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The Silent Epidemic in Chitral: Prevalent Causes of Suicide and The Transformative Journey from Self-Destruction to Self-Adornment — A Qualitative Sociological Analysis

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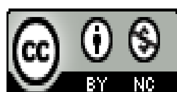

Abstract: *Suicide remains a deeply hidden and ongoing social crisis in many rural and socially conservative settings, where stigma, honor norms, and institutional neglect conceal both its prevalence and causes. This study examines suicidal vulnerability in District Chitral, a mountainous region of northern Pakistan, using a qualitative multiple-case study design that moves beyond individualistic and clinical explanations. Drawing on purposive sampling, the study analyzes 20 detailed case studies through reflexive thematic analysis to identify patterned social mechanisms across cases. Findings demonstrate that suicide is not an isolated psychological act but a socially constructed process shaped by the interaction of five interconnected domains: structural and cultural forces, long-term psychosocial suffering, silence and stigma, institutional and service provision gaps, and family-based vulnerability. Persistent strain arising from economic insecurity, academic and career pressures, gendered expectations, and livelihood instability is often mediated through family environments characterized by emotional neglect, abuse, authoritarian control, or relational dismissal. Cultural imperatives surrounding honor and moral restraint further suppress disclosure, delay help-seeking, and transform distress into hidden suffering. Limited access to affordable and continuous mental health services removes critical protective buffers, increasing vulnerability in this geographically remote setting. By integrating sociological theories of strain, social regulation, stigma, gender, and psychosocial pain, this study conceptualizes suicide as a collective social phenomenon rather than an individual failure. The findings highlight the need for suicide prevention strategies that prioritize family dynamics, cultural discourse, and institutional accountability alongside individual-level mental health interventions, particularly in marginalized and remote regions.*

Introduction

Suicide is one of the most enigmatic and yet possible social and public-health issues of the modern world. The number of people who die by suicide every year is greater than 720,000 across the world and is a major reason for the years of life lost in the global context, as it is one of the primary causes of

death among adolescents and young adults (World Health Organization [WHO], 2023; Turecki et al., 2019). In addition to mortality, the long-term impacts of suicide on families, communities, and institutions were psychological, social, and economic in nature and typically destabilized already weak social systems (Thomas et al., 2020; TA et al., 2007, WHO, 2021). Although epidemiological statistics are necessary in estimating how widespread it is, they lack the explanation of why suicide exists, how it is a socially constructed phenomenon, and why it is shrouded in secrecy in some societies.

Some low- and middle-income nations are so ingrained in moral, religious, and legal frameworks that define how suicide is interpreted and addressed. Instead of being perceived as a mental-health issue, suicide is often perceived as a moral failure, spiritual weakness, or social disgrace that results in silence, secrecy, and underreporting (Goffman, 2009; Vijayakumar et al., 2005; Ommeren et al., 2012). Pakistan has a history of criminalizing and highly stigmatizing suicide, which creates fear of legal consequences and reputational harm that deters disclosure and help-seeking (Brenda K., et al., 2022; Moosa et al., 2008). Such dynamics make it difficult to properly see the size of the problem and to establish effective and culturally responsive prevention strategies.

A very interesting sociological example is the Chitral District, which is in the mountainous part of the north of Khyber Pakhtunkhwa. The high levels of suicide, particularly in young people and married women, have remained rather high in the district, despite the strong communal bonds, high religious participation, and relatively good literacy levels (Ahmed et al., 2016; Sanauddin and Mahmood, 2022). The paradox complicates the traditional beliefs according to which education, religiosity, and social cohesion are protective factors which are inherently automatic. It instead refers to the existence of complicated structural, cultural, and gendered pressures that exist beyond the realm of ordinary life.

To explain suicide in Chitral, in other words, one must transcend individualistic explanations and attempt to engage in a sociological account in which self-destructive behavior is put into context by regimes of inequality, honor rules, family relations of authority, and institutional voids. Although there is increased awareness of the concept of social determinants of suicide, there is little information about the functioning of these forces using daily family interactions, moral controls, and institutional deficit in remote areas such as Chitral.

Overview of the Research Topic

Suicide is turning out to be more widely understood as a phenomenon that is not just determined by the psychological distress of the individuals in terms of individualism, but also by the prevailing societal setups in which the individuals exist, interact, and give meaning to the experiences they go through. Sociological research has traditionally understood suicide as a socially constituted process, shaped by trends of social integration, control, and inequality and not singular pathology (Durkheim, 1897/1951; Ramtekkar et al; 2022). Modern studies also point to the fact that suicidal vulnerability is a cumulative result of a long-term exposure to structural strain, relationship conflict, and emotional suppression, especially in a socially regulated setting (Marmot, 2005; Stack, 2000).

The situation in District Chitral is that suicide is staged in an extremely intimate moral framework in which the reputation of family, the norms of honor, and the collective opinion heavily govern the expression of emotions. Psychological distress has yet to be revealed, as it is generally hidden to prevent stigma and moralization, as well as to provide opportunities to reveal them and act in time (Goffman, 2009; Khan et al., 2021). This kind of concealment worsens emotional pain as it would deprive individuals of social and institutional support. Such forces emphasize the inquiry of strictly biomedical explanations and the necessity of sociological directions that would describe how cultural norms, power relations, and institutional absence influence suicidal vulnerability (Kleinman, 1988; WHO, 2014).

Background of the Study

Chitral district has a unique sociocultural and geographic background where suicide is minimally reported and not well understood. Being a geographically secluded mountain area, Chitral has structural limitations such as lack of job opportunities, insufficient access to higher education, and insufficiency of mental-health facilities (Arafat, 2019; WHO, 2021). These structural demands are overlapping with strong cultural values that ascribe honor, conformity, and emotional restrain in family and communal existence. The social roles of marriage, gender behavior, education, or economic productivity are usually subject to moral judgment instead of psychosocial support of deviations (Niaz, 2016; Shaikh and Hatcher, 2005).

Stigma is a dynamic social process that deters a request to be helped and defines mental illness as a sign of moral incompetence or individual failure (Goffman, 2009; Corrigan and Watson, 2002). In these situations, people who are in distress often repress their emotions to preserve family pride, leading to a long period of isolation and accrual of mental torture. Biomedical models, which focus on diagnosis and treatment, are inadequate in describing these dynamics because they do not consider the social construction of distress and the influence of institutional neglect on vulnerability formation (Kleinman, 1988; Joiner, 2005). To explain suicide in Chitral, therefore, a sociologically based analysis is required to explain that it is the result of social organization and not just because of individual pathology.

Significance of the Study

The significance of this work is that it helps redefine suicide as a social phenomenon instead of an individual or clinical issue. The study proposes the challenge to biomedical models of suicide vulnerability that relegate the influence of stigma, honor-based regulation, and family power dynamic in defining suicidal vulnerability (Durkheim, 1897/1951; Ramtekkar et al; 2022). This sociological approach is especially applicable to the nature of the setting where mental-health services are scarce, such as Chitral, where moral and reputation issues restrict disclosure (Arafat, 2019; WHO, 2014).

Theoretically, the research brings together sociological theories of strain, stigma, honor shame, and social regulation in one integrated qualitative model based on empirical analysis of cases (Merton, 1938; Goffman, 2009). It empirically adds unique qualitative data in a geographically remote and culturally controlled area, with an essential gap in the suicide literature of Pakistan (Khan et al., 2021). In practice, the results highlight the importance of prevention strategies that would not only focus on individual treatment, but also on family-oriented treatment, stigma reduction, and intuitive institutional support, thus providing a socially sensitive basis of suicide prevention in societies governed by honor.

Problem Statement

Suicide in District Chitral is an urgent but highly hidden social issue that is controlled by culture, stigma, and inadequate institutional ability. Although suicide-related cases have become widely reported and reported in the media, the phenomenon is not adequately reported and treated because of high honor-related norms and moralization of mental distress. Such processes lead to concealment of distress and delayed interaction with support systems that are long-term (Goffman, 12009; Khan et al., 2008). This secrecy turns the distress into a personal kind of burden and not a social issue. Structural and geographic limitations also add to the urgency of the problem. Being a mountainous and remote area, Chitral is characterized by a lack of employment opportunities, a lack of mobility in terms of education, and insufficient access to affordable and sustainable mental-health care (Arafat, 2019; World Health Organization [WHO], 2021). Family and relational processes that involve rank hierarchy, gendered division of roles and responsibilities, and lack of emotional expression interact with these conditions to build environments where distressing circumstances have no feasible support.

Notably, the suicide phenomenon within this context cannot be sufficiently attributed to individual psychopathology, as most victims feel vulnerable due to social rejection, relationship disharmony, and institutional abuse instead of having any form of mental illness. This crisis is further increased by the lack of culturally responsive prevention strategies and community based mental-health infrastructure. Where provided, biomedical and clinical responses are often divided and not in correspondence with the realities of local social settings, reducing their efficacy (Kleinman, 1988; WHO, 2014). Suicide in Chitral is therefore an acute social and public-health concern that requires context sensitive sociological based research to inform effective prevention and intervention initiatives.

Research Gap

Although there has been extensive literature on suicide in the global and regional arena, the current literature on suicide within Pakistan has been biomedical, epidemiological, and urban oriented based. Most investigations focus on prevalence rates, risk-factor associations, or clinical diagnoses, which provide a little comprehension of how suicide is socially constructed during the routine interactions, cultural practices, and institutionalization (Joiner, 2005; Ramtekkar et al; 2022).

Consequently, the lived experience of people in remote and geographically distant areas like the District Chitral is still a very unfamiliar topic of academia. In particular, the absence of qualitative and sociologically based studies, which engage suicide as the process rooted in the social structure and influenced by honor-shame dynamics, stigma, power relations in the family, and structural constraint, is evident. Very little research uses in-depth case-based or phenomenological methods that can capture the dynamics of distress throughout the time periods and how social silence, moral control and institutional absence interact to bring about suicidal vulnerability (Durkheim, 1897/1951; Goffman, 2009). In the mountainous areas, this disparity is especially clear as geographic isolation is an additional mediator of resources and assistance.

Besides, the literature does not often combine classical and modern sociological theory strain, social regulation, and stigma into empirical research on suicide in Pakistan. Lack of such integrative frameworks inhibits theoretical development as well as restricting the formulation of culturally responsive prevention strategies (Merton, 1938; Stack, 2000). To fill in this gap in the scholarly literature, it is necessary to employ qualitative and context-based studies that preempt lived experience and place suicide within its broader social, cultural, and institutional background. The current research is placed in the position to address this gap by providing a multiple case study analysis that contributes to the future theoretical knowledge and empirical evidence concerning suicide in a marginalized context.

Objectives of the Study

This paper critically analyzes the socio-demographic and economic features of suicidal vulnerability persons in the Chitral district, putting the attributes in their wider social and structural contexts. It also determines the common causes of suicide and how economic condition, social positioning, and relations interact to carve out ways to suicide.

Research Questions

What are the prevalent causes of suicide in District Chitral? This question examines how socio-demographic, economic, familial, cultural, and institutional factors interact to shape suicidal vulnerability within the local sociocultural context.

Literature Review

The prevailing literature about suicide has mostly been characterized by biomedical and psychological paradigms that have placed a lot of emphasis on individual pathology, mental illness, and clinical risk factors (Hawton and Williams, 2001; Ramtekkar et al; 2022). Although such methods have served as

useful in determining proximate causes of suicidal behavior, these methods tend to under-emphasize the larger social, cultural, and structural circumstances in which suicide takes place. Therefore, suicide is often constructed as an individual or as a medically caused event instead of a socially constructed one.

Sociological views criticize this individualistic conceptualization by showing that the rate and meaning of suicide differ systematically between societies. Classical sociological writings have revealed that social integration and regulation levels are decisive factors shaping suicidal behavior and that suicide is both established in social organization and not rooted in individual psychology (Durkheim, 1897/1951). This understanding has later been expanded by sociological research that studied how family relationships, gender norms, economic insecurity, and social marginalization affect susceptibility to suicide (Stack, 2000; Wray et al., 2011).

Cultural approaches further state that suicide is inexplicable outside the context of local meanings, moral codes, and social expectations. Cultural norms influence the experience, expression and meaning of distress, stigmatization, secrecy, or normalization of suicide in particular communities (Kleinman, 1988; Colucci, 2013). These views highlight the shortcomings of the universal explanatory models in which they are used in various sociocultural settings.

Research from low- and middle-income countries remains comparatively limited, especially in geographically isolated and culturally different areas. Suicide in countries like Pakistan is under-reported because of legal prohibitions, religious bans and high levels of social stigma, therefore, leaving large gaps in verifiable statistics (Khan and Reza, 2000; WHO, 2014). The current literature tends to base its research on secondary data or quantitative research, providing little information on lived experiences and local perceptions of suicide. Table 1 summarizes key studies on suicide in Chitral and related contexts, highlighting structural, cultural, gendered, and institutional factors over time.

Table 1. Chronological Summary of Key Literature on Suicide in Chitral and Related Context

Ref	Study Focus / Context	Key Findings	Relevance to Present Study
Ahmed et al. (2016)	Suicide Trends in Chitral with Focus on Youth and Women	Identified high suicide rates among young people, particularly women; drowning and poisoning were common methods; strong association with social pressure, cultural demands, and lack of mental health facilities	Establishes Chitral as a high-risk region and foregrounds structural and institutional deficits
Ahmed et al. (2019)	Suicide as a Social Dilemma in Pakistan	Framed suicide as embedded in social fragmentation, weak community cohesion, and structural inequality; advocated multilevel policy reforms	Provides macro-level sociological grounding for suicide as a collective social issue
Bibi et al. (2019)	Social Determinants of Female Suicide in Chitral	Patriarchal norms, forced marriages, domestic violence, and honor restrictions severely limit women's autonomy and contribute to mental distress	Supports gendered and family-centered analysis of suicidal vulnerability
Ghazal et al. (2021)	Perceptions of Suicide Among Young Adults in Northern Pakistan	Suicide perceived as a "cry for help" in a culture where mental health discussion is taboo; stigma promotes silence	Reinforces themes of stigma, concealment, and communicative distress

Hussain et al. (2022)	Mental Health Policy Gaps in Pakistan	Highlighted severe shortages of mental health resources, especially in remote districts like Chitral; recommended regionally tailored services	Highlights institutional neglect and policy-level gaps central to the study
Sana et al. (2022)	Rising Suicide Rates Among Youth in Chitral	Linked youth suicides to academic stress, unemployment, and generational conflict; unmet aspirations produced despair	Strengthens analysis of socio-economic strain and youth vulnerability
Zahra et al. (2024)	National Overview of Suicide Causes in Pakistan	Identified mental health disorders, socio-economic crises, academic stress, and family conflict; emphasized regional variation	Situates Chitral within national patterns while emphasizing context-specific risk
Hussain et al. (2025)	Suicide Among Married Women in Chitral	Family conflict, emotional abuse, and social isolation within joint families elevated suicide risk; lack of counseling intensified distress	Directly aligns with themes of family power, emotional abuse, and institutional absence

Collectively, these studies highlight persistent structural, cultural, and institutional factors shaping suicidal vulnerability, while revealing limited attention to lived experience and interactional dynamics. This paper fills these gaps by embracing the sociological and cultural perspective which places suicide in the social and cultural context of people in Chitral. Arguing the end of biomedical reductionism, the literature review educates an interpretive approach to the foregrounding of social relations, cultural norms, economic pressures, and geographic isolation in understanding suicide. In that way, it builds a theoretical framework on how empirical results can be analyzed and provides a contribution towards the contextually more grounded view of suicide in marginalized contexts.

Synthesis of Literature and Positioning of the Study

The reviewed literature generally proves that suicide is a complex phenomenon, the formation of which is influenced by the combination of structural conditions, cultural norms, relations, and individual psychological distress. In classical sociology, suicide was defined as a social fact, and the importance of social integration and regulation in defining suicidal behavior was established (Durkheim, 1897/1951). The later sociological and social-health studies built upon this information by illustrating how economic strain, unemployment, and social inequality can create environments of persistent stress and susceptibility (Merton, 1938; Stack, 2000; Marmot, 2005). Such views dispute reductionist views that place suicide in the domain of individual pathology.

In more recent research, stigma, honor-based moral regulation, and fear of social labeling are also found to have dramatic effects on how distress is perceived, expressed, and managed, especially in collectivist and conservative societies (Goffman, 2009; Corrigan and Watson, 2002; Kleinman, 1988). Under these circumstances, emotional pain is usually hidden with the aim of preserving the family image, postponing the assistance process, and increasing isolation. Investigations in Pakistan and other comparable environments always report underreporting of suicide and low use of mental-health services, in large part, because of stigma, cultural customs and organizational restrictions (Khan et al., 2008; Arafat, 2019; WHO, 2014).

However, research on the subject to date is still dominated by biomedical, epidemiological, and urban-based tools that give more importance to prevalence rates, risk-factor associations, and clinical-level

diagnoses (Joiner, 2005; Ramtekkar et al; 2022). Although useful, these methods tend to undervalue the way suicide is a social construction based on the daily life dynamics of families, patriarchal systems, ethical norms, and the lack of institutions, specifically in areas where the geographical distance is large and where social and cultural control over space and time dictates the situation. There are few qualitative and case-based sociological analysis which anticipates the lived experience and contextual meaning that foresight rural and mountainous Pakistan.

It is in this gap that the current study contributes to the literature through providing a qualitative and multiple case study analysis on suicidal vulnerability in District Chitral. The combination of sociological strain, stigma, honor, and shame theories with empirical narratives will help the research to transcend the individualistic and biomedical models of suicide to develop a new conceptualization of the process itself as a socially rooted phenomenon. By so doing, it adds context-sensitive knowledge that not only expands the theoretical knowledge, but also guides culturally responsive prevention and intervention approaches in marginalized environments.

Conceptual Framework

This study views suicide as a process that is socially institutionalized through the cumulative interplay of structural conditions, cultural norms, relational processes, and institutional contexts, but not because of individual psychopathology. The framework is based on classical and modern sociological theories, which place suicidal vulnerability as developing with time, based on patterned exposure to social strain, emotional suppression, and constrained agency. This method is based on the primal premise of Durkheim in his claim that suicide indicates the level of social integration and control in a society (Durkheim, 1897/1951), and is furthered by subsequent theorizing influences on inequality, stigma, and power relations.

Structurally, the framework also includes strain and relative deprivation points of view that interpret the creation of chronic frustration and mental distress on the part of economic insecurity, unemployment, educational mismatch, and blocked social mobility (Merton, 1938; Stack, 2000). All these pressures are still especially relevant in geographically remote areas with limited economic opportunities such as District Chitral, where feelings of failure and social comparison are exacerbated. Structural strain does not work independently but is mediated by family systems and cultural demands that influence the ways of interpreting and addressing the distress. Honor, shame, and moral regulation are cultural norms of the framework. Based on stigma theory (Goffman, 2009) and anthropological criticism of biomedical universality (Kleinman, 1988), the framework emphasizes the fact that emotional suffering is often hidden to preserve the family image and keep out of the social ghetto. This concealment will slow down aid seeking, make suffering a norm, and make distress a personalized burden. In honor-regulated situations, silence does not exist as a lack of communication but as the functioning of a social process to maintain the vulnerable situation.

The framework also highlights the role of family and relational lineages that are oriented by feminist theory and interpersonal approaches that elucidate how power relations, patriarchal control, emotional abandonment, mistreatment, and identity repression influence lived lives of distress (Joiner, 2005; Niaz, 2016). Family settings serve as direct social contexts through which structural pressures are buffered or accentuated, and this may make the difference between people feeling belonging, validated, and supported or feeling isolated and entrapped. Lastly, the framework incorporates the thinking of ecological systems to explain institutional and service-level disconnects such as scarce mental-health infrastructure, financial obstacles, and poor continuity of care (World Health Organization [WHO], 2014). The absence of institutions eliminates the essential protective cushions, and cumulative strains

and silence develop into suicidal vulnerability.

In this research, a Socially Embedded Suicidal Vulnerability Framework has been put forward and helps to further develop the discourse on suicide by unifying structural stress, cultural regulation, family power relations, and institutional absence into a monolithic framework based on lived experience. The connection between empirical case accounts and well-known sociological theories allows the framework to transcend reductionist biomedical frameworks and provides a context-sensitive approach to understanding suicide as a group social process created by limited agency. Figure. 1 provides the conceptual pathway by which structural deprivation, combined with family-marital processes, recreates chronic psychosocial stress conditions that result in suicidal vulnerability, as well as indicates the possible protective and transformational pathways based on social support and recovery-focused interventions.

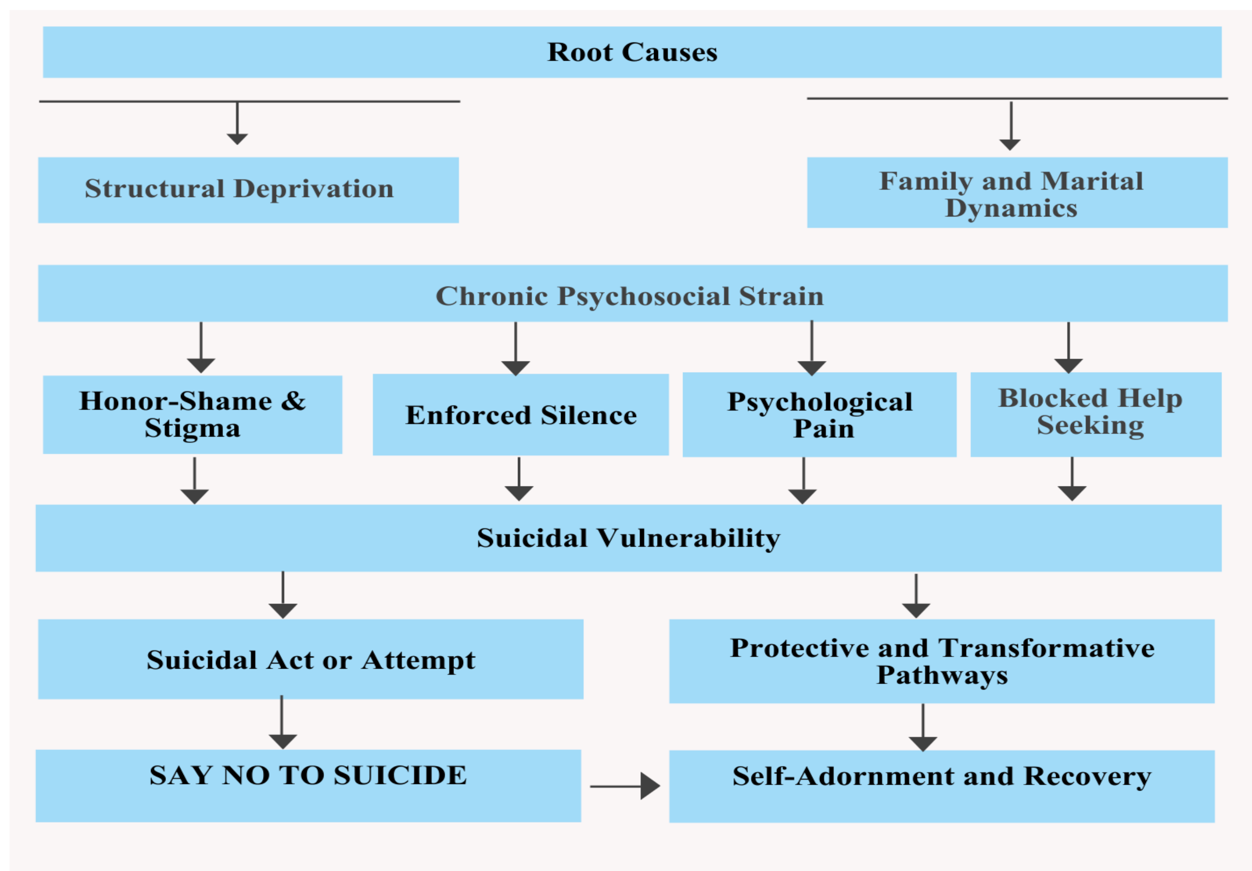

Figure 1: Conceptual model illustrating the progression from structural and familial root causes through chronic psychosocial strain to suicidal vulnerability, alongside alternative protective and transformative pathways leading toward self-adornment and recovery.

As shown in Figure 1, suicidal vulnerability emerges as a cumulative outcome of honor–shame stigma, enforced silence, psychological pain, and blocked help-seeking, rather than as an isolated or impulsive act.

Methodology

Figure 2 shows the sequential and integrative methodology that used in the investigation. The present research was based on a qualitative research methodology with an interpretive paradigm to investigate suicide as a social phenomenon embedded within living conditions, social interactions, and cultural meanings. Qualitative inquiry is especially suitable to investigate sensitive topics such as suicide when

subjective interpretation, emotional processes, and contextual effects are of priority for meaningful study.

Research Philosophy and Epistemological Positioning

The interpretivism informs the study as it assumes that social reality is made by people interacting and creating meaning instead of being a measurable and objective object. In this sense, suicidal behavior is seen as a process, rather than as a psychological determinant, arising out of people perceptions of social conditions, relations, and expectations. The research is epistemologically consistent with social constructivism in the sense that it acknowledges that knowledge on suicide is a co-production involving narratives of the participants and the process of interpretation of the researcher. The ontological approach of the research is relativist in nature, whereby several contextually specific realities exist based on social position, gender, family structure, and cultural norms exist (Tamminen et al; 2020).

Research Design and Strategy

As it is consistent with such an interpretivist position, the study is a qualitative multiple case study. The case study design can be used to examine suicide-related experiences in their social contexts in detail, which makes it particularly appropriate in describing the intricacy of the familial, cultural, and institutional factors in District Chitral. Instead of pursuing statistical generalization, the design focuses on depth of analysis and contextual insight, which allows identifying common social mechanisms in cases. The phenomenological elements are also captured in the study to preempt the lived experiences of distress, silence, and relational strain by the participants. This is because it allows the detailed within-case study as well as the cross-case thematic study, which makes the results explanatory (Hauberg, J. (2011).

Sampling and Data Collection

The purposive sampling was applied to choose cases that was provided information-rich cases that help in understanding various pathways towards suicidal vulnerability. Semi-structured interview generated the data with the assistance of field observation and document review. The described triangulation improved the richness and authenticity of the data and enabled participants to describe their experiences in their own words. Since the topic under consideration is sensitive, the ethical issues, such as informed consent, confidentiality, and even emotional safety, were paid close attention to during the data collection process.

Data Analysis

The data analysis was performed through reflexive thematic analysis through the lens of Braun and Clarke (Braun & Clarke, 2006). The themes were formed inductively by familiarization, coding, and refinement instead of being established a priori by existing theory. The researcher's position was respected in the analysis process to reflect the role of positionality and interpretively in the research, so that the results could be based on the narrative of the participants, but at the same time, they should be informed by a theory. Lastly, the findings were integrated and packaged using analytically constructive themes, case scenarios using examples, and a context-dependent prevention model, which was based on empirical evidence. In combination, the figure shows a logical methodological flow, i.e. between the philosophical positioning and the results of the analysis, which proves the internal consistency, rigor, and transparency of the design itself.

INTERPRETIVIST PARADIGM	The interpretivist paradigm focuses on understanding social reality through people's subjective meanings and lived experiences within their specific contexts.
QUALITATIVE STRATEGY	The qualitative strategy explores social phenomena through in-depth, non-numerical data to capture meanings, experiences, and contextual complexity.
PURPOSIVE SAMPLING	Purposive sampling involves deliberately selecting participants who have relevant experiences or knowledge central to the research topic.
DATA COLLECTION	Data collection involved semi-structured interviews and personal observation to capture participants' experiences, meanings, and social contexts in depth.
REFLEXIVE THEMATIC ANALYSIS	Reflexive thematic analysis is a flexible analytic approach used to identify, interpret, and reflect on patterns of meaning across qualitative data.
RESULTS	Results were presented through key themes, illustrative case narratives, and a prevention model derived from the empirical findings.

Figure 2: Methodology Process Flow

Results and Discussion

This section gives the results and a discussion of the findings achieved after the qualitative study performed on the analysis of the in-depth case studies of the District Chitral, based on the analysis of the 20 case studies. The combination of empirical stories with thematic and theoretical explanation shows how suicidal vulnerability is created because of the interaction of structural conditions, psychosocial distress, cultural regulation, family relations, and institutional absence in the section. Instead of viewing suicide as an individual phenomenon, the findings show that suicidal vulnerability is a social construction that is created by interacting structural, cultural, and relational forces. The debate contextualizes these results in sociological and psychological theories, and this provides a contextualized interpretation of suicide based on experiences.

Overview of Case-Based Findings

It contains the findings of the 20 comprehensive case studies, which report suicidal thoughts, attempts, and susceptibility in District Chitral. The cases have varied socio-demographic backgrounds, such as age, gender, marital status, education, employment, family structure, and economic position. Despite all this diversity, the analysis demonstrates that there is a high level of convergence in the small number of recurrent social mechanisms that determine suicidal vulnerability. The development of suicide is not spontaneous or an isolated event; it is a cumulative psychosocial psychological press caused by structural pressures, family life, cultural control, and institutional vacuity.

In all cases, suicidal vulnerability should be understood as a socially mediated process, with increasing despair, emotional silence and limited agency coming together to generate trapping conditions. This process is summarized by five major themes which are in turn reinforced by several sub-themes. Table 2 indicates thematic synthesis of the cross- case results, which summarizes the general themes and patterns of analysis of the case studies.

Core Themes Emerging from the Empirical Analysis

The qualitative analysis of the case studies showed that there are five interrelated core themes which explain together how the suicidal vulnerability is socially constructed in District Chitral. First, there were structural and cultural stressors such as poverty, joblessness, education-employment mismatch, dowry,

and social comparison, which led to the development of continuous stress and sense of failure. Second, these pressures were known as psychosocial distress and emotional burden, whereby stress is long-term, hopelessness, psychache, and feelings of entrapment. Third, silence, stigma, and concealment turned out to be influential social processes according to which distress was kept secret to maintain family respect and avoid moralizing thus postponing the help-seeking. Fourth, key protective buffers were eliminated by institutional and service-level vulnerability, including the limited access to mental-health services, economic obstacles, and low awareness. Lastly, family and relationship routes such as abuse, neglect, authoritarian control, relational rejection, and identity suppression worked as immediate contexts wherein the intensification of distress occurred. These themes were interdependent and accumulative resulting in a path where suicide became not a hasty experience, but a caged reaction to long-term social, emotional, and structural disadvantage.

Table 2. Thematic Synthesis with Illustrative Analytic Phrases, where T1=Structural and Cultural Pressures, T2=Psychosocial Distress and Emotional Overload, T3=Silence, Stigma, and Concealment, T4= Institutional and Service-Level Gaps and T5= Pathways to Suicidal Vulnerability

Theme	Core Sub-Themes	Illustrative Analytic Phrase
T1	Poverty and unemployment; livelihood instability; education–employment mismatch; dowry and career expectations; social comparison	Participants frequently described persistent financial strain and blocked social mobility, where material hardship was experienced as personal failure and loss of social worth due to constant comparison with economically successful others.
T2	Chronic stress; hopelessness; psychache; emotional exhaustion; perceived entrapment	Across cases, emotional distress accumulated gradually, producing sustained exhaustion, loss of hope, and a growing sense that no socially acceptable exit from distressing circumstances was available.
T3	Honor–shame norms; moralization of distress; non-disclosure; fear of labeling; community judgment	Many individuals reported deliberately concealing emotional suffering to protect family reputation and avoid moral judgment, even when distress had reached overwhelming levels.
T4	Limited mental-health services; financial barriers; low awareness; weak follow-up; geographic isolation	Participants repeatedly indicated that service unavailability, cost barriers, and limited awareness restricted timely access to care, leaving distress to be managed privately or within already strained family environments.
T5	Family abuse and neglect; patriarchal control; marital conflict; identity suppression; elder abandonment; relational rejection	Family environments were frequently experienced as spaces of emotional control, neglect, or conflict, where individuals felt unable to express distress, exercise autonomy, or seek validation for their experiences.

Figure3: Visualized Themes, Core Themes, and Theoretical Foundations

Theme 1: Structural and Cultural Pressures

In most instances, the layer of vulnerability was comprised of structural stressors. Persistent stressors such as economic insecurity, unemployment, underemployment, livelihood instability, and discrepancy between educational attainment and economic opportunity was recurrent. Such forces were not felt as material deprivation but symbolic failure, a betrayal of personal dignity and social value, where production activity is strongly linked to identity and respect (Eskin, 2018).

These pressures were exacerbated by cultural requirements. Dowry demands, career success norms, scholastic comparison and gendered expectations changed structural restrictions to moral judgments. Those who were unemployed failed in their crops or their careers internalized it as their inadequacy, but not the structural constraint. This trend can be regarded as consistent with strain and relative deprivation theories, which argue that blocked aspirations and social comparison leads to the creation of psychological distress, and Durkheim concept of anomic strain, where people lose their capacity to pursue socially desirable ends.

Theme 2: Psychosocial Distress and Emotional Overload

In cases, the emotional overload was a result of a long-term experience of unresolved stressors, including hopelessness, anxiety, exhaustion, and a sense of a lack of escape. Distress did not occur in short bursts; rather, it built up over time due to the repetitive experiences of failure, conflict, and disappointment. People indicated that they were stuck, empty, or got tired of living which is a form of deep psychological pain and not impulsivity (Raisa, 2022).

Notably, emotional distress used to be covert because people remained active in the society whilst they

were being tortured internally. This trend is associated with psychache theory, which theorizes suicide as an expression of intolerable psychological distress, and with interpersonal-psychological ones, especially perceived burdensomeness, and emotional alienation. Emotional overload played the role of immediate psychological state through which structural and relational pressures were converted into suicidal vulnerability.

Theme 3: Silence, Stigma, and Concealment

Silence and stigma were one of the most common discoveries across cases and helped to keep people susceptible to suicide. The distress of mind was often moralized and expressed in terms of weakness, failure, or spiritual weakness. This was done through disclosure because people are afraid of being labeled as social outcasts, disrespect of the family, and reputational harm, or gossip in the community. This led to the systematic hiding of distress, postponed seeking of help and making of distress normal as a way of dealing with it privately (Sudak et al; 2008). Stigma worked on both interpersonal and community levels, which strengthened the emotional isolation even in the family. People tended to say that they did know that there are people who can help but they do not want to approach them because of the shame or fear of being judged. This relationship is consistent with stigma theory and honor shame models, in which the reputation of a person within society is more important than their own wellbeing. Silence was therefore not just the lack of utterance but a social process that enhanced insecurity.

Theme 4: Institutional and Service-Level Gaps

Lack of organizational presence became a risk to be critical. Numerous instances were found to have poor access to mental-health services, financial constraints to care, unawareness, poor referral pathways and poor follow-up. In situations where people turned to professional assistance they were usually treated in bits or not maintained long enough and underlying distress continued to go unattended.

Institutional gaps were even more intense in rural and agrarian settings where geographic isolation and lack of services contributed to the sense of abandonment. The institutional failure was not a causative factor of distress but eliminated the possible protective buffers, which allowed the development of psychosocial strain to occur freely. The trend is indicative of ecological systems views where institutional settings have a controlling influence on the outcome of individuals through support or lack thereof.

Theme 5: Pathways to Suicidal Vulnerability

The most direct and emotionally heightened avenues of suicidal vulnerability were family and relational dynamics. In cases, there were high levels of emotional neglect, domestic violence, marital strife, authoritarian control, rejection, and lack of autonomy. In joint and extended families, people especially women, young people and the seniors were likely to complain that they had less power to make decisions and that they did not express their emotions.

In the case of women, the patriarchal rules, in-law abuse, humiliation based on dowry, and enforced obedience resulted in chronic entrapment and agency loss, which are aligned with the feminist and gender-specific theories of structural vulnerability. In males, failure to satisfy the provision requirements or rejection in relationships compromised the masculinity and self-esteem. Identity suppression and parental control among adolescents and youth generated a conflict within the individual goals and the roles they are assigned. Such dynamics echo Durkheimian ideas of fatalistic suicide, when too much social control over an individual inhibits freedom of choice, and interpersonal approaches that focus on frustrated belongingness. Family environments had served as the prime social group and, in most instances, the main location of psychological damage.

Integrated Discussion: Suicide as a Socially Produced Process

Combined, the findings show that suicide in District Chitral can best be considered a socially constructed and culturally controlled phenomenon, and not an individual psychological deviation. Structural pressures impose a permanent stress; the strain is mediated and personalized by family systems; the strain is quieted by cultural norms and institutional gaps leave no way of acting in time. The interaction of these forces is cumulative and leads to emotional overload and felt trapping.

One of the most important contributions of this analysis is the demonstration of the active role of stigma and silence which changes the distress that can be treated into hidden suffering. Suicide in this case is not a wish to die but a means of trying to come out of an unavoidable social and emotional state. This meaning supports sociological theories which place suicide into regimes of inequality, control, and breakdown of relations, and in which prevention programs must target at the same time family contexts, cultural practices, and institutional forms.

Through the empirical validation of the interaction between stigma, family regulation and institutional absence with structural strain, the study extrapolates sociological theories of suicide in a geographically remote as well as an honor-controlled setting. It adds a qualitative description that is relatively unique to northern Pakistan and that defies universalized approaches towards suicide and the importance of localized prevention models.

Table 2. Cross-Case Thematic Interpretation and Theoretical Alignment

Theme	Key Sub-Themes	Empirical Patterns Observed Across Cases	Theoretical Interpretation
T1:	Poverty and unemployment; livelihood instability; education–employment mismatch; dowry and economic expectations; social comparison	Individuals across age and gender groups experienced prolonged economic insecurity or aspiration–opportunity gaps. Even where basic needs were met, failure to achieve socially valued economic roles produced shame, frustration, and loss of self-worth. Agricultural failure and unemployment were especially destabilizing in rural contexts.	Strain theory and relative deprivation explain how blocked aspirations and social comparison generate psychological distress; Durkheim's anomic conditions highlight norm–goal disjunction.
T2:	Chronic stress; hopelessness; anxiety; psychache; perceived entrapment	Emotional distress accumulated over time rather than emerging abruptly. Participants described feeling trapped, exhausted, and unable to envision alternatives, indicating sustained psychological pain rather than impulsivity.	Psychache theory conceptualizes suicide as a response to unbearable psychological pain; interpersonal–psychological theory highlights perceived burdensomeness and isolation.
T3:	Fear of disgrace; moralization of distress; non-disclosure;community labeling; honor–shame dynamics	Stigma consistently delayed or prevented help-seeking. Distress was concealed to protect family reputation, leading to prolonged suffering in isolation. Silence functioned as an active social mechanism rather than	Stigma theory (Goffman) and honor–shame frameworks explain how moral regulation suppresses disclosure and transforms distress into private

		absence of communication.	suffering.
T4:	Limited mental-health services; financial barriers; low awareness; weak follow-up; geographic isolation	Institutional absence removed protective buffers. Even when care was sought, fragmented services and lack of continuity left distress unresolved. Rural residents were especially affected by service unavailability.	Ecological systems theory emphasizes how institutional environments shape vulnerability through absence or failure of support structures.
T5:	Family abuse and neglect; marital conflict; patriarchal control; identity suppression; elder abandonment; relational rejection	Family environments frequently acted as immediate sites of harm. Women, youth, and the elderly experienced constrained autonomy, emotional neglect, or abuse, producing entrapment and loss of agency.	Durkheim's fatalistic suicide (excessive regulation) and feminist theory explain how power asymmetries and control intensify vulnerability; interpersonal theory highlights thwarted belongingness.

Conclusion

This research paper offers a qualitative, case study sociological analysis of suicidal vulnerability in the District of Chitral and exposes suicide as a cumulatively produced, social phenomenon, as opposed to an individual psychological behavior. Based on 20 in-depth case studies, the results show that suicidal vulnerability develops based on combination of structural forces, sustained psychosocial stress, cultural norms of silence and stigma, family and relation processes, and institutional failures in providing mental-health care. Financial uncertainty, academic and professional demands, gender expectations, and financial insecurity lead to continuous stress, which is then mediated by family conditions that can either repress emotional expression or be actively involved in causing distress by being abusive, controlling, and neglectful.

One of the main contributions of the study is the emphasis on the active mechanisms of stigma and honor-based cultural regulation as a way of hiding pain, postponing seeking help, and making the acceptance of suffering a normal part of cultural order. The results also indicate that economic resources or education are not enough to safeguard the psychologist; the emotional security, relation support, and responsiveness of institutions are the decisive factors that define the outcomes of mental health. Placing the personal experience in the context of the larger sociological and theoretical context, the study contributes to the comprehensive vision of suicide as a social crisis that is based on inequality, regulation, and systemic disregard. These understandings demonstrate the need to have prevention strategies that are not just individual level but family systems, cultural narratives, and institutional responsibilities. This work relocates suicide by placing it in intersecting economies, cultures, families, and a lack of institutional structures as a sociological event that is determined by limited agency.

Future Work

Further studies must develop on this study by extending the qualitative investigation to comparative studies across the districts with a varied sociocultural and economic background to evaluate the context-dependent and generalizable route to suicidal vulnerability. The longitudinal qualitative research is desirable to follow the dynamics of distress over time and how the important life events (marriage, migration, unemployment, or bereavement) change the risk patterns. Causal inference and policy relevance can be further enhanced using mixed methods designs that would involve the integration of the qualitative narratives with quantitative indicators at the community level.

Also, consideration should be made in the future of working with those areas that have inadequately studied because it is better to represent the intersectional vulnerability based on the age of patients, gender, and power relations, i.e., adolescents, the elderly, informal workers, women in joint-family structures. The studies that evaluate the efficacy of interventions with cultural basis, including family-based counseling, community gatekeeper programs, and stigma-reduction programs, would be valuable evidence in prevention planning. Lastly, rural, and mountainous area institutional ethnographies of mental-health service provision might indicate the systemic obstacles to care and can inform the creation of sustainable and locally responsive mental-health systems. The community-based prevention models and culturally based counseling interventions should also be tested in the future to determine their efficacy in lowering the risk of suicide in honor-based societies.

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