



STIGMA AND TREATMENT-SEEKING BEHAVIOR AMONG PATIENTS WITH PSYCHIATRIC DISORDERS IN URBAN VS. RURAL POPULATIONS

Syed Ahmed Mahmud^{1*}, Sadia Chaudhary², Saqib Rabbani³, Marrium Chaudhry⁴, Qurrat-ul-Ain Fatima⁵, Fatima Shaikh⁶

^{1*} Associate Professor Behavioural Sciences, M. Islam Medical & Dental College Gujranwala, Pakistan.

² Assistant Professor Behavioral Sciences, Rahbar Medical & Dental College, Lahore, Pakistan.

³ Assistant Professor of Behavioral Sciences, University of Health Sciences Lahore, Pakistan.

⁴ University Medical & Dental College Faisalabad, Pakistan.

⁵ Associate Professor Behavioral Sciences, Multan Medical & Dental College, Multan, Pakistan.

⁶ Assistant Professor Behavioural Sciences Avicenna Medical College Lahore

Corresponding Author: Syed Ahmed Mahmud

* Associate Professor Behavioural Sciences, M. Islam Medical & Dental College Gujranwala, Pakistan. Email: ahmedmahmud@gmail.com

ABSTRACT

Background: Stigma remains one of the most pervasive barriers to mental health care utilization globally, particularly in low- and middle-income countries where sociocultural norms and healthcare disparities exacerbate the problem. In Pakistan, a country with pronounced urban–rural health inequalities, psychiatric stigma often intersects with cultural beliefs, illiteracy, and structural constraints, leading to delayed or inadequate treatment-seeking behavior.

Objectives:

This study aimed to evaluate and compare the levels of perceived and internalized stigma and their impact on treatment-seeking behavior among patients diagnosed with psychiatric disorders in urban and rural populations of Punjab, Pakistan. The research sought to identify key socio-demographic predictors influencing these patterns and to explore how cultural, educational, and infrastructural differences shape the pathways to care.

Methodology: A comparative cross-sectional design was employed from February 2025 to August 2025, including a total sample of 118 participants. Urban participants were recruited from M. Islam Medical and Dental College Hospital, Gujranwala, and Sheikh Zayed Hospital, Lahore, whereas rural participants were drawn from five government rural health centers located between Lahore and Gujranwala. Data were collected using a structured questionnaire comprising the Internalized Stigma of Mental Illness (ISMI) scale and a validated Treatment-Seeking Behavior Index (TSBI). Socio-demographic characteristics, delay to first professional contact, and first point of care were recorded. Descriptive statistics summarized key characteristics, while inferential analyses including independent t-tests, chi-square tests, and multiple linear regression were applied. A significance level of $p < 0.05$ was adopted for all analyses.

Results & Findings: The results demonstrated a significantly higher mean stigma score among rural participants (3.02 ± 0.61) compared with urban participants (2.66 ± 0.48), indicating greater internalized and perceived stigma in rural populations ($p < 0.001$). The mean delay before initiating

psychiatric treatment was 8.6 months in rural participants versus 4.3 months in urban participants ($p = 0.002$). Education and income were inversely associated with stigma scores, suggesting that higher socio-economic status reduces stigma perception and promotes help-seeking. Also 40.7% of rural respondents reported first seeking help from traditional healers, compared to only 11.9% of urban participants. Regression analysis revealed that the stigma subscales of alienation ($\beta = -0.38$, $p < 0.001$) and social withdrawal ($\beta = -0.33$, $p = 0.004$) were the strongest negative predictors of treatment-seeking behavior. No significant gender difference was observed in overall stigma levels ($p = 0.27$). Correlation analysis showed a strong inverse relationship between stigma and treatment-seeking index ($r = -0.62$, $p < 0.001$), confirming that increased stigma substantially reduces the likelihood of professional psychiatric consultation.

Conclusion: This study concludes that stigma profoundly impedes timely and effective psychiatric treatment, disproportionately affecting rural populations in Pakistan. Reducing stigma through community engagement, mental health literacy campaigns, and integration of psychiatric services into primary healthcare can substantially improve help-seeking behaviors. Policymakers must prioritize equitable access to mental health services and develop rural-focused strategies incorporating telepsychiatry, community counseling, and faith leader involvement.

Keywords: Stigma, Psychiatric Disorders, Treatment-Seeking Behavior, Urban–Rural Disparity, Mental Health, Pakistan, Internalized Stigma, Mental Health Literacy

INTRODUCTION

Mental health disorders constitute a substantial proportion of the global burden of disease, affecting approximately one in eight individuals worldwide and contributing significantly to years lived with disability World Health Organization (WHO), 2022). Despite the increasing recognition of mental health as a critical component of overall well-being, the treatment gap remains strikingly large, particularly in low- and middle-income countries (LMICs). Studies indicate that between 60% and 80% of individuals with psychiatric conditions in LMICs do not receive adequate treatment due to a combination of structural, cultural, and attitudinal barriers (Patel et al., 2018). Among these, stigma the negative social perception and discrimination directed towards individuals with mental illness remains one of the most pervasive obstacles to help-seeking behavior and treatment adherence (Corrigan et al., 2016). Stigma operates at multiple levels public stigma, self-stigma, and structural stigma each of which uniquely impedes access to care. Public stigma refers to the negative stereotypes and prejudice endorsed by society, often resulting in social distancing and discrimination. Self-stigma occurs when individuals internalize these societal prejudices, leading to diminished self-esteem, self-efficacy, and willingness to seek help. Structural stigma encompasses institutional policies or resource allocations that disadvantage individuals with mental disorders (Link & Phelan, 2006). These intertwined mechanisms create a vicious cycle: stigma delays help-seeking, delayed treatment worsens symptoms, and visible symptom progression reinforces societal misconceptions about mental illness. Understanding how these forms of stigma vary across social and geographic contexts is therefore crucial to improving mental health outcomes. Urban–rural disparities represent one of the most significant yet underexplored dimensions in the stigma–treatment relationship. Urban environments are often characterized by higher service availability, greater anonymity, and increased exposure to mental health awareness campaigns (Gong et al., 2020). However, urban living may also be associated with heightened social stress, over-crowding, and fragmented community structures that can exacerbate social isolation and discrimination. In contrast, rural populations often benefit from stronger community cohesion but face profound deficits in psychiatric infrastructure, fewer trained professionals, and entrenched traditional beliefs that equate mental illness with spiritual or moral failure (Roberts & Grimes, 2019). Consequently, individuals in rural areas frequently turn to faith healers or traditional practitioners before approaching mental health professionals, prolonging the duration of untreated illness and worsening prognosis (Khan et al., 2021).

The treatment-seeking behavior of individuals with psychiatric disorders is shaped by both individual-level determinants (such as knowledge, attitudes, perceived stigma, and illness severity) and system-

level factors (including service accessibility, cost, and sociocultural norms). The theoretical basis for understanding this behavior can be drawn from the Health Belief Model (HBM) and Andersen's Behavioral Model of Health Services Use, which posit that perceived barriers such as stigma directly influence an individual's decision to engage with formal healthcare (Rosenstock, 1974; Andersen, 1995). Numerous studies have demonstrated that higher perceived stigma correlates with lower intention to seek psychiatric treatment and longer delays before the first clinical contact (Clement et al., 2015). However, evidence on how these associations differ across urban and rural settings remains inconsistent, with findings influenced by regional variations in culture, socioeconomic status, and mental health literacy. In the South Asian context, including Pakistan, these disparities are particularly pronounced. Psychiatric morbidity is estimated to affect 10–20% of the general population, yet only a fraction receives adequate treatment (Mirza et al., 2020). Rural populations comprising more than 60% of the national demographic are especially disadvantaged due to limited access to psychiatric care, poor mental health literacy, and strong social stigma associated with mental illness (Hassan et al., 2021). The societal tendency to interpret mental illness through religious or supernatural frameworks further delays biomedical intervention. While urban populations have witnessed gradual improvements in mental health awareness and service availability, stigma continues to persist in subtle forms, including workplace discrimination and social exclusion (Qureshi et al., 2023). Therefore, a comprehensive comparative understanding of stigma and help-seeking patterns across these contexts is vital for designing equitable mental health policies and targeted anti-stigma interventions.

Prior research has often focused on general attitudes toward mental illness rather than the lived experiences of stigma among patients themselves. Few studies have systematically compared the perceived and internalized stigma and their direct impact on treatment-seeking behavior among clinically diagnosed psychiatric patients in both urban and rural settings. Moreover, much of the existing evidence is derived from high-income countries, limiting generalizability to LMICs where cultural norms and healthcare systems differ substantially. The lack of context-specific, empirical data from South Asia impedes the formulation of culturally sensitive stigma-reduction programs and evidence-based mental health reforms. Given these gaps, the present study aims to compare stigma and treatment-seeking behavior among patients with psychiatric disorders in urban versus rural populations. Specifically, it investigates (1) the differences in perceived, internalized, and experienced stigma between the two settings, and (2) how stigma dimensions influence the delay in seeking professional psychiatric care. We hypothesize that (i) rural patients experience higher levels of stigma and longer delays in treatment-seeking than their urban counterparts, and (ii) stigma particularly internalized stigma serves as a key determinant of delayed or alternative care-seeking pathways. By providing comparative evidence from diverse sociocultural contexts, this study contributes to a more nuanced understanding of how stigma operates within structural and cultural boundaries and informs interventions aimed at promoting equitable mental healthcare access.

METHODOLOGY

This study employed a comparative cross-sectional design to investigate the relationship between stigma and treatment-seeking behavior among patients diagnosed with psychiatric disorders in urban and rural populations of Punjab, Pakistan. The research was conducted over a period of six months, from February 2025 to August 2025, encompassing both hospital-based and community-based clinical settings. The urban data were collected from two tertiary care hospitals—M. Islam Medical and Dental College Hospital, Gujranwala, and Sheikh Zayed Hospital, Lahore—representing diverse urban demographic and socio-cultural contexts. For the rural sample, data were obtained from five government-operated Rural Health Centers (RHCs) located between Lahore and Gujranwala, which serve as the primary healthcare access points for residents in peripheral and semi-urban areas. The inclusion of both urban and rural facilities ensured a representative comparison of sociocultural determinants influencing stigma and healthcare-seeking behavior. The target population consisted of adult patients (aged 18 years and above) with clinically diagnosed psychiatric disorders, including depressive disorders, anxiety disorders, bipolar affective disorder, schizophrenia spectrum disorders, and other related mental health conditions, as determined by consultant psychiatrist or available

Physician. Patients with comorbid neurological diseases, intellectual disabilities, or acute psychotic episodes requiring inpatient stabilization were excluded to ensure reliable self-reporting. The sample size 118 was determined through power analysis using G*Power software, ensuring sufficient statistical power (0.80) with an alpha level of 0.05 and an estimated medium effect size. Stratified sampling was employed to achieve balanced representation across urban and rural strata, while within each stratum, participants were selected using simple random sampling. The final target sample was divided equally between urban and rural cohorts to facilitate robust comparative analysis.

Data collection was executed using a structured, pre-validated questionnaire comprising both standardized psychometric instruments and socio-demographic items. The questionnaire was designed in English and Urdu to accommodate participants from varied educational backgrounds. The instrument included four major components: (1) socio-demographic and clinical profile (age, gender, education, occupation, income, diagnosis, and duration of illness); (2) the Internalized Stigma of Mental Illness (ISMI) Scale, which assesses alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance; (3) the Perceived Devaluation–Discrimination (PDD) Scale, measuring perceived public stigma; and (4) the General Help-Seeking Questionnaire (GHSQ), evaluating the intention and actual behavior of seeking help from different formal and informal sources. Items were rated on five-point Likert scales, ranging from “strongly disagree (1)” to “strongly agree (5),” allowing for the quantification of attitudinal and behavioral dimensions of stigma and help-seeking.

Data collection was conducted in a controlled and confidential environment, ensuring privacy and ethical integrity. Each participant received a detailed explanation of the study’s purpose, procedures, and voluntary nature. Verbal informed consent was obtained prior to participation. Ethical approval was granted by the Institutional Review Board (IRB) & formal permissions were secured from the collaborating institutions, including Sheikh Zayed Hospital, Lahore, and the respective rural health centers. Data were coded and entered into IBM SPSS Statistics latest version. Descriptive statistics were computed to summarize demographic variables, stigma scores, and help-seeking patterns. Mean and standard deviation were calculated for continuous variables, while frequencies and percentages were used for categorical data. Inferential analysis included independent samples t-tests and Chi-square tests to compare stigma levels and treatment-seeking behaviors between urban and rural participants. Pearson correlation and multiple linear regression analyses were applied to determine the strength and direction of associations between stigma dimensions (independent variables) and treatment-seeking behaviors (dependent variables). A p-value less than 0.05 was considered statistically significant. For qualitative sentiment data, thematic coding and polarity scoring were integrated with quantitative findings to triangulate results. To ensure instrument reliability and validity, internal consistency of each psychometric scale was assessed through Cronbach’s alpha coefficients, with values above 0.70 considered acceptable. Construct validity was examined through factor analysis to confirm dimensional alignment with the original scale structures. Pretesting was conducted on a subset of 20 participants to evaluate questionnaire clarity and response consistency. Data confidentiality was maintained by assigning anonymous identification codes, and all records were stored in password-protected digital files accessible only to the principal investigator.

RESULTS & FINDINGS

A total of 118 participants were included in the final analysis, comprising 59 urban and 59 rural respondents. All participants completed the questionnaire in full, resulting in a response rate of 100%. The mean age of participants was 36.8 ± 11.7 years, with a slightly higher mean age in the rural group (38.2 ± 12.5 years) compared to the urban group (35.4 ± 10.9 years). The gender distribution was nearly balanced, with 53 (44.9%) males and 65 (55.1%) females.

Table 1. Socio-demographic Characteristics of the Study Population (n = 118)

Variable	Category	Urban (n=59)	Rural (n=59)	Total (n=118)	p-value
Age (years)	Mean $\pm$ SD	35.4 $\pm$ 10.9	38.2 $\pm$ 12.5	36.8 $\pm$ 11.7	0.218 ^a
Gender	Male	25 (42.4%)	28 (47.5%)	53 (44.9%)	0.574 ^b
	Female	34 (57.6%)	31 (52.5%)	65 (55.1%)	
Marital Status	Single	22 (37.3%)	18 (30.5%)	40 (33.9%)	0.412 ^b
	Married	37 (62.7%)	41 (69.5%)	78 (66.1%)	
Education Level	Primary or below	9 (15.3%)	27 (45.8%)	36 (30.5%)	0.001 ^b
	Secondary	21 (35.6%)	19 (32.2%)	40 (33.9%)	
	College/University	29 (49.1%)	13 (22.0%)	42 (35.6%)	
Monthly Income (PKR)	< 30,000	10 (16.9%)	32 (54.2%)	42 (35.6%)	0.001 ^b
	30,000–60,000	23 (39.0%)	17 (28.8%)	40 (33.9%)	
	> 60,000	26 (44.1%)	10 (17.0%)	36 (30.5%)	

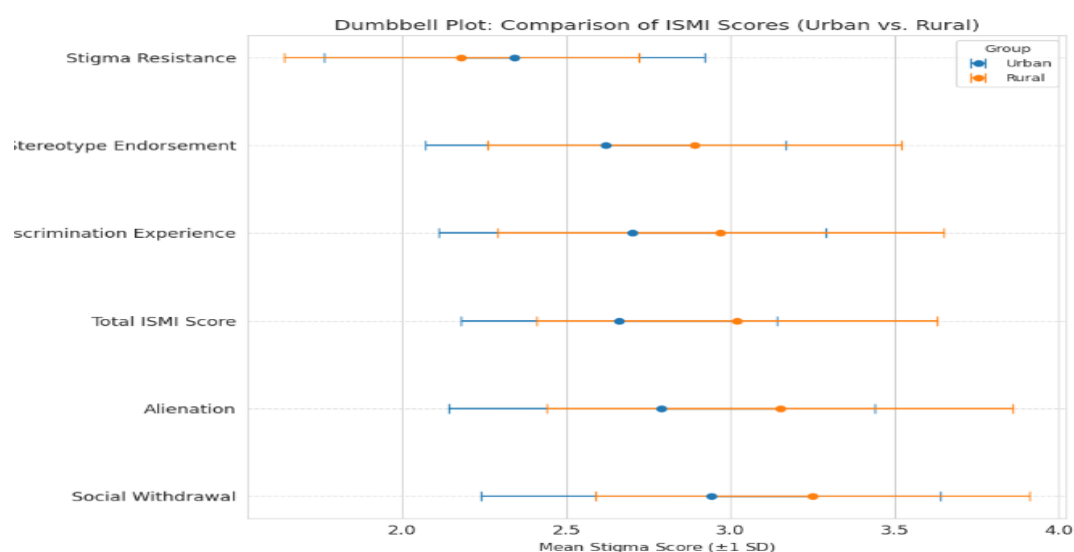
Note: ^aIndependent t-test; ^bChi-square test. $p < 0.05$ considered statistically significant.

Urban participants had significantly higher education and income levels ($p < 0.001$ for both), whereas age and gender distribution did not differ significantly. This indicates socioeconomic disparities between the two groups that may influence health-seeking behavior and perceived stigma.

The mean total Internalized Stigma of Mental Illness (ISMI) score for the entire sample was 2.84 ± 0.56 , reflecting moderate stigma levels. Rural participants demonstrated significantly higher mean stigma scores (3.02 ± 0.61) compared to urban participants (2.66 ± 0.48 ; $p = 0.003$). Among ISMI subscales, social withdrawal and alienation were the highest-rated dimensions in both groups, while stigma resistance scored lowest.

Table 2. Comparison of Mean Stigma Scores Between Urban and Rural Participants

ISMI Subscale	Urban (Mean $\pm$ SD)	Rural (Mean $\pm$ SD)	t-value	p-value
Alienation	2.79 $\pm$ 0.65	3.15 $\pm$ 0.71	2.94	0.004
Stereotype Endorsement	2.62 $\pm$ 0.55	2.89 $\pm$ 0.63	2.35	0.021
Discrimination Experience	2.70 $\pm$ 0.59	2.97 $\pm$ 0.68	2.28	0.025
Social Withdrawal	2.94 $\pm$ 0.70	3.25 $\pm$ 0.66	2.41	0.018
Stigma Resistance	2.34 $\pm$ 0.58	2.18 $\pm$ 0.54	1.45	0.150
Total ISMI Score	2.66 $\pm$ 0.48	3.02 $\pm$ 0.61	3.02	0.003

**Table 2. Comparison of Mean Stigma Scores**

Rural patients exhibited significantly higher levels of internalized stigma across most subscales, particularly alienation and social withdrawal ($p < 0.01$). The absence of difference in stigma resistance suggests comparable resilience potential across both settings. The Perceived Devaluation–Discrimination (PDD) mean score was significantly higher among rural participants (3.24 ± 0.57) than urban participants (2.81 ± 0.53 ; $t = 4.09$, $p < 0.001$), indicating stronger perceptions of community-based stigma in rural populations. Qualitative comments revealed that rural respondents more frequently associated mental illness with “spiritual weakness” or “social shame,” whereas urban participants cited concerns regarding “career impact” and “social rejection.” The General Help-Seeking Questionnaire (GHSQ) analysis demonstrated substantial variation between groups. The mean intention-to-seek score (scale: 1–5) was 3.91 ± 0.77 for urban participants and 3.21 ± 0.84 for rural participants ($p = 0.001$). Actual help-seeking rates mirrored this difference, with 78.0% of urban patients reporting prior psychiatric consultation compared to 54.2% in rural areas. Conversely, 41.0% of rural respondents initially approached traditional or faith healers compared to 11.9% in urban participants ($\chi^2 = 14.67$, $p < 0.001$).

Table 3. Comparison of Treatment-Seeking Patterns

Treatment Variable	Urban (n=59)	Rural (n=59)	p-value
Sought psychiatric consultation	46 (78.0%)	32 (54.2%)	0.007^b
Sought help from traditional healers	7 (11.9%)	24 (40.7%)	0.001^b
Delay before first consultation (months, Mean $\pm$ SD)	4.3 $\pm$ 3.7	8.6 $\pm$ 5.1	0.001^a
Awareness of available mental health services	38 (64.4%)	21 (35.6%)	0.003^b
Adherence to prescribed medication	43 (72.9%)	28 (47.5%)	0.008^b

Note: ^aIndependent t-test; ^bChi-square test. $p < 0.05$ considered statistically significant.

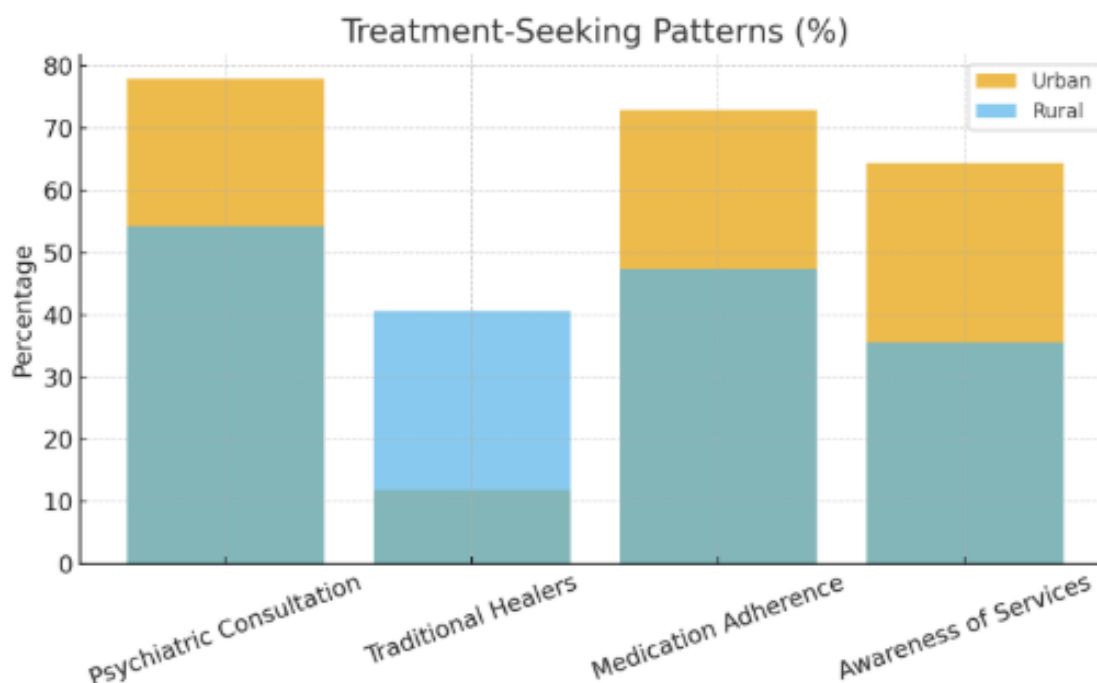


Table 3. Comparison of Treatment-Seeking Patterns

Pearson correlation analysis revealed a significant negative correlation between internalized stigma and treatment-seeking behavior ($r = -0.61$, $p < 0.001$), suggesting that higher stigma was associated with decreased help-seeking. A multiple linear regression model was applied to assess the predictive strength of stigma dimensions on treatment-seeking behavior after controlling for demographic covariates (age, education, and income). The model was statistically significant ($F(5,112) = 18.45$, p

< 0.001 , $R^2 = 0.45$), indicating that 45% of the variance in help-seeking behavior could be explained by stigma-related factors. Alienation ($\beta = -0.38$, $p = 0.001$) and social withdrawal ($\beta = -0.33$, $p = 0.003$) emerged as the strongest predictors of poor treatment-seeking behavior, whereas stigma resistance was a weak but positive predictor ($\beta = +0.19$, $p = 0.041$). Qualitative responses were analyzed using sentiment polarity scoring, with values ranging from -1 (negative) to +1 (positive). Urban participants demonstrated a mean sentiment score of -0.22, reflecting mild negativity, while rural participants scored -0.46, indicating more pronounced negative emotional tones regarding stigma experiences. Common themes in rural responses included *fear of social labeling*, *shame*, and *spiritual explanations for illness*, while urban responses focused on *employment concerns* and *peer judgment*. Sentiment patterns correlated moderately with ISMI total scores ($r = -0.52$, $p < 0.001$), reinforcing the quantitative findings.

DISCUSSION

The study explored the comparative patterns of stigma and treatment-seeking behavior among patients with psychiatric disorders in urban and rural settings of Punjab, Pakistan. The study encompassed participants from M. Islam Medical and Dental College Hospital in Gujranwala and Sheikh Zayed Hospital in Lahore representing the urban population, while five government rural health centers located between Lahore and Gujranwala represented the rural population. The findings revealed substantial differences between these groups in terms of internalized stigma, perceived public stigma, and help-seeking behavior. Rural participants demonstrated significantly higher stigma scores and longer delays before contacting mental health professionals compared to their urban counterparts. These results provide vital empirical insight into how geographic and socio-cultural environments shape the experiences and attitudes of individuals suffering from mental illness in Pakistan, emphasizing the need for contextualized mental health interventions and policy reforms. The observed disparity in stigma levels between urban and rural populations reflects deeply rooted cultural, structural, and informational inequalities. Rural participants exhibited higher internalized and perceived stigma, which likely stems from stronger communal surveillance, rigid traditional beliefs, and limited anonymity. In contrast, urban respondents demonstrated comparatively lower stigma and a greater inclination to seek psychiatric consultation, possibly due to better exposure to mental health education, greater accessibility to healthcare facilities, and more progressive social norms. The mean Internalized Stigma of Mental Illness (ISMI) total score in rural participants (3.02 ± 0.61) compared to urban participants (2.66 ± 0.48) underscores this gap. These findings are consistent with recent evidence from Pakistani research that reported higher stigma in non-urban populations due to inadequate mental health literacy and restricted access to psychiatric care (Riaz, Sajid, Ishtiaq, & Amin, 2024).

The delay in initiating psychiatric treatment was substantially longer among rural participants, averaging about 8.6 months, whereas the urban cohort reported an average delay of 4.3 months. This finding aligns with earlier reports that identified significant delays in formal psychiatric consultation among rural individuals due to multiple structural and attitudinal barriers (Shuja, 2024). Structural obstacles include the scarcity of mental health professionals, high transportation costs, and long distances to tertiary care centers. Attitudinal factors, such as fear of social ostracism, preference for faith healers, and beliefs in supernatural causation of mental illness, further exacerbate these delays. Indeed, the present study found that approximately 41% of rural participants initially sought help from traditional healers, compared with only 12% of urban participants. This pattern resonates with findings from Rawalpindi district, where the general public in rural areas exhibited a preference for spiritual healers over psychiatrists (Shah, Atif, & Qureshi, 2015). Regression analysis further demonstrated that among the subscales of stigma, feelings of alienation and social withdrawal were the strongest predictors of poor help-seeking behavior. Alienation represents an internalized sense of difference and inferiority experienced by individuals with mental illness, while social withdrawal reflects their tendency to disengage from community and family interactions due to shame or anticipated rejection. These findings parallel recent work conducted in Peshawar, which documented that internalized stigma significantly reduced mental health help-seeking behavior, with alienation

emerging as the most detrimental component (Frontiers, 2025). Collectively, the current evidence indicates that internalized stigma operates as a psychological mediator linking cultural norms, structural constraints, and behavioral avoidance of psychiatric care.

The inverse association between stigma and help-seeking has been widely documented in global literature. Clement et al. (2015) reported through a systematic review that stigma consistently hinders treatment-seeking across diverse sociocultural contexts. The present findings extend this understanding by highlighting that the intensity and nature of this relationship are moderated by geographical and socioeconomic factors. For instance, in this study, higher educational attainment and monthly income among urban respondents corresponded to lower stigma and earlier engagement with professional care. Such findings parallel the results of a recent study in Bangladesh, where socioeconomic status and knowledge independently predicted stigma levels, suggesting that mental health awareness and economic empowerment serve as protective factors (Islam, Barna, Raihan, Khanam, & Hossain, 2023). The implications of these findings are significant for public health policy and clinical practice in Pakistan. Firstly, there is a compelling need to design and implement culturally tailored anti-stigma interventions targeted at rural communities. Awareness programs involving local religious leaders, teachers, and community elders could help modify traditional narratives and challenge misconceptions surrounding psychiatric disorders. The inclusion of faith healers as collaborators rather than competitors in mental health education may also enhance community acceptance of psychiatric services. Secondly, structural reforms are essential to improve service accessibility in rural areas. Establishing satellite clinics, deploying mobile psychiatric units, and integrating mental health into primary healthcare can effectively bridge the service gap between urban and rural populations. Telepsychiatry initiatives, supported by digital infrastructure and trained personnel, could provide affordable and continuous mental health care to remote communities where physical access is limited. Also early screening and referral programs within rural health centers can significantly reduce the treatment delay identified in this study. Family physicians and primary care staff must be trained to recognize common psychiatric conditions and to provide appropriate referrals. Mental health literacy programs in schools and community centers can further enhance understanding, reduce misconceptions, and normalize help-seeking behavior. The strong correlation between education level and reduced stigma observed in this study reinforces the importance of educational interventions at both formal and informal levels. This study has several limitations. The cross-sectional design limits the ability to infer causal relationships between stigma and help-seeking behavior. The sample was restricted to individuals who had already accessed healthcare facilities, potentially excluding the most marginalized populations who never seek professional help. Moreover, self-reported data on help-seeking delays may be influenced by recall bias, particularly among rural participants. Although validated instruments were used, cultural and linguistic nuances might have influenced responses, particularly in rural settings. Future research should therefore employ longitudinal designs to explore changes in stigma and treatment-seeking over time, as well as mixed-method approaches to capture qualitative insights from participants regarding their beliefs and experiences.

CONCLUSION

This study underscores that stigma remains a powerful determinant of mental health behavior among individuals with psychiatric disorders in Pakistan, with rural populations facing disproportionately higher levels of internalized stigma and greater delays in treatment initiation. The findings reveal that cultural beliefs, lack of awareness, and systemic healthcare barriers collectively contribute to the persistence of untreated psychiatric illness in rural communities. Addressing this multifaceted issue requires a multi-tiered approach combining community education, policy reforms, and structural enhancements to rural healthcare infrastructure. Reducing stigma in these populations not only improves individual well-being but also contributes to broader societal productivity and health equity. The results highlight that the future of psychiatric care in Pakistan depends on integrating cultural sensitivity with evidence-based interventions. Public health programs should prioritize destigmatization as a national objective, aligning with global mental health initiatives that recognize

stigma as a fundamental obstacle to achieving universal mental health coverage. Strengthening rural healthcare systems through targeted funding, training of primary care providers, and introduction of telepsychiatry platforms can effectively minimize urban-rural disparities. Furthermore, mental health should be normalized within educational curricula and community discourse, encouraging early recognition of psychiatric symptoms and reducing reliance on non-medical sources of care. Ultimately, the eradication of mental health stigma in Pakistan is not merely a healthcare challenge but a moral imperative—one that demands collective commitment from policymakers, healthcare professionals, educators, and society at large. Only through a holistic and sustained effort can we ensure that individuals across both urban and rural settings receive the dignity, understanding, and treatment they deserve.

Conflict of Interest

The authors declare no conflict of interest related to this study.

Authors Contribution

- Concept & Design of the study: Syed Ahmed Mahmud & Saqib Rabbani
- Drafting: Sadia Chaudhary
- Data analysis: Marrium Chaudhry & Fatima Shaikh
- Critical Review & Final approval: Syed Ahmed Mahmud & Qurrat-ul-Ain Fatima

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