam Kainat Rana[5]
[1] PhD Scholar, Department of Psychology, Bursa Uludag University, Turkey
[2] Private Practitioner, Family Medicine, Liaquat National Hospital and Medical College, Karachi, Pakistan
[3] MPhil Psychology Student, National University of Medical Sciences (NUMS), Pakistan
[4] Counselling Psychologist, Multiverse Mind Care Clinic, Swabi, Pakistan
[5] Research Associate, University of Central Punjab, Pakistan
Corresponding Author
Pulwasha Anwar
Email: pulwashakhansrk@gmail.com

Abstract
Mental health stigma remains a pervasive barrier to help-seeking, particularly in collectivistic societies such as Pakistan, where cultural norms, family honor, and religious interpretations shape responses to psychological distress. Despite growing awareness, young adults continue to face persistent barriers in accessing professional mental health support. However, existing research has largely relied on quantitative approaches, offering limited insight into the lived experiences and decision-making processes underlying help-seeking.
This study aimed to examine how young adults in Pakistan experience mental health stigma and how these experiences influence their help-seeking pathways. A qualitative research design was employed using reflexive thematic analysis. Semi-structured interviews were conducted with 16 young adults (aged 18–29), recruited through purposive sampling from urban and rural backgrounds. Data were collected bilingually (Urdu and English) and analyzed following Braun and Clarke's six-phase framework.
Four interconnected themes emerged: (1) internalized and anticipated stigma, (2) family honor and social surveillance, (3) religious and moral interpretations of mental health, and (4) delayed and negotiated help-seeking pathways. Findings demonstrate that stigma operates across intrapersonal, interpersonal, and socio-cultural levels, leading to concealment, self-reliance, and delayed engagement with professional services.
The study highlights the need for culturally sensitive, family-inclusive, and awareness-driven interventions to reduce stigma and improve mental health service utilization among young adults in Pakistan.

Keywords: Mental health stigma; Help-seeking pathways; Young adults; Pakistan; Reflexive thematic analysis; Cultural context; Qualitative research

Introduction
Mental health disorders constitute a substantial and growing component of the global burden of disease, with early onset and long-term functional consequences if left unaddressed (World Health Organization [WHO], 2022). Despite increasing recognition of mental health as integral to overall well-being, help-seeking for psychological difficulties remains disproportionately low in low- and middle-income countries (LMICs), including Pakistan (Patel et al., 2018). Among the multiple barriers identified, stigma consistently emerges as a central and enduring impediment to accessing professional support (Corrigan et al., 2014).
Stigma surrounding mental illness is a multifaceted construct encompassing public stigma, self-stigma, and structural stigma, each operating across different layers of social life and influencing attitudes, behaviors, and institutional responses (Hatzenbuehler & Link, 2014). In collectivistic societies, these dimensions are intensified by cultural expectations emphasizing social conformity, family honor, and preservation of reputation (Hofstede, 2001). Within the Pakistani context, psychological distress is often interpreted through moral and religious frameworks, where symptoms may be attributed to weak faith, supernatural causes, or personal shortcomings rather than recognized as legitimate health concerns (Karim et al., 2004). Such

QUALITATIVE RESEARCH JOURNAL FOR SOCIAL STUDIES
ISSN Online: 3006-4686, ISSN Print: 3006-4678
Volume No: 03 Issue No: 01 (2026)

interpretations contribute to the marginalization of individuals experiencing distress and discourage engagement with formal mental health services.

The influence of stigma in Pakistan extends beyond the individual and is deeply embedded within family systems. Mental illness is frequently perceived as a threat to collective social standing, leading to concealment, delayed disclosure, and avoidance of professional care (Zafar et al., 2008). Family members often act as gatekeepers to help-seeking, particularly for young adults, shaping decisions through approval, restriction, or negotiation (Gulliver et al., 2010). Concerns regarding social judgment, marriage prospects, and reputational consequences further reinforce these barriers, highlighting the interpersonal nature of stigma in culturally embedded contexts (Khan et al., 2010). Religious and spiritual interpretations also intersect with these dynamics, as individuals may prioritize faith-based coping or spiritual healing, which, while meaningful, can delay access to evidence-based treatment when used as a sole explanatory framework (Ullah et al., 2021; Koenig, 2012).

At the intrapersonal level, stigma is internalized, affecting how individuals perceive themselves and their distress. Internalized stigma has been associated with reduced self-esteem, diminished self-efficacy, and increased shame, often leading individuals to avoid or delay seeking help even when experiencing significant psychological difficulties (Livingston & Boyd, 2010; Clement et al., 2015). Help-seeking, therefore, is not a singular act but a dynamic and staged process involving recognition of distress, evaluation of options, and engagement with services, all of which are shaped by personal beliefs and social context (Rickwood et al., 2005). In stigmatizing environments, individuals may struggle to progress through these stages due to anticipated discrimination, fear of labeling, and internal conflict between personal needs and societal expectations (Ajzen, 1991).

Young adulthood represents a critical period for examining these processes, as a substantial proportion of mental health disorders emerge before the age of 30 (Kessler et al., 2005). In Pakistan, young adults navigate a complex intersection of traditional cultural norms and rapidly evolving social influences, including increased access to digital media and mental health information. Emerging evidence suggests that exposure to mental health content through digital platforms may improve awareness and attitudes toward help-seeking, although it may also introduce misinformation and oversimplified understandings of psychological distress (Naslund et al., 2020; O'Reilly et al., 2018). This evolving landscape positions young adults as both recipients and negotiators of changing stigma narratives.

Despite growing research on mental health stigma and help-seeking, significant gaps remain in the Pakistani context. Much of the existing literature relies on quantitative methodologies that assess attitudes and intentions, offering limited insight into how stigma is subjectively experienced and negotiated in everyday life (Jorm, 2012). There is a lack of qualitative, process-oriented research that captures the complexity of help-seeking as a lived and evolving experience, particularly among young adults situated within culturally and socially embedded systems.

In response to these gaps, the present study aims to explore how young adults in Pakistan experience mental health stigma and how these experiences shape their help-seeking decisions. By adopting a qualitative approach grounded in reflexive thematic analysis, this study seeks to provide a culturally contextualized and process-oriented understanding of stigma and help-seeking, contributing to the development of more effective and culturally sensitive mental health interventions.

Research Questions

1. How do young adults in Pakistan experience and interpret mental health stigma?
2. How does mental health stigma influence their decisions regarding seeking professional psychological help?

QUALITATIVE RESEARCH JOURNAL FOR SOCIAL STUDIES
ISSN Online: 3006-4686, ISSN Print: 3006-4678
Volume No: 03 Issue No: 01 (2026)

3. What socio-cultural, familial, and religious factors shape the help-seeking pathways of young adults in Pakistan?
4. How do young adults negotiate stigma when deciding whether to seek, delay, or avoid mental health support?
5. What turning points or critical experiences facilitate the transition from psychological distress to active help-seeking?

Method

Research Design

This study employed a qualitative research design to explore the lived experiences of mental health stigma and help-seeking among young adults in Pakistan. A qualitative approach was deemed appropriate as the study aimed to capture subjective meanings, personal narratives, and culturally embedded interpretations that cannot be adequately examined through quantitative methods. Specifically, **reflexive thematic analysis** was utilized, following the framework proposed by Braun and Clarke, to identify patterns of meaning across participants' accounts.

Reflexive thematic analysis was selected due to its theoretical flexibility and suitability for examining complex, context-dependent phenomena such as stigma and help-seeking. This approach allows for an interpretative engagement with the data, acknowledging the active role of the researcher in meaning-making while remaining sensitive to participants' voices and socio-cultural context. The study adopts an interpretivist epistemological stance, emphasizing subjective meaning-making and the co-construction of reality between researcher and participants.

Participants

The study included **16 young adults** aged **18–29 years**, consistent with global definitions of young adulthood provided by international health frameworks. Participants were recruited from **urban and semi-urban areas of Pakistan** and represented diverse educational and socio-economic backgrounds. The sample consisted of both **male and female participants**, allowing for exploration of gendered experiences of stigma.

Inclusion criteria were: (a) age between 18 and 29 years, (b) self-reported experience of psychological distress (e.g., anxiety, low mood, stress), and (c) willingness to discuss personal experiences related to mental health and help-seeking. Individuals currently experiencing severe psychiatric conditions requiring immediate intervention were not included to ensure ethical appropriateness of participation.

Sampling Strategy

A **purposive sampling** strategy combined with **maximum variation sampling** was employed to ensure diversity in participants' experiences across gender, background, and socio-cultural contexts. This approach was considered appropriate for qualitative inquiry as it facilitates the inclusion of information-rich cases that can provide in-depth insights into the phenomenon under study. Maximum variation further strengthened the analytical depth by capturing a range of perspectives, enhancing the transferability of findings.

Data Collection

Data were collected through **semi-structured, in-depth interviews**, allowing flexibility to explore participants' experiences while maintaining consistency across key topics. Interviews were conducted using a **hybrid mode**, including both online platforms (e.g., Zoom/WhatsApp) and, where feasible, in-person interactions.

Interviews were conducted in a **bilingual format (Urdu and English)** to ensure participants could express themselves comfortably and authentically. Each interview lasted approximately **45–60 minutes**. The interview protocol included open-ended questions exploring perceptions

QUALITATIVE RESEARCH JOURNAL FOR SOCIAL STUDIES
ISSN Online: 3006-4686, ISSN Print: 3006-4678
Volume No: 03 Issue No: 01 (2026)

of mental health, experiences of stigma, family and societal influences, and help-seeking decisions.

Interview Guide

A semi-structured interview guide was developed based on existing literature and theoretical frameworks related to stigma and help-seeking. The guide included broad thematic areas such as personal understanding of mental health, experiences of stigma (self, family, societal), coping strategies, and decision-making processes related to seeking help. Probing questions were used to elicit deeper reflections and clarify responses.

Procedure

Participants were recruited through social media platforms and informal networks using invitation messages outlining the purpose of the study. Interested individuals contacted the researcher voluntarily. Prior to participation, informed consent was obtained, and participants were briefed about the study's aims, confidentiality, and their right to withdraw at any time.

Interviews were scheduled at participants' convenience and conducted in a private setting to ensure comfort and openness. All interviews were audio-recorded with permission and later transcribed verbatim. Transcripts were anonymized to protect participants' identities.

Data Analysis

Data were analyzed using **reflexive thematic analysis** following Braun and Clarke's six-phase approach: (1) familiarization with the data, (2) generation of initial codes, (3) construction of themes, (4) review of themes, (5) definition and naming of themes, and (6) production of the report. Analysis was iterative and recursive, allowing themes to evolve through continuous engagement with the data.

A reflexive approach was maintained throughout, acknowledging the researcher's interpretative role and ensuring that analysis remained grounded in participants' accounts while being theoretically informed.

Trustworthiness / Rigor

To ensure methodological rigor, several strategies were employed:

- **Credibility:** Prolonged engagement with the data and use of rich, verbatim quotations enhanced the authenticity and accuracy of interpretations.
- **Dependability:** A systematic and transparent analytic process was followed, with clear documentation of coding and theme development.
- **Reflexivity:** The researcher engaged in ongoing self-reflection to acknowledge potential biases and their influence on data interpretation.
- **Transparency:** Detailed descriptions of the research process, sampling, and analysis were provided to allow for evaluation and potential replication.

Ethical Considerations

Ethical standards were strictly maintained throughout the study. **Informed consent** was obtained from all participants prior to data collection. Participants were assured of **confidentiality and anonymity**, and identifying information was removed from transcripts. Participation was voluntary, and individuals had the right to withdraw at any stage without consequence.

Where applicable, the study adhered to institutional ethical guidelines, and approval was obtained or deemed not required based on the nature of the research. Participants were also provided with information about mental health support resources in case discussing their experiences caused discomfort.

Results

The analysis generated four interrelated themes that capture how young adults in Pakistan experience mental health stigma and navigate their help-seeking decisions. These themes reflect the multi-level nature of stigma, operating across intrapersonal, interpersonal, and socio-

cultural domains. Participants' narratives reveal that help-seeking is not a linear process but a negotiated pathway shaped by internal conflict, family dynamics, and broader cultural and religious frameworks.

Theme 1: Internalized and Anticipated Stigma

Participants described stigma not only as something imposed by society but also as something deeply internalized. Many reported feelings of shame, self-doubt, and fear of being labeled as "weak" or "mentally unstable." Anticipated stigma—expectations of negative judgment—often prevented individuals from openly acknowledging their distress or seeking help.

Participants frequently minimized their own struggles, interpreting them as personal failings rather than legitimate mental health concerns.

"I felt like maybe I'm just overreacting… like I should be stronger instead of thinking something is wrong with me." (P3)

"Even before telling anyone, I was already judging myself… like what if they think I'm crazy?" (P11)

This internal conflict created a barrier at the earliest stage of help-seeking, delaying recognition and acceptance of the need for support.

This suggests that stigma is internalized early in the help-seeking process, shaping self-perceptions before individuals engage with external support systems.

Theme 2: Family Honor and Social Surveillance

Family emerged as a central influence, often acting as both a source of support and a barrier to help-seeking. Participants described a strong sense of **social surveillance**, where their actions were perceived as reflecting on the family's reputation. Concerns about "log kya kahenge" (what will people say) were prominent.

Seeking psychological help was often viewed as a risk to family honor, particularly in relation to marriage prospects and social image.

"In our family, if someone goes to a psychologist, it becomes a big issue… like people will start talking." (P7)

"My parents said it's better to keep these things inside, otherwise it can affect my future rishta." (P2)

As a result, help-seeking decisions were not purely individual but required negotiation within family structures, often leading to concealment or delay.

This indicates that help-seeking decisions are socially regulated, reflecting the collective nature of identity and decision-making in the Pakistani context.

Theme 3: Religious and Moral Framing of Mental Health

Participants highlighted the strong influence of religious and moral interpretations in shaping their understanding of mental health. Distress was often framed as a result of weak faith, lack of religious practice, or spiritual trials.

While some participants found comfort in religious coping, others felt that such interpretations invalidated their experiences and discouraged professional help-seeking.

"People told me to pray more and everything will be fine… but I felt like my problem was deeper than that." (P9)

"Sometimes I thought maybe it's my fault, like I'm not close enough to God, that's why I feel this way." (P14)

This moral framing contributed to self-blame and reinforced stigma, making it more difficult for individuals to conceptualize their distress as a psychological issue requiring professional support.

This highlights how moral and religious interpretations can simultaneously provide meaning and reinforce stigma, complicating pathways to professional care.

QUALITATIVE RESEARCH JOURNAL FOR SOCIAL STUDIES
ISSN Online: 3006-4686, ISSN Print: 3006-4678
Volume No: 03 Issue No: 01 (2026)

Theme 4: Delayed and Negotiated Help-Seeking Pathways

Help-seeking emerged as a **delayed and negotiated process**, often initiated only when distress reached a critical threshold. Participants described prolonged periods of self-reliance, avoidance, or informal coping before considering professional help.

Turning points included worsening symptoms, functional impairment, or encouragement from trusted individuals.

"I kept ignoring it for months, thinking it will go away… but when it started affecting my studies, I realized I need help." (P5)

"A friend told me it's okay to talk to someone, that's when I started thinking maybe I should try therapy." (P12)

In some cases, exposure to mental health content on social media played a role in normalizing help-seeking and reducing stigma.

"Seeing posts about anxiety and therapy online made me feel like I'm not alone… it made it easier to accept that I need help." (P16)

Despite these shifts, help-seeking remained a complex decision influenced by ongoing negotiation between personal needs and socio-cultural constraints.

This demonstrates that help-seeking is a threshold-based and iterative process rather than a linear decision, shaped by both internal realization and external validation.

Discussion

The present study explored how young adults in Pakistan experience mental health stigma and how these experiences shape their help-seeking decisions. The findings reveal that stigma operates as a multi-layered and dynamic process, influencing individuals at intrapersonal, interpersonal, and socio-cultural levels. Across participants' accounts, help-seeking did not emerge as a straightforward or immediate response to distress; rather, it was a delayed and negotiated pathway shaped by internalized stigma, family expectations, religious interpretations, and evolving social influences. Notably, the identification of turning points—such as functional impairment or external validation—highlights the threshold-based nature of help-seeking among young adults.

These findings are consistent with existing literature that conceptualizes stigma as a multifaceted construct encompassing internalized, anticipated, and public dimensions, all of which contribute to reduced service utilization (Corrigan et al., 2014; Hatzenbuehler & Link, 2014). The prominence of internalized and anticipated stigma in participants' narratives aligns with prior research indicating that individuals often adopt societal stereotypes, leading to shame, self-doubt, and reluctance to seek help (Livingston & Boyd, 2010; Clement et al., 2015). However, the current study extends this literature by demonstrating how these internal processes are not static but actively negotiated, with individuals oscillating between recognition of distress and resistance to labeling themselves as "mentally ill."

The role of family as both a barrier and a regulatory force further supports research highlighting the interpersonal nature of stigma in collectivistic contexts (Gulliver et al., 2010; Khan et al., 2010). Participants' concerns about family honor, reputation, and marriage prospects reflect broader socio-cultural dynamics in which individual behavior is closely tied to collective identity. This finding reinforces the argument that help-seeking in such contexts cannot be understood solely as an individual decision but must be viewed as a relational process embedded within family systems. The concept of "social surveillance" identified in this study adds nuance to existing literature by illustrating how perceived observation and judgment from others shape behavioral choices even in the absence of direct interaction.

Religious and moral framing of mental health also emerged as a significant theme, consistent with previous findings that psychological distress in Pakistan is often interpreted through spiritual or moral lenses (Ullah et al., 2021; Koenig, 2012). While religious coping can serve

as a protective factor, the present findings suggest that when distress is exclusively framed in moral or spiritual terms, it may contribute to self-blame and delay professional help-seeking. This dual role of religion—as both a resource and a barrier—highlights the complexity of culturally embedded belief systems and underscores the need for integrative approaches that respect religious values while promoting psychological understanding.

From a theoretical perspective, the findings support and extend process-oriented models of help-seeking, which conceptualize it as a multi-stage pathway involving problem recognition, intention formation, and service engagement (Rickwood et al., 2005). The data illustrate how stigma disrupts progression through these stages, particularly at the level of problem recognition and intention formation. Additionally, elements of the Theory of Planned Behavior are reflected in participants' accounts, where perceived social norms and anticipated consequences influence behavioral intentions (Ajzen, 1991). By integrating these frameworks with stigma theory, the study provides a more comprehensive understanding of how cognitive, social, and cultural factors interact to shape help-seeking decisions.

Importantly, the study contributes a culturally grounded perspective by situating stigma within the broader socio-cultural context of Pakistan. The findings highlight how collectivism, family honor, and gender norms intersect to create unique patterns of stigma and help-seeking. For instance, women's concerns about reputational damage and marital prospects, alongside men's pressure to suppress emotional vulnerability, reflect deeply ingrained gendered expectations that influence both the expression of distress and willingness to seek support. These insights emphasize that stigma is not merely an individual or psychological phenomenon but a socially constructed experience embedded within cultural systems.

Furthermore, the emerging role of digital media as a facilitator of awareness and normalization reflects ongoing societal shifts. Participants' references to social media as a source of validation and information suggest that younger generations may be renegotiating traditional stigma narratives. This aligns with recent research indicating that digital platforms can enhance mental health literacy and reduce stigma, although their impact remains complex and context-dependent (Naslund et al., 2020; O'Reilly et al., 2018). In the present study, digital exposure appeared to function as a bridge between private distress and public discourse, enabling individuals to reconsider help-seeking as a viable option.

Overall, the findings underscore that mental health stigma in Pakistan is not a static barrier but an evolving, contextually embedded process that shapes and is shaped by individual, familial, and societal dynamics. Understanding this complexity is essential for developing interventions that move beyond awareness-raising toward addressing the relational and cultural dimensions of stigma.

This study contributes to the literature by conceptualizing help-seeking as a culturally negotiated and non-linear process, rather than an individual and immediate response to psychological distress.

Implications

Clinical Implications

The findings highlight the need for **culturally sensitive and contextually grounded therapeutic approaches** in Pakistan. Mental health professionals should explicitly address **internalized stigma** within therapy, helping clients reframe self-blame and normalize psychological distress. Given the strong influence of family systems, **family-inclusive interventions** may enhance treatment acceptance and adherence, particularly for young adults whose help-seeking decisions are often negotiated within familial contexts. Additionally, integrating **religiously informed therapeutic practices**—where appropriate—may help bridge the gap between spiritual beliefs and psychological care, reducing resistance to professional services.

QUALITATIVE RESEARCH JOURNAL FOR SOCIAL STUDIES
ISSN Online: 3006-4686, ISSN Print: 3006-4678
Volume No: 03 Issue No: 01 (2026)

Policy Implications

At the policy level, there is a critical need to strengthen **community-based mental health services** that are accessible, affordable, and culturally appropriate. Public health campaigns should move beyond general awareness and specifically target **stigma reduction at the family and community levels**, addressing misconceptions related to honor, morality, and mental illness. Incorporating mental health education into **school and university curricula** can promote early awareness and normalize help-seeking among young adults. Furthermore, policies should support the integration of mental health into **primary healthcare systems**, reducing structural barriers and improving service reach in both urban and semi-urban areas.

Social Implications

The study underscores the importance of shifting societal narratives around mental health. Community-level initiatives, including **media campaigns and digital advocacy**, can play a pivotal role in challenging stigma and promoting open dialogue. Given the influence of social media identified in this study, leveraging **digital platforms** to disseminate accurate, culturally relevant mental health information may help reshape attitudes among younger populations. Efforts should also focus on addressing **gendered norms**, encouraging emotional expression among men and reducing reputational pressures faced by women.

Limitations

Several limitations should be considered when interpreting the findings of this study. First, the sample size was relatively small and limited to young adults, which may restrict the generalizability of findings to other age groups or populations. Second, participants were primarily recruited through online platforms, which may have resulted in the inclusion of individuals with greater access to digital resources and potentially higher mental health awareness. Third, as with all qualitative research, findings are based on self-reported experiences and may be influenced by participants' willingness to disclose sensitive information.

Additionally, the study reflects the interpretative role of the researcher inherent in reflexive thematic analysis. While efforts were made to ensure rigor and transparency, alternative interpretations of the data may be possible. Despite these limitations, the study provides valuable, in-depth insights into the lived experiences of mental health stigma and help-seeking in a culturally specific context.

Future Directions

Future research should expand on these findings by including **larger and more diverse samples**, particularly from rural and underserved populations, to capture a broader range of experiences. Longitudinal studies may provide further insight into how help-seeking pathways evolve over time and in response to changing social dynamics. Additionally, mixed-methods research could complement qualitative findings by examining the relationship between stigma and help-seeking at a population level.

Given the emerging role of digital media, future studies should explore how **online mental health content influences attitudes, beliefs, and behaviors** in more depth. Research examining **intervention-based approaches**, such as stigma reduction programs or family-focused mental health education, would also be valuable in translating findings into practice.

Conclusion

This study provides a nuanced, culturally grounded understanding of how mental health stigma shapes help-seeking among young adults in Pakistan. By highlighting stigma as a dynamic and multi-level process embedded within personal, familial, and societal contexts, the findings emphasize the need for interventions that move beyond individual awareness toward addressing broader cultural and relational factors. Promoting accessible, culturally responsive

mental health care is essential for improving help-seeking and overall psychological well-being in Pakistan.

References

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5–14. https://doi.org/10.1037/0003-066X.58.1.5

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? *Psychological Medicine, 45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16–20.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people. *BMC Psychiatry, 10*, 113. https://doi.org/10.1186/1471-244X-10-113

Hatzenbuehler, M. L., & Link, B. G. (2014). Introduction to the special issue on structural stigma. *Social Science & Medicine, 103*, 1–6. https://doi.org/10.1016/j.socscimed.2013.12.017

Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions and organizations across nations* (2nd ed.). Sage.

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action. *American Psychologist, 67*(3), 231–243. https://doi.org/10.1037/a0025957

Karim, S., Saeed, K., Rana, M. H., Mubbashar, M. H., & Jenkins, R. (2004). Pakistan mental health country profile. *International Review of Psychiatry, 16*(1–2), 83–92. https://doi.org/10.1080/09540260310001635131

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders. *Archives of General Psychiatry, 62*(6), 593–602. https://doi.org/10.1001/archpsyc.62.6.593

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry, 2012*, 278730. https://doi.org/10.5402/2012/278730

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma. *Social Science & Medicine, 71*(12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Naslund, J. A., Bondre, A., Torous, J., & Aschbrenner, K. A. (2020). Social media and mental health. *Current Psychiatry Reports, 22*(3), 1–10. https://doi.org/10.1007/s11920-020-1131-9

O'Reilly, M., Dogra, N., Whiteman, N., Hughes, J., Eruyar, S., & Reilly, P. (2018). Is social media bad for mental health? *Clinical Child Psychology and Psychiatry, 23*(4), 601–613. https://doi.org/10.1177/1359104518775154

Patel, V., et al. (2018). The Lancet Commission on global mental health. *The Lancet, 392*(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4*(3), 218–251.

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. https://www.who.int