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Unraveling Despair: A Qualitative Sociological Study of Suicide in Chitral District, Pakistan

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ABSTRACT
Suicide is still a very hidden and underexplored social crisis in rural and socially conservative environments, as stigma around the issue, honor-related principles, and institutional failure obscure the commonality of suicide, as well as factors that can lead to it. This article investigates suicidal vulnerability in the mountainous and geographically isolated district of Chitral, located in the northern part of Pakistan, using a qualitative and sociological approach that goes beyond individualistic and clinical explanations. Based on purposely chosen information from 100 plus cases of survivors of suicide attempts and relatives of those who commit suicide, the paper uses the reflexive thematic analysis approach to establish patterned social processes that contribute to suicidal behavior. The results demonstrate that suicide in Chitral is not a chance mental event, but a process of accumulation and social construction that is created through the interaction of five domains that are interrelated, such as structural and cultural regulation, prolonged psychosocial suffering, silence and stigma, gaps in institutions and services, and vulnerability through the family. The sustained strain is caused by economic instability, lack of education-employment fit, gendered expectations, and limited life opportunities, which, in most cases, are exacerbated at the family level with emotional neglect, authoritarian authority, violence, or relational rejection. Cultural demands of respect, restraint and perseverance further inhibit the expression of emotions and postpone help-seeking, converting distress into extended silent distress. Lack of access to culturally responsive and affordable mental health services at the institutional level eliminates the most crucial protective buffers, which give way to vulnerability in the long run. This paper is based on the sociological theories of strain, social regulation, stigma, gender, and psychosocial pain, which conceptualize suicide as a societal social failure and not an individual failure. Their results highlight the importance of suicide prevention programs that are based not only on biomedical services but also on family relationships, cultural discourses, and institutional responsibility, especially in marginalized and geographically remote settings. With its infrequent qualitative data on a less studied area, the study will provide context-related sociological knowledge for national and global suicide prevention discussions.

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Introduction

Suicide is a worldwide menace that kills more than 700,000 people each year, therefore, it is one of the critical causes of death on the earth (World Health Organization [WHO], 2021). It is a psychological or psychiatric phenomenon as well as a deeply rooted social problem, which is indicative of the health of a society in terms of structures, cultures, and institutions. Research regularly indicates that suicide is prone in a setting where social inclusion is fragile, mental health assistance is scarce, and cultural shame includes emotional distress (Turecki and Brent, 2016). This combination of individual victimization and social pressures is especially evident in nations such as Pakistan, where religious, cultural, and gender conventions dominate the incidence and experience of suicide.

The Chitral District of Khyber Pakhtunkhwa is a concerning situation within Pakistan. Although it is a highly educated area in the province, the number of suicides, in particular cases, among young married women and educated youth, has become alarming (Ahmed, 2019). What is even more disturbing about the issue is the extreme underreporting of suicides because of religious taboos, social stigmatization, and legal vagueness because suicide is criminalized according to Pakistani law (Arafat et al., 2022). Families, because of fear of dishonor and legal penalties, tend to fixate on the cases of suicide as accidents, which creates a big statistical blind spot in the national and regional suicide statistics (Sanauddin, 2022).

Chitral provides a special sociological terrain. It is a mountainous and rather remote area with high communalism and is also characterized by strict patriarchal set ups, economic stagnation, and institutional inadequacy. These contradictions create an environment of social chaos where people, and especially women, are in the middle of modern desires and traditional norms. As an illustration, women have not achieved economic mobility or personal freedom despite the increase in their education levels, leading to a great deal of frustration and emotional repression (Majeed, 2021). The conventions of gender are very conservative; women are married off, they are not allowed to have their own way, they are to maintain the family honor, including when it comes to being emotionally or physically abused (Shah, 2020). In these environments, suicide is not only an individual problem, but also a symptom of social breakdown within a system.

To their detriment, most of the existing academic research on suicide in Pakistan is urban-based and rooted in biomedical or psychiatric frameworks that fail to consider the rural and conservative population such as Chitral (Noor, 2024). The few existing studies are inclined towards individual level pathology, but not structural or cultural dynamics. This presents a significant gap in sociological knowledge, particularly where religious weakening, family structure, and codes influence the way of experiencing, reporting, and interpreting suicide. This lack is especially evident in a gender-sensitive, sociologically based approach to the suicide crisis at Chitral.

This paper attempts to fill this gap by examining the sociological causes of suicide in Chitral. It is directed by the classical theory of suicide developed by Durkheim, according to which suicide is associated with measures of social integration and regulation (Durkheim, 1951). It also includes the theory of feminism and the impact of gender roles and patriarchal power systems on emotional torment in women and structural strain theory, indicating that frustration and hopelessness are caused by the failure of society and opportunities to meet expectations in the lives of people (Merton, 2017). Through these structures, it is possible to locate suicide not as a deed of

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desperation, but rather it is a social reaction to cumulative strains, frustrated aspirations, and cultural oppression.

This study, based on qualitative research, examines the integration of socio-cultural norms, institutional failures, and economic constraints to formulate the concept of suicidal vulnerability in Chitral. Especially young women and educated youth receive special attention as they are overrepresented in suicide cases. The study aims to expose the andragogy of hidden emotional burdens, power relations, and survival strategies involved by foreshadowing their lived experiences. By so doing, the study would be added to academic and policy level discourse. It suggests a contextually culturally aware strategy for suicide prevention, which does not impose local values but opposes unhealthy norms. It highlights why it is necessary to transcend the discourses of mental illness and to perceive suicide in Chitral as a compounded social process that exists as inequality, gender injustice, cultural fixity, and institutional disregard.

Literature Review

A good literature review cannot be just a review of what is already known but a critique that will reveal patterns, controversies, and lack of knowledge. To conduct a sociological study on suicide in Chitral, it is essential to examine the current research on the subject by taking several perspectives in global, regional, national, and local dimensions to place the study at a wider intellectual and empirical framework. This part is a critical review of the available literature on suicide, its epidemiology, theoretical developments, methodological fashions, and a gap in rural, gendered, and sociocultural aspects, particularly, in northern Pakistan.

Suicide as a Global Social Phenomenon

In the whole world, suicide has historically been conceptualized in the definite biomedical and psychiatric paradigm, which is commonly perceived as the result of untreated mental illness, particularly, depression, substance abuse, and psychological trauma (Turecki and Brent, 2016). Although this model has been the basis of most prevention programs, it has also been criticized because it is individualistic and does not consider the social determinants, which include poverty, inequality, and cultural stigma (Shneidman, 1993).

This was disputed in the late 19th century by sociological theorists such as Emile Durkheim who argued that suicide is not solely a personal act but rather a social reality, a product of disturbed or unbalanced social bonding and regulation (Durkheim, 1951). His typology egoistic, altruistic, anomic, and fatalistic suicide is considered basic in the interpretation of the way different social surroundings bring forth different suicidal tendencies. This has been broadened by contemporary scholars to include structural and symbolic aspects because in most cases, suicide is an indication of a social breakdown in society to offer meaning, bond, and support (Kleinman, 2006).

South Asian Views: Culturally Incumbent Vulnerability

Suicide has begun to be interpreted more as a sociocultural contextual phenomenon in South Asia but not as a psychiatric phenomenon. Indian, Sri Lankan, Nepalese, and Bangladesh research points out that social organizations, gender roles, and family influences can be critical factors in defining suicidal behaviors (Jordans et al., 2018; Vijayakumar, 2017). The most remarkable characteristic in this respect is the overrepresentation of young women in the list of suicide victims.

Empirical research in the region indicates that it is a combination of factors including:

FORCED AND EARLY MARRIAGES

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DOWRY-RELATED VIOLENCE
DOMESTIC ABUSE
LACK OF MOBILITY AND AUTONOMY.
GREAT ACADEMIC OR FAMILY PERFORMANCE EXPECTATIONS.

They are gender specific drivers that are frequently heightened by cultural scripts of shame, duty, and perseverance so that women find it hard to express distress or request help. Such instances lead to suicide as a desperate means of resistance or escape and this may be done without supportive institutions or laws (Arafat et al., 2021).

In addition, the academic stress among young people in South Asia, especially in families of middle income, has also been among the overwhelming risk factors. Failure to fulfill the expectations of the family and the society tends to translate to shame, isolation and hopelessness. Nonetheless, these obvious social tendencies notwithstanding, in most of South Asian nations, the idea of suicide is still discussed in the context of individual-level pathology without references to the relational, structural, and systemic factors of suicidal thoughts.

Suicide in Pakistan: Stigma, Law, and Silence

In Pakistan, the research on suicide is not only under researched, but it is also a subject that is being silenced. Suicide and attempted suicide are criminalized in Section 325 of the Pakistan Penal Code, which supports the perspective that suicide is a moral and legal crime and not a cry of help (Arafat et al., 2022). This legal system, religious criticism, and cultural stigma leads to gross underreporting of suicide, as families tend to ascribe these deaths to accidents or nature not to disgrace themselves (Sanauddin, 2022).

Data that is available is very much fragmented and this available data is mostly based on urban hospital records, police reports or media coverage and has little or no triangulation as well as verification. The marginalized people and rural locations are still out of sight in the policy and academic discourse in this landscape. Existing studies are inclined to posit suicide in a medical/psychiatric framework, with quantitative surveys that are inappropriate to assess subtle social and cultural motivators (Noor, 2024). Moreover, intersectional analysis is usually missing in the Pakistani literature. Gender, class, geographic, and cultural issues are seldom addressed together, and thus, limitations of the generalized results share the realities that people at the most vulnerable endure. More specifically, women (or more precisely, rural, or mountainous women) are being virtually muted out of the national discourse on suicide.

Chitral Case: A Theoretical and Empirical Blind Spot

Chitral, a small area in the North Khyber Pakhtunkhwa, is a very essential although less studied place where suicide can be understood in Pakistan. Chitral, even with one of the highest literacy rates in the province, has seen the number of suicides, especially in young married women and students (Ahmed, 2016; Hussain, 2025). This worrying trend, however, has attracted little academic coverage, and the information present is largely limited to the media reports or NGO anecdotal information (Bibi, 2019) . A few structural and cultural processes precondition Chitral as an analytically unique case:

Geographic remoteness with the cities and services.
High educational attainment and ineffective employment uptake.
Strict gender roles and family respect institutions.
Weak presence of states and institutional inadequacy.
Increased digital divide making communities remote to resources and networks.

Such circumstances establish an environment in which emotional pain is chronic and unacknowledged, and suicide is a personal discontinuity and a social accusation. In

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Chitral, unlike in urban Pakistan, where a mental health discourse is gradually becoming more and more popular, suicide is shrouded in silence, as religious taboos obstruct it, and honor codes conceal it. In addition, the aspiration-reality gap, especially among young, educated people, brings about a deep sense of alienation, stagnation, and hopelessness (Majeed, 2021). No systematic, peer-reviewed study, which thoroughly analyzes the socio-gendered and cultural paths to suicide in Chitral, exists now. This gap results in epistemic vacuum in which the policy makers, mental health practitioners and civil society actors do not have any data, theory, or lingo to solve the crisis.

Table 1: Literature Review: Sociological Perspectives on Suicide in South Asia and Beyond

Author(s) & Year	Focus / Context	Key Findings	Relevance to Current Study
Durkheim (1951)	Classical sociological theory on suicide	Identified types of suicide: egoistic, anomic, altruistic, and fatalistic; emphasized social integration and regulation	Provides the theoretical base for interpreting suicide as a socially patterned rather than individual phenomenon
Merton (2017)	Social strain theory	Suicide arises when societal goals (e.g., success) are not matched by accessible means	Explains suicide among Chitrali youth who face education-employment disjunction
Goffman (1963)	Stigma theory	Social stigma prevents individuals from disclosing distress, leading to isolation and identity conflict	Explains silence and concealment of suicide in Chitral due to honor, religion, and social pressure
Jack (1991)	Feminist psychology and emotional repression	Women suppress emotional needs to maintain relationships, leading to depression and suicidality	Highly relevant to married women's experiences of silencing and endurance in Chitral
Crenshaw (1989)	Intersectionality theory	Multiple social identities (e.g., gender, class, ethnicity) intersect to shape lived vulnerability	Highlights compounded oppression of women in Chitral (gender, rural isolation, religious control)
Shneidman (1993)	Psychology of suicide (Psychache)	Suicide is driven by unbearable emotional pain and the absence of hope	Supports findings that suicide is often the final response to accumulated unaddressed pain

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Kleinman (2006)	Social suffering	Psychological pain is embedded in social and cultural contexts; mental health must be understood in relation to systemic injustice	Frames suicide as a culturally shaped form of suffering, not merely a clinical issue
Swidler (1986)	Cultural script theory	People draw on cultural "toolkits" to make meaning and act, even in distress	Explains why people in Chitral internalize silence and obedience, even at the cost of mental health
Vijayakumar (2015)	Suicide among women in South Asia	Women's suicide often results from domestic violence, dowry issues, infertility, and cultural pressure	Parallels found in Chitral, especially among young brides in patriarchal settings
Jordans et al. (2014)	Community mental health in low-income countries	Found that community-based, culturally adapted interventions improve help-seeking and reduce distress	Supports recommendation for community-level interventions in Chitral where formal services are absent
WHO (2014, 2021)	Global suicide prevention guidelines	Emphasize reducing stigma, building services, and intersectoral collaboration	Provides global best practices that inform the study's policy recommendations

Theoretical and Methodological Gaps

Although the classical theories of Durkheim and new theories of feminist, cultural, and structural theories offer a considerable framework in analyzing suicide, not many Pakistani studies use these theories in rural backgrounds. The quantitative survey, as well as medical records, are dominating methodologically as they are insufficient in those areas where stigma, misreporting, and fear of prosecution distort the available data.

Qualitative, context-based methods based on lived experiences, local stories, and discourses of a community are urgently needed. This paper identifies itself against this requirement- through a qualitative inquiry of how structural marginalization, gendered oppression, and cultural silence make people of Chitral vulnerable to suicide. It addresses a gaping gap in the empirical record as well as theoretical investigation of suicide in Pakistan in conservative, mountainous areas.

Summary: Literature-Informed Rationale for the Study

Some of the most important trends, as discussed by the reviewed literature, include the prevailing role of biomedical explanations, the rising role of sociocultural and structural determinants, ongoing gaps in the empirical body of knowledge on the marginalized contexts (e.g. a lack of research), and a growing necessity to adopt the qualitative and context-sensitive research methods.

Suicide is a socially embedded phenomenon, not merely a clinical one.

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In South Asia, suicide is shaped by patriarchal structures, cultural codes, and economic stress.

In Pakistan, there is an urban and biomedical bias, with little research in rural or gendered contexts.

Chitral, despite its rising suicide rate, remains a theoretical and empirical blind spot.

These patterns underscore the necessity of a sociological, gender-sensitive, and qualitative investigation into suicide in Chitral. This study builds upon existing theoretical foundations while introducing local, grounded knowledge that is currently missing in both national and international discourse.

Table 2: Theoretical Framework for Understanding Suicide in Chitral

Theoretical Approach	Core Concepts	Key Thinkers / Sources	Application to Chitral Context
Durkheim's Theory	Egoistic, Altruistic, Anomic, Fatalistic suicide; Social integration/regulation	Émile Durkheim (1951)	Explains how lack of integration (youth), over-regulation (women), and anomie (education-employment mismatch) foster suicide.
Strain Theory	Disjunction between culturally defined goals and means; frustration and failure	Robert Merton (2017)	Youth aspire to modern life but face structural barriers (poverty, joblessness), causing strain and hopelessness.
Feminist Theory	Gendered power, patriarchy, silencing, intersectionality	Jack (1991); Crenshaw (1989)	Highlights how married women are vulnerable due to silencing, domestic violence, and lack of autonomy.
Stigma Theory	Social labeling, shame, concealment, identity management	Erving Goffman (1963)	Suicide is hidden due to religious and social shame; families misreport deaths to preserve honor.
Cultural Script	Shared narratives that shape behavior and emotional expression	Swidler (1986); Kleinman (2006)	Cultural norms of endurance and obedience prevent help-seeking, especially among women.
Psychache Theory	Unbearable psychological pain, cognitive disintegration	Edwin Shneidman (1993)	Lack of support leads to intense internal pain, particularly among youth and women with no access to therapy.
Interpersonal Theory	Perceived burdensomeness, thwarted belongingness	Joiner (2005)	Educated youth feel isolated and like a burden when aspirations are unmet.
Ecological Systems	Interactions across micro-, meso-, exo-, and macrosystems	Bronfenbrenner (1979)	Factors like family, community, state institutions, and cultural

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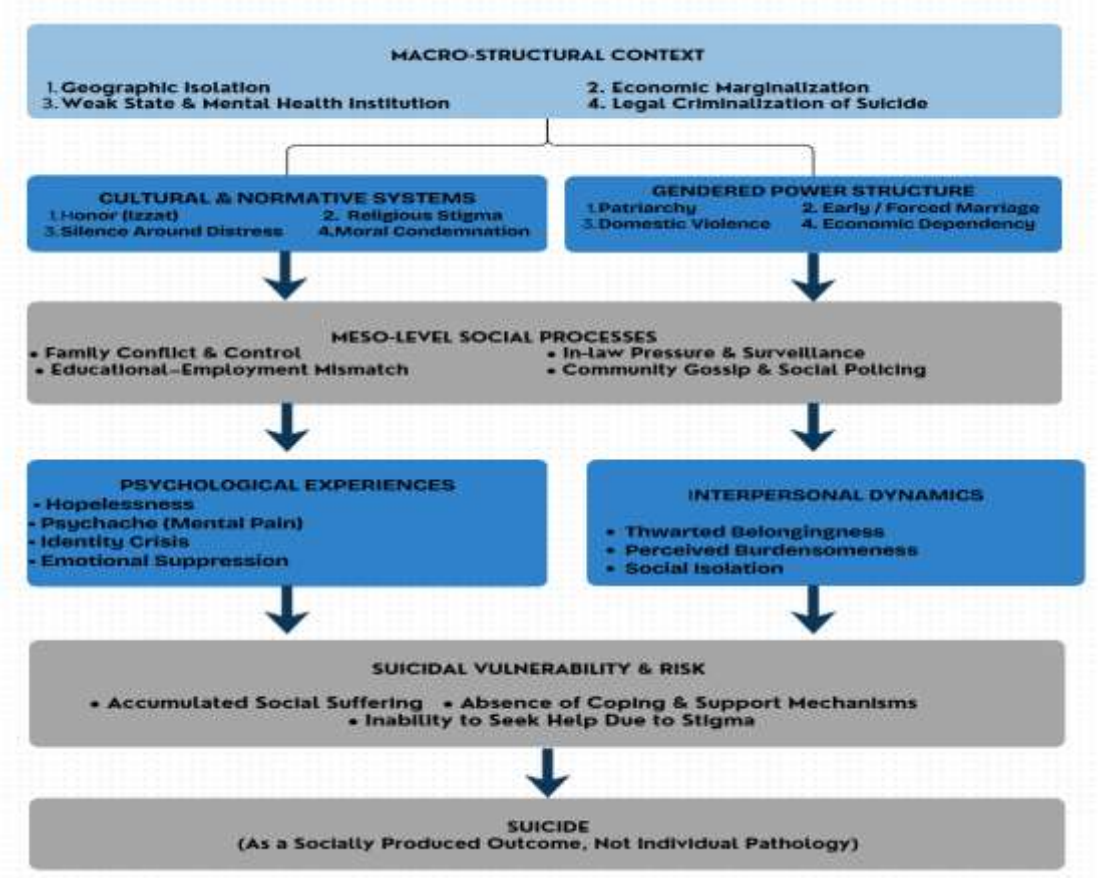
			norms interact to shape vulnerability.
Relative Deprivation	Frustration from comparing one's life to others	Runciman (1966); Demir (2023)	Exposure to urban life or digital media increases dissatisfaction and perceived failure in rural Chitral.

Figure 1 presents an integrated sociological conceptual framework illustrating how suicide in Chitral emerges through the interaction of structural, cultural, gendered, and psychological processes. At the macro level, geographic isolation, economic marginalization, weak institutional presence, and the criminalization of suicide create an enabling environment for distress. These forces intersect with deeply embedded cultural norms—such as honor, religious stigma, and emotional silence—and patriarchal gender relations that disproportionately constrain women's agency.

At the MESO level, family systems, community surveillance, and the mismatch between education and employment opportunities intensify emotional strain. These social pressures translate into micro-level psychological experiences, including hopelessness, psychache, identity crises, and suppressed emotions, alongside interpersonal dynamics of perceived burdensomeness and social isolation. The cumulative effect of these layers produces suicidal vulnerability, wherein individuals experience prolonged suffering without socially acceptable avenues for expression or support. Suicide is thus conceptualized not as an individual pathology, but as a socially produced outcome rooted in structural inequality, gendered oppression, and cultural silencing.



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Research Methodology

The research design taken in this study is the qualitative approach to research to examine the sociological impact of suicide in Chitral in Khyber Pakhtunkhwa. The qualitative approach is appropriate due to the sensitive, contextual, and highly personal nature of suicidal behavior because the researcher can acquire lived experiences, cultural meanings, and multifaceted social processes, which are not reflected in quantitative surveys.

Research Paradigm

The paradigm behind the study is the interpretivist paradigm that focuses on the subjective meanings and social constructions that people would attribute to their experiences. In this interpretation, suicide becomes not a psychological product but a socially constructed dimension, which is influenced by the context, culture, and power relations. Interpretivism also favors inquiries into the way individuals make sense of their suffering and the mediating role of social constructions on suffering (Creswell and Poth, 2018).

Research Design

This study employs a qualitative research design to explore suicide in District Chitral as a socially embedded phenomenon. The approach allows for an open and flexible examination of how gender, culture, religion, education, economic conditions, and structural constraints interact to shape suicidal vulnerability within the local social context.

Research Questions

The central research question that orients this study is the following.

What are the sociocultural, structural, and interpersonal factors that contribute to suicidal behavior in district Chitral, especially among young people and women?

To answer this general question, the sub-questions discussed in the study include:

What is the influence of gender norm and family structures on emotional distress experience?

What do people and their families perceive and attribute to suicide in the local culture?

What social mechanisms and processes perpetuate silence, stigma, and helplessness over suicide?

What are the obstacles to help-seeking behavior and mental health assistance?

Sampling Strategy

In this study, purposive sampling, in this case, using criterion-based selection, was used to select the participants who had direct or indirect exposure to suicidal-related events. Participants included:

FAMILIES OF SUICIDE VICTIMS
SURVIVORS OF ATTEMPTED SUICIDE

At least 100 participants were interviewed, so there was diversity in terms of age, gender, socioeconomic status, and their involvement in suicide occurrences. The data did not generate any additional themes, which was the point of saturation.

Data Collection Methods

The study used qualitative data collection techniques to examine sociocultural and structural issues that are related to suicide in the Chitral district. The methodology focused on depth, cultural sensitivity, and contextual knowledge of lived experiences of the participants.

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Semi-Structured Interviews

Semi-structured interviews were conducted in depth and semi-structured interviews were utilized among people who had lost a family member to suicide or had close affiliations to the problem in the community. The semi-structured interview allowed the respondents to share their own stories and social interpretations of the concept of suicide, and at the same time cover essential topics like gender relations, family relationships, cultural silence and institutional void. The interviews were conducted in Khowar and Urdu with the informed consent of the participants and transcribed and translated into English to be subjected to the thematic analysis.

Field Observations

In the community environment, such as schools, health centers, religious groups, and local markets, non-intervention field research was conducted. Field notes documented social interactions, gender relations, and non verbal expressions of distress, which added context to data interpretation of interviews.

Data Analysis

Thematic analysis framework was used to analyze the data as suggested by Braun and Clarke (2006). The researcher went through the process of familiarization of the interview transcripts and field notes in a repeated manner, then proceeded to code the data line-by-line using NVivo to retrieve the salient sociocultural meaning. The codes that were related were grouped into bigger themes that were debated, narrowed down, and well defined. The concluding discussion merged participant descriptions with sociological theory to produce an explanatory report on suicidal vulnerability within the Chitral district.

Trustworthiness and Rigor

The methodological rigor was taken care of according to the criterion of Lincoln and Guba (1985). Data triangulation and member check were used to increase credibility. Thick contextual description supported transferability, and audit trails and reflexive journaling were used to address dependability and confirmability.

Ethical Considerations

Data were collected with ethical approval. The right to withdraw, confidentiality, and informed consent was upheld during the study. Sensitivity was used in the interviewing process with the goal of preventing any harm and referring to local support services when necessary.

Results and Discussion

This section presents and interprets the findings of the study by integrating empirical narratives with sociological theory. Drawing on in-depth interviews with survivors of suicide attempts and family members of suicide victims, alongside sustained field observations, the analysis identifies suicide in Chitral as a cumulative, socially produced process rather than an impulsive or purely psychological act. The findings are organized into five interrelated themes. Each theme is first grounded in participants' lived experiences and then interpreted through relevant sociological and psychological frameworks to demonstrate how individual distress is embedded within cultural, familial, and institutional structures. Table 3 presents illustrative respondent narratives mapped to each theme, demonstrating how participants experienced and articulated the processes

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leading to suicidal vulnerability.

Table 3: Respondent Comments by Theme

Theme	Representative Respondent Comments
Structural and Cultural Pressures	"Here, everything is decided for you—your marriage, your behavior, even your silence."
	"Honor controls people's lives here. If you cross the line, you are alone."
	"Tradition is so strong that even suffering becomes normal."
Psychosocial Distress and Emotional Overload	"He kept everything inside until it became too heavy to carry."
	"She was always tired, mentally tired. There was no rest from expectations."
	"Pressure builds slowly, but when it breaks, it breaks completely."
Silence, Stigma, and Concealment	"People fear talking more than they fear dying."
	"Families hide the truth because suicide brings shame."
	"He never said he was depressed because men are not allowed to be weak."
Institutional and Service-Level Gaps	"There is no one trained to listen, no place to go when the mind collapses."
	"Doctors treat the body, not the pain inside."
	"Schools and mosques talk about discipline, not mental health."
Pathways to Suicidal Vulnerability	"She stayed silent for years; suicide was the only way left to speak."
	"For some people, death feels like relief from constant pain."
	"It is never sudden. It is a long road that no one notices."

Theme 01: Structural and Cultural Pressures

Suicide was always framed by the respondents as the result of strict expectations of culture and structure and not immediate psychological breakdown. The ideals of honor (Izzat), shame (Sharam), obedience, and moral conformity became some of the effective regulatory measures, especially in gender and family roles. The act of breaking these norms was seen as an overall failure, and a high level of social pressure was created.

These results are consistent with the idea of fatalistic suicide by Durkheim in which too much regulation and moral observation leads to a sense of entrapment. The same has been documented in honor-based cultures in South Asia and the Middle East, which have cultural inflexibility that affects emotional expression and seeks help. This work builds on the literature that has already been done by demonstrating how these pressures work continuously throughout the life course, slowly creating vulnerability in suicide.

Empirical Findings: Participants consistently framed suicidal distress as emerging from long-standing structural and cultural pressures, rather than sudden emotional breakdowns. Decisions regarding education, marriage, employment, and social conduct were described as externally imposed, leaving little room for personal agency. This was especially pronounced for women and young people. The illustrative quotations compiled in Table 3 provide analytic depth to the thematic findings by foregrounding participants.

Discussion: The results of this study are very close to the idea of fatalistic suicide expressed by Durkheim, in which over-controlling social factors leads to a sense of being trapped and feeling hopeless. In Chitral, strict cultural norms are enforced as a form of morality, which restricts freedom of expression of emotions and freedom of choice. This setting contrasts with anomic contexts where there is the lack of norms, but it is rather an

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indication of over-regulation, especially to married women where they lack autonomy due to the patriarchal family set-ups.

A feminist sociological approach to these pressures would imply that gendered power relations turn everyday life into a place of continued control. The suffering of women was not occasional; it was structural as it was entrenched in the concept of marriage, reproductive roles, and the imposed silence. In the youth and more so educated men, the mismatch between cultural demands of becoming successful and the lack of structural opportunity gave rise to chronic strain. This is a reinforcement of the strain theory proposed by Merton in which the socially desirable objectives fail to be obtained by the legitimacy and thus induce frustration and hopelessness.

Theme 02: Psychosocial Distress and Emotional Overload

The resultant shows chronic psychosocial distress that is characterized by emotional suppression, guilt, hopelessness, and exhaustion. Instead of acute mental illness, the respondents talked about the long-term emotional burden due to family conflict, economic dependence, and unmet ambitions. This trend echoes the psychache theory of Shneidman and the interpersonal-psychological theory of suicide as put forward by Joiner, especially perceived burdensomeness, and thwarted belongingness. In line with the research in the conservative and rural setting, the results indicate that emotional suffering gathers in silence when society does not allow it to be expressed. The study contributes in that it highlights the socially constructed aspect of emotional overload, indicating the inadequacy of the individual level of intervention.

Empirical Findings: Rather than describing clinical mental illness, participants emphasized prolonged emotional exhaustion, marked by suppressed anger, sadness, guilt, and hopelessness. Distress accumulated gradually over years of unmet expectations, family conflict, and social comparison. The illustrative quotations compiled in Table 3.

Discussion : These stories are consistent with the concept of psychache introduced by Shneidman (psychological pain that is unbearable due to the lack of fulfillment of emotional needs). Notably, the research shows that this suffering is a product of the society rather than a pathology of an individual. Emotional overload was brought about by years of constraint, neglect, and judgment, as opposed to acute psychiatric episodes.

The results also demonstrate the interpersonal-psychological theory of suicide proposed by Joiner especially the perceived burdensomeness and thwarted belongingness. Nevertheless, this paper goes further to place such psychological states into a context of family hierarchies, gender conventions, and economic precarity in which over time social environments foster the development of internal distress.

Theme 03: Silence, Stigma, and Concealment

Silence has become a main process that perpetuated suicidal vulnerability. According to the respondents, distress was something that could not be articulated due to fear of gossip, moral condemnation, and harm to family respect. Suicide attempts or patient death were usually hidden in the family, which reinforced stigma and invisibility. Based on the theory of cultural scripts and social constructionism, suicide in Chitral is socially constructed as a moral failure and not a health concern for the people. The research is even subtler, as it illustrates the work of silence at personal, family, and institutional levels to avoid telling, postpone the intervention, and justify the long-term suffering.

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Empirical Findings: Silence emerged as a dominant social mechanism shaping suicidal vulnerability. Participants described fear of gossip, moral condemnation, and dishonor as primary reasons for concealing distress. Emotional disclosure was widely perceived as weakness, especially for men. The illustrative quotations compiled in Table 3.

Discussion: Based on the stigma theory expressed by Goffman, suicide in Chitral is socially created to be a moral failure and not a health problem. This stigmatization takes place on several levels individual, familial, and institutional in nature, to the effect that a culture of secrecy and delayed help seeking is created. The theory of cultural script also describes the normalization of silence into a moral imperative. People make endurance their virtue and do so to such a degree that it destroys them. This observation shows that stigma is not merely the result of suicide but a contributor of vulnerability by secluding people prior to the onset of crises.

Theme 04: Institutional and Service-Level Gaps

According to the respondents, there was low access to mental health services due to geographic isolation, finances, and cultural mistrust. Medical facilities were viewed as the treatment of physical illness and the lack of emotional suffering, post follow-up, and crisis intervention. In line with ecological systems theory, the lack of responsive institutions contributed to increased vulnerability in that individuals are left without a choice but to endure or remain silent. In this study, institutional neglect is demonstrated to be not an inactive phenomenon; it perpetuates stigma and concealment, further isolate vulnerable people.

Empirical Findings: Participants consistently reported a lack of accessible and culturally responsive mental health services. Health facilities were described as focused on physical illness, with little recognition of emotional distress. The illustrative quotations compiled in Table 3.

Discussion: These findings demonstrate the enforcement of individual vulnerability by the exosystem level of institutional neglect using the ecological systems theory by Bronfenbrenner. Lack of support systems that are close and trusted, which are available locally, makes people cope with distress in secret, which strengthens stigma and silence. Failure in institutions here is not passive. The institutions of ignoring the emotional suffering unwillingly legitimize cultural norms that discourage help-seeking. This is in line with the theories of structural violence, in which violence is created by systemic nonaction and not by open abuse.

Theme 05: Pathways to Suicidal Vulnerability

Instead of singular causation factors, the results also show a progressive route of suicide. Emotional overload is created by structural and cultural pressures and silenced by stigma and eventually enhanced by institutional absence. Although suicide becomes a perceived way of escape from long term entrapment, it is not an impulsive act. This processual interpretation develops suicide studies by modeling vulnerability as a socially created and accumulated process. The analysis places this path in a sociologically distinct cultural context, enabling the study to add a detailed construct of how suicide could be understood in a way other than through the psychopathology of an individual.

Empirical Findings: Participants overwhelmingly rejected the idea of suicide as sudden or impulsive. Instead, they described a progressive trajectory, beginning with cultural pressure, followed by emotional suppression, social isolation, and institutional

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abandonment. The illustrative quotations compiled in Table 3.

Discussion: This processual knowledge is a challenge to the prevailing biomedical concepts and a redefinition of suicide as a socially mediated product. The study conceptualizes suicide as the completion of decades of entrapment by combining Durkheim's fatalistic and anomic suicide, Shneidman psychache, and life-course theories. This research places suicide in contexts of stratified social environments: family, culture, economy, and institutions, which adds to the contextual sensitive sociological model beyond the individual pathology.

Synthesis: Linking Themes, Theory, and Prevention

Table 4 and 5 links empirical themes to sociological theory and translates findings into actionable policy directions, demonstrating the applied relevance of the study. Taken together, the findings demonstrate that suicide in Chitral is produced through the interaction of:

Cultural over-regulation
Gendered and familial power relations
Chronic psychosocial strain
Stigma-driven silence
Institutional absence

This integrated analysis underscores that effective prevention must address social conditions, not merely individual symptoms.

Table 4: Major Themes and Empirical Indicators of Suicidal Vulnerability

Theme	Core Empirical Indicators	Social Level
1	Honor norms, forced conformity, restricted autonomy, education–employment mismatch	Macro
2	Emotional suppression, exhaustion, guilt, hopelessness	Micro
3	Fear of gossip, moral judgment, misreporting of suicide	Micro–Meso
4	Lack of mental health services, dismissive healthcare encounters	Exo
5	Long-term accumulation of strain, perceived entrapment	Cross-level

Table 5: Theory–Theme–Policy Linkage Table

Theme	Theoretical Linkages	Policy Implications
1	Durkheim – Fatalistic Suicide Feminist Theory (Patriarchy, Control) Cultural Script Theory	• Reform family and marriage laws to reduce coercion. • Community education programs challenging harmful honor norms.
2	Shneidman – Psychache Stress Accumulation Models Symbolic Interactionism	• Early psychosocial screening in schools • Community-based emotional support initiatives

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3	Goffman – Stigma Theory Durkheim – Egoistic Suicide Kleinman – Social Suffering	• Public anti-stigma mental health campaigns Religious leader engagement to normalize help-seeking.
4	Bronfenbrenner Ecological Systems Theory Structural Violence Theory	• Establish mental health services in district hospitals. • Train teachers, health workers, and religious leaders in basic counseling
5	Durkheim – Anomic Suicide Cumulative Risk Models Life Course Perspective	• Suicide surveillance and early warning systems. • Survivor-informed prevention strategies

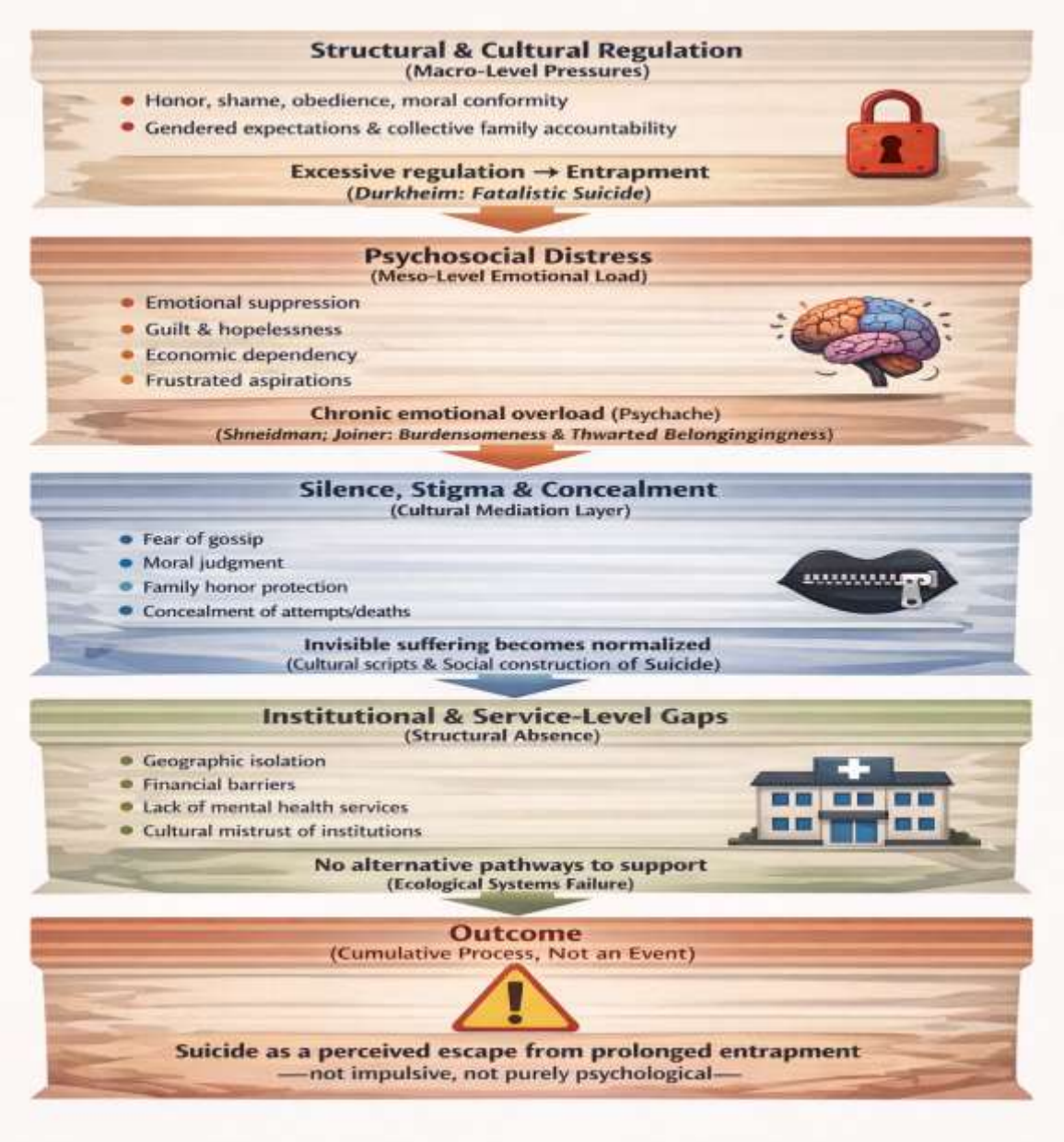

Figure 2. A Layered Framework for Understanding Suicide as a Cumulative Process

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The Figure 2 illustrates a multi-level framework that maps how cultural regulation, psychosocial distress, stigma, and institutional absences interact over time to entrench individuals in prolonged suffering. Rather than depicting suicide as an impulsive or isolated event, this model conceptualizes it as a perceived escape from sustained entrapment, highlighting fatalistic suicide (Durkheim), psychache (Shneidman), and thwarted belongingness (Joiner) within a culturally and structurally mediated context.

Conclusions

This paper aimed at demystifying the sociological forces behind suicide in the Chitral district of Khyber Pakhtunkhwa, Pakistan, a land characterized by beautiful extremes, culturally diverse, and structural inequalities instilled in one way or the other. The study, in a qualitative, interpretivist perspective, helped to reveal how suicide in the context is not purely a psychological or personal behavior, but a socially constructed phenomenon, which is based on gendered oppression, cultural silence, institutional disregard, and invisibility of emotion. The results show that the cumulative social pressures in the Chitral area influence the act of suicide: structural demands, gender roles, and honor, the gap between educational goals and socioeconomic facts, and the lack of culturally competent mental health services.

Suicide was not represented as an irrational break, but the ultimate manifestation of stifled suffering and a tragic conclusion to years of limited agency, emotional invisibility, and untreated trauma. The use of participant narratives underscored that suicide is often a form of protest, communication, or relief. These deeply human accounts offer a counter-narrative to dominant psychiatric framings, instead urging scholars and policymakers to consider suicide through a sociological, gender-sensitive, and rights-based lens.

This research affirms that intervention must go beyond biomedical approaches. A transformative response must address cultural change, social protection, legal reform, and community-based healing. This includes empowering women, building mental health capacity, challenging stigma, and restoring institutional trust.

Future Research Direction

Although this research is a critical one about suicide in Chitral, there are several areas that this study should expand on:

Gender-Specific Ethnographies: Future studies must cover unique aspects of women experiences in various valleys of Chitral to understand the subtleties of gendered suffering in various local cultures and kinship systems.

Youth and Digital Exposure: Future research might explore the nature in which exposure to digital media and urban life formulates aspiration, identity conflict, and suicidal risk in educated rural-residing youth.

Religious Interpretations and Mental Health: The understanding of how religious leaders interpret and react to suicide may be used to inform culturally sensitive, psychologically efficacious faith-based suicide prevention models.

Comparative Regional Analysis: Comparative work in other districts within Khyber Pakhtunkhwa or Gilgit-Baltistan would be able to understand whether comparable sociocultural dynamics are evident and would provide a way of differentiating context-specific and region-wide factors.

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Postvention and Survivor Voices: More in-depth work is needed on families of suicide victims and attempt survivors to understand long-term psychological, social, and economic impacts, and to inform community healing strategies.

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