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Stigma, Silence, and Survival: A Sociological Study of Mental Health Narratives in Nepal's Terai Region

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Abstract

Mental illness constitutes a substantial and growing share of Nepal's disease burden, yet it remains marked by silence, stigma, and systemic neglect. This qualitative study examined how mental health stigma is experienced and negotiated in selected communities in Bara and Parsa districts, Madhesh Province. Drawing on Goffman, Link, and Phelan, Foucault, feminist theory, and intersectionality, the analysis conceptualises stigma as a relational and structural process shaped by caste, gender, poverty, and migration. Data were generated through 40 semi-structured interviews and three focus group discussions involving 30 participants. The findings show that household silence can protect family reputation and marriage prospects while delaying disclosure, help-seeking, and support. Derogatory labels such as "pagal" reinforce exclusion, while women experience intersecting burdens as people living with distress and as caregivers. Youth accounts reveal tension between growing mental health awareness and persistent social sanctions. Participants further indicated a local gap between national mental health commitments and available services. Rather than estimating prevalence, the study identifies the mechanisms that produce, negotiate, and resist stigma and silence. Moreover, it conceptualises silence as a protective yet stigma-reproducing social practice and identifies context-sensitive implications for primary care, schools, caregivers, and community-led anti-stigma initiatives.

Keywords: coping mechanisms; mental health; stigma; silence; survival; Nepal; sociological study



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1. Introduction

Mental health is increasingly recognised as a critical component of global public health, yet many low- and middle-income countries still neglect it [1]. Despite growing awareness, mental illness continues to be obscured by silence and stigma, particularly in rural and semi-urban settings [2]. Whereas physical illness often attracts social empathy and state attention, mental illness is frequently concealed, denied, or interpreted in moral or spiritual terms [3]. Such silence delays care, worsens outcomes, and reinforces systemic neglect. Understanding how silence operates and why stigma persists is therefore essential to developing effective interventions. This paper examines these dynamics sociologically, drawing on data from Bara and Parsa, two districts in Nepal's Terai region.

The Nepal Terai, also known as Madhesh, is a fertile plain bordering India that is culturally distinct from the country's hill and mountain regions. Bara and Parsa are ethnically

and linguistically diverse districts in Madhesh Province, where Maithili, Bhojpuri, and Tharu are widely spoken. The region has long experienced economic marginalisation and limited political representation, and its health indicators remain below national averages. High levels of poverty and illiteracy, together with caste-based discrimination, strongly influence health-seeking behaviour [4]. Within this sociopolitical context, mental illness remains highly stigmatised. Depression, anxiety, schizophrenia, and substance use disorders may be understood not as medical conditions but as evidence of personal failure, divine punishment, or karmic debt. These interpretations reinforce stigma, encourage concealment, and impede early intervention.

Silence surrounding mental illness is more than an absence of dialogue; it is a social practice. Families may conceal a relative's mental illness to protect their reputation and preserve the marriage prospects of family members [5,6]. In contexts where marriageability shapes social standing, a person labelled as mentally ill (and sometimes their siblings) may be regarded as unsuitable for marriage. Fear of these consequences can lead families to conceal the condition, avoid public disclosure, and manage it within the household. Although silence may function as a survival strategy, it carries substantial costs: affected individuals and families endure distress in isolation, caregivers receive little support, and symptoms may worsen before care is sought. Community stigma further reinforces this silence. Mental illness may be associated with "*pagalpan*" (madness), a term laden with contempt and fear. People who are labelled as such may be mocked, avoided, or subjected to pity. Such language reduces individuals to a diagnosis, undermining their dignity and social identity, and can deter them from seeking professional support. In this sense, the social consequences of labelling may become more disabling than the illness itself.

Gender intensifies both stigma and suffering. Women with mental illness may be doubly stigmatised: for having a psychiatric condition and for being perceived as failing to fulfil expected roles as wives and mothers [7]. Their distress may be dismissed as emotional fragility or attributed to spiritual causes, while domestic violence, early marriage, and financial dependence may further increase vulnerability. Men may also experience stigma when mental illness is interpreted as a failure to fulfil the provider role; however, women frequently bear an additional and disproportionate burden of caregiving.

Caste further complicates these dynamics. Dalits and other marginalised caste groups may experience discrimination on two intersecting grounds: mental illness and caste identity [8]. This convergence can intensify stigma, restrict access to care and social support, and increase the likelihood that mental health needs remain unrecognised or untreated. Mental health stigma must therefore be understood within the broader power relations that sustain caste-based exclusion.

Migration is another important feature of life in Bara and Parsa. Men commonly migrate to India or the Gulf States for employment, leaving women to manage households and caregiving responsibilities. Separation can generate emotional and financial strain for those who remain, increasing vulnerability to mental distress [9]. Migrants may likewise experience isolation, insecurity, and exploitative working conditions [10,11]. Yet mental health services for migrants and their families were described as limited, while seeking such care may itself be seen as stigmatising or culturally unacceptable.

The state response to mental health needs in Bara and Parsa remains limited. Nepal adopted a National Mental Health Policy in 1996; a proposed replacement policy in 2017 remained a draft, and a National Mental Health Strategy and Action Plan was introduced in 2020 [12]. Although the policy articulates progressive objectives, including the integration of mental health into primary care, implementation remains uneven. Health posts continue to face shortages of trained personnel, psychotropic medicines, and effective referral pathways.

Despite these constraints, there are signs of change. Nongovernmental and community-based organisations have sought to reduce mental health stigma through awareness campaigns, support groups, and school-based interventions. Youth groups in Bara and Parsa have used social media campaigns, street theatre, and radio discussions to challenge stigma and encourage help-seeking. Although limited in scale, these initiatives represent important efforts to shift prevailing norms and demonstrate the potential of community-led responses to mental health concerns.

Against this background, the study examines how mental health stigma is produced, negotiated, and resisted in selected communities in Bara and Parsa. It analyses the interplay among household strategies, community labelling, intersecting inequalities, and help-seeking pathways. Rather than estimating prevalence, the study seeks to explain the social mechanisms through which stigma and silence shape everyday life and access to care.

The study addresses four research questions (RQs): (1) How do individuals, families, caregivers, and frontline health workers understand and negotiate mental health stigma and silence in the study settings? (2) How do gender, caste, migration, and socioeconomic position shape experiences of stigma, caregiving, and help-seeking? (3) How do participant accounts illuminate the relationship between national mental health commitments and local service realities? (4) What forms of resistance, resilience, and community-level change are evident in the data?

1.1. Theoretical Foundations of Stigma

Sociological scholarship on stigma was profoundly shaped by Erving Goffman's seminal 1963 work, *Stigma: Notes on the Management of Spoiled Identity* [13]. Goffman conceptualised stigma as a social process through which an individual is "transformed from a whole and usual person to a tainted, discounted one" [13]. Moving beyond approaches concerned primarily with the application of labels, he examined the everyday interactions through which people manage discredited or potentially discreditable identities. Stigma is therefore relational: a difference becomes consequential when it is socially interpreted as discrediting. This perspective has been especially influential in the sociology of mental health because psychiatric categories often acquire meaning and force through such interactions.

Later theorists extended Goffman's interactional account by examining how stigma is produced and sustained structurally. Link and Phelan conceptualised stigma as the convergence of four interrelated processes: distinguishing and labelling human differences, associating those differences with negative stereotypes, separating "us" from "them," and authorising status loss and discrimination through unequal relations of power [14]. This power-sensitive framework is particularly relevant in South Asia, where caste, class, and gender hierarchies shape who has the authority to label others and whose identities become socially discredited.

Foucault's concept of power/knowledge further suggests that silence is not merely an absence of speech but a modality through which power operates [15,16]. Families that conceal a daughter's depression are therefore not simply passive; they actively produce and regulate silence as a form of domestic governance. Feminist and intersectional theories deepen this analysis by showing that stigma is not experienced uniformly: women, Dalit households, and migrants encounter qualitatively different forms of discredit, surveillance, and exclusion.

1.2. Global Patterns of Mental Health Stigma

Globally, stigma remains a major barrier to equitable and effective mental health care [17]. Even in countries with well-resourced health systems, stereotypes continue to portray people with mental illness as dangerous, unpredictable, or incompetent [18,19].

Public education may improve knowledge, but attitudinal gains do not necessarily translate into behavioural change; Doh et al., by contrast, emphasise the value of social contact in challenging prejudice [20]. In low- and middle-income countries, stigma is compounded by resource constraints, including long waiting times, limited specialist care, reliance on traditional practitioners, and substantial out-of-pocket costs [21]. Under such conditions, silence may become a rational response: disclosure can invite ridicule without guaranteeing treatment or support. This tension is evident in Nepal, where district-level mental health resources are limited and specialist services remain concentrated in urban centres.

1.3. South Asian Perspectives on Mental Health

South Asia offers important insights into the ways cultural and religious frameworks shape the expression of psychological distress. Idioms such as “tension” in India and “heart-mind problems” in Nepal enable people to communicate suffering in culturally intelligible terms without invoking explicitly psychiatric labels. Anthropological research shows that such idioms can protect individuals from severe stigma while simultaneously limiting recognition of conditions that might benefit from clinical intervention [22].

Supernatural and spiritual explanations of illness are common across India, Pakistan, and Bangladesh, where families may consult religious healers, astrologers, or temples before approaching clinical services [23–25]. Comparable patterns are evident in Bara and Parsa, where households may move iteratively among healers, pharmacies, and private doctors. Reliance on spiritual or traditional explanations is not merely a cultural preference; it is also pragmatic, because these forms of care are often more accessible, affordable, and socially acceptable than scarce psychiatric services.

Gender is central to understanding mental health stigma in South Asia. Women experiencing postpartum depression, domestic violence, or infertility-related trauma may be labelled weak, cursed, or morally deficient [26]. Such interpretations moralise women’s suffering and can increase the risk of rejection or abandonment. In the Terai, women with mental illness may be regarded as economic liabilities whose condition threatens both their own futures and their families’ honour within social arrangements shaped by dowry and patrilineal inheritance.

1.4. Nepali Research on Stigma

Nepali scholarship on mental health stigma has expanded notably, particularly following the civil conflict and the 2015 earthquakes, which brought heightened attention to population-level exposure to psychosocial adversity. Researchers such as Kohrt and Carruth have examined how structural inequalities, including caste divisions, shape mental health risks and responses [27]. Collectively, this literature documents persistent stigma alongside substantial gaps in community mental health knowledge.

Research in rural Nepal indicates that silence and euphemistic language can serve protective functions. Families may avoid the term “*manasik rog*” (mental illness), preferring less overtly stigmatising expressions such as “*dimag kamjor*” (weak brain) or “*dil ko samasya*” (heart-mind problem). Although these terms can make distress more socially communicable, they may also minimise the seriousness of conditions requiring care. Community members may distance themselves from someone described as mentally ill, while responding with greater sympathy to a person said to be experiencing “tension” or “overthinking.”

At the policy level, Nepal introduced a National Mental Health Policy in 1996, while a 2017 replacement remained a draft; this was followed by the National Mental Health Strategy and Action Plan in 2020 [12]. Nevertheless, the integration of mental health into primary health care remains incomplete. Reported shortages of psychotropic medicines at

district hospitals, together with limited training among health professionals, constrain the availability and quality of care [28–30]. Consequently, even where stigma is challenged, inaccessible services may reinforce concealment and silence.

1.5. Intersectional Dynamics: Caste, Gender, Migration

Mental health stigma in Nepal is not experienced as a singular form of disadvantage; an intersectional analysis is therefore essential. Gender norms in the Terai position women primarily within domestic and familial roles, making it difficult to disclose distress without risking judgement or sanction [31]. A woman identified as depressed or unstable may face abandonment, blame related to infertility, or criticism of her mothering. Dalit communities may experience compounded stigma, as caste-based exclusion intersects with negative attitudes towards mental illness. Migration further intensifies these pressures [32]. Men working abroad may conceal depression or distress for fear of jeopardising employment contracts, while women who remain at home may face social isolation, financial strain, and community scrutiny with limited sources of support.

1.6. Gaps in the Literature

Despite important scholarship on mental health stigma in Nepal, several gaps remain. First, much of the literature focuses on hill districts or post-disaster contexts, leaving the densely populated and culturally distinctive Terai comparatively underexamined. Second, limited attention has been given to the relational production of silence within households, including how families negotiate what may be disclosed, to whom, and under what conditions. Third, the role of unequal power in shaping the local implementation of mental health policy remains insufficiently analysed. Finally, although stigma is well documented, less is known about how individuals and communities resist, negotiate, or transform it through everyday practices of resilience.

1.7. Contribution of This Study

This study offers a contextually grounded account of mental health stigma in Bara and Parsa by examining how marriageability, caste relations, migration, caregiving, and uneven service provision intersect. Its principal conceptual contribution is to theorise silence not simply as an absence of speech or a symptom of stigma but as a negotiated social practice. Silence may temporarily protect household reputation while simultaneously reproducing the conditions that make disclosure and care-seeking risky. By foregrounding this dual function, the study qualifies approaches that treat disclosure as uniformly beneficial and shows why anti-stigma interventions must address the social and institutional costs associated with speaking openly.

2. Materials and Methods

The study employed a qualitative, multi-source design to examine the relational, cultural, and institutional dimensions of mental health-related stigma in communities across Bara and Parsa. Semi-structured interviews and focus group discussions (FGDs) generated complementary forms of evidence while remaining responsive to ethical and cultural considerations. Together, these methods enabled the study to address the research questions (RQs): how stigma and silence were understood and negotiated (RQ1); how intersecting social positions shaped caregiving and help-seeking (RQ2); how policy commitments related to local service realities (RQ3); and how resistance, resilience, and community-level change were expressed (RQ4). Silence was therefore analysed not simply as an absence of disclosure but as a socially embedded practice shaped by relationships, norms, inequalities, and institutional conditions.

A qualitative approach was appropriate because mental health-related stigma is experienced individually but produced and negotiated through social relationships, cultural meanings, and institutional arrangements. It enabled detailed examination of how families sustain or disrupt silence, how stigmatising language circulates within communities, and how participants experience caregiving, help-seeking, and gaps between policy and service provision. These processes could not be adequately captured through quantitative measures alone.

The study was conducted in Kalaiya, Simara, and Jeetpur in Bara District and Birgunj in Parsa District, Madhesh Province, Nepal. All primary fieldwork took place between May 2025 and November 2025. These sites were chosen because their densely populated, cross-border, caste-stratified, and migration-affected contexts were directly relevant to the research questions. The lead researcher (first author) used purposive sampling to recruit participants with direct or professionally relevant experience of mental health-related stigma through local health workers, hospitals, and community organisations. Some participants were additionally recruited through referrals from initial contacts and participants (snowball sampling). Semi-structured interviews, ranging from 30 to 45 min each, were conducted with 40 participants: 15 people who self-identified as experiencing symptoms of depression, anxiety, psychosis, or substance use; 15 family members who provided daily care and support; and 10 frontline health providers, including female community health volunteers, health-post in-charges, and chemists. These groups provided complementary perspectives on how stigma and silence were produced and negotiated (RQ1) and how gender, caste, migration, and socioeconomic position shaped caregiving and help-seeking (RQ2). A further 30 participants, including young people, took part in three focus group discussions (ranging from 60 to 90 min each), bringing the total sample to 70 and generating evidence on collective norms, resistance, resilience, and community-level change (RQ4).

Participants were included if they lived or worked in the selected municipalities, had relevant lived experience, caregiving, community, or frontline health experience, and provided informed consent or, where applicable, assent with parental or guardian consent. They were excluded if they were outside the study area, lacked relevant experience, could not provide consent or assent, or could not participate safely in recruitment. Sample adequacy was considered in relation to the study aims and the specificity, diversity, and depth of participants' accounts rather than statistical representativeness. Many patterns recurred across accounts, while some participants introduced additional issues; the study therefore does not claim complete data saturation.

Semi-structured interviews explored experiences of distress, community responses, help-seeking, caregiving, and encounters with health services. Interviews with people experiencing mental health difficulties examined interpretations of symptoms, coping practices, and family and community responses. Caregiver interviews focused on care work, concealment, and treatment decision-making, while interviews with frontline workers examined service constraints and stigma within care settings.

Vignettes were used in the focus groups to elicit discussion of collective perceptions and social norms without requiring participants to disclose personal experiences. The scenarios concerned a young person experiencing panic attacks and a mother experiencing depressive symptoms after childbirth. Interviews and focus groups were conducted in Maithili and Bhojpuri by the lead researcher (first author) and two trained field assistants. Field notes were prepared, and sessions were audio-recorded with participants' permission. The lead researcher (first author) translated the source-language materials into Nepali and English; the researcher's master's-level academic supervisor reviewed the translated materials alongside the original-language materials. Culturally embedded terms, including

“tension” and “dimag kamjor” (“weak brain”), were retained through transliteration when direct English equivalents would have obscured their contextual meaning.

Data were analysed using Braun and Clarke’s six-phase thematic approach [33]: familiarisation, initial coding, development of candidate themes, theme review, definition and naming of themes, and production of the analytic accounts. Coding and theme development were led by the lead researcher, with limited assistance from the researcher’s master’s-level academic supervisor on selected coding tasks. Coding combined deductive attention to concepts such as silence, labelling, and help-seeking with inductively generated codes, including marriageability concerns and caregiver invisibility. Themes were developed by examining patterned meanings across participant groups and data sources, alongside negative or divergent cases. Findings from interviews and focus group discussions were compared to identify areas of convergence and tension. For example, caregivers (interviews) often described silence as protective, whereas youth (focus group) accounts emphasised its interpersonal and intergenerational costs. Reflexivity was supported through journals, team debriefings, and positionality discussions. The researchers considered how their disciplinary, linguistic, cultural, and institutional positions may have shaped data generation and interpretation.

Ethical safeguards included written or verbal informed consent according to participants’ literacy levels and preferences, the use of pseudonyms, omission of identifying details, and the conduct of interviews in private settings. A distress protocol allowed participants to pause or discontinue an interview and provided for referral to local psychological services. No active referrals were made during data collection, although participants received information about available psychological services. The study was conducted per the Declaration of Helsinki and approved by the Human Research Ethics Committee of Tribhuvan University, Kathmandu, Nepal (protocol code: 51/082-083, 03 May 2025).

3. Results

The findings illustrate the complex and pervasive character of mental health stigma in the Bara and Parsa districts of Nepal. The analysis generated seven interrelated themes: household silence as a survival strategy; community labelling and social exclusion; intersectional burdens associated with gender, caste, and migration; pluralistic help-seeking pathways; caregiver burden; youth perspectives; and emerging forms of change and resilience.

3.1. Household Silence as a Survival Strategy

Household silence was a prominent pattern in the interview accounts. Among the 15 interviewed caregivers, 12 described concealing a relative’s mental health difficulty from neighbours, relatives, or other family members. This count describes the study sample only and is not a prevalence estimate. Participants linked concealment to concerns about social reputation, especially marriageability. One caregiver, a 45-year-old woman from Parsa, explained:

“If people know my son has panic attacks, who will give their daughter to him? And what about my younger daughter? Her marriage will also be ruined. It is better to keep quiet. We tell people he has a stomach problem when he misses work.”

Silence also operated within households. People experiencing distress were often discouraged from speaking openly because families feared gossip and sought to preserve family honour. A 32-year-old mother in Bara who experienced postpartum depression stated:

“When I cried at night, my mother-in-law said, ‘Don’t talk about this. If people hear, they will say our house has bad karma.’ She told me to pray harder and keep silent. I felt I was choking, but I had no choice.”

Although silence offered short-term protection from reputational harm, participants described substantial longer-term costs. Families often delayed seeking professional care until symptoms had become severe, in some cases several years after onset.

3.2. Community Labelling and Social Exclusion

At the community level, stigma was expressed through derogatory labelling. Terms such as “pagal” (mad), “jhari manasikta” (weak-minded), and “dimag kharab” (spoiled brain) appeared frequently in interviews and focus group discussions. Participants described these labels as deeply degrading because they reduced individuals to their perceived illness and reinforced their social marginalisation. A 19-year-old participant in a youth FGD explained:

“Once someone is called ‘pagal,’ it sticks forever. Even if they get better, people don’t forget. Boys don’t want to sit with them, and girls don’t want to talk to them. It’s like a permanent mark.”

Community gossip further reinforced exclusion. Families reported that neighbours sometimes discouraged others from interacting with them. One caregiver in Bara explained that shopkeepers refused to serve her brother because they feared his behaviour:

“They say, ‘Don’t let him come here, he will create trouble.’ But he only wanted to buy biscuits. They laugh at him behind his back.”

Exclusion also extended to social events. Several participants described being omitted from weddings, festivals, and religious ceremonies. In Bara and Parsa, where social participation is central to community identity and belonging, such exclusion was experienced as particularly painful.

3.3. Intersectional Burdens: Gender, Caste, and Migration

Women described gender-specific forms of stigma. A 26-year-old woman with bipolar disorder recounted being abandoned by her husband after he learned of her diagnosis:

“He said I was not a proper wife. He told people I was possessed. After that, nobody wanted to visit me. Even my sisters-in-law avoid me.”

Caregiving responsibilities also fell disproportionately on women. Mothers, sisters, and daughters-in-law described sacrificing education, employment, and personal well-being to care for relatives while continuing to manage household responsibilities and protecting family honour. In one FGD, a Dalit woman explained:

“When my son acts strangely, people say, ‘Of course, he is Dalit, what else can you expect?’ They make it about caste as well as illness. We cannot hide as easily as rich families.”

Participants further observed that higher-caste families could conceal mental illness more readily by obtaining care from clinics located away from their communities. By contrast, Dalit families often lacked the financial resources to travel or pay consultation fees and were consequently exposed to greater community scrutiny.

Participants also described migration as shaping both the emergence and management of distress. Some families reported that male relatives developed anxiety or substance-use problems while working in India or the Gulf States. Women who remained at home experienced loneliness, financial hardship, gossip, and heightened community scrutiny. A 30-year-old woman explained:

“They ask us, ‘Why is your husband not sending you enough funds? Is he drunk in another country?’ I feel embarrassed by such questions. Whenever I feel upset, they call it weakness, not sickness.”

These accounts show how stigma was embedded within migration economies, producing distinct vulnerabilities for migrants and family members who remained at home.

3.4. Help-Seeking Patterns

Families described pluralistic and often iterative treatment pathways. Initial help was commonly sought from traditional healers or religious sites, followed by consultations with pharmacies, private practitioners, or government health facilities. Table 1 summarises illustrative pathways reported by households in which some form of treatment was sought. These pathways were not necessarily sequential or shared by all households.

Table 1. Illustrative help-seeking pathways among interviewed households.

Step in Pathway	Typical Actors/Places Consulted	Primary Reasons for Choice	Reported Outcomes
First Step	Traditional healers (dhami/jhankri), temples, astrologers	Accessible, affordable, culturally resonant, perceived spiritual causes, and avoids medical labels	Temporary relief; validation of spiritual or karmic explanation; delay in diagnosis
Second Step	Local pharmacies, unlicensed drug sellers	Quick symptom relief, no stigma of diagnosis, low cost, privacy	Short-term symptom management; risk of misuse or side effects
Third Step	Private clinics (often in nearby cities), general practitioners	Quality, confidentiality, and avoidance of local gossip	Out-of-pocket payment, incomplete diagnosis, variable quality of care
Final/Formal Step	Government health posts, district hospitals, and psychiatric referrals	Used as a last resort when symptoms escalated, serious harm was feared, or other options had been exhausted	Long travel distances, unavailable medicines, incomplete care, and stigma within facilities
Parallel/Recurrent Steps	Religious sites, repeated visits to healers, and family advice networks	Continued search for a cure, cultural reinforcement, and declining confidence in biomedical services	Cycle of help-seeking, accumulation of debt, caregiver burnout, perpetuation of stigma

Participants also described delays in accessing formal treatment. Among interviewed households for which a help-seeking pathway was discussed, several accounts involved delays of more than six months. These accounts illustrate mechanisms contributing to delayed care, including fear of gossip and religious interpretations of distress; they should not be read as prevalence estimates for households in Bara, Parsa, or Nepal.

3.5. Caregiver Burden

Caregivers, particularly women, described substantial emotional, practical, and financial burdens. Their accounts included sleepless nights, constant vigilance, reduced employment opportunities, and personal financial sacrifice. One caregiver explained:

“I feel like I live two lives, mine and my daughter’s. I cannot work outside because I must watch her. People don’t see this effort; they only blame me.”

Caregivers also experienced stigma by association. Some were labelled “weak-minded” or blamed for causing the illness, compounding their social isolation and rendering their care work largely invisible.

3.6. Youth Perspectives

Youth focus group discussions revealed marked ambivalence. Participants readily acknowledged that “tension” and examination-related stress were common, yet feared ridicule if they sought support. Boys referred to expectations of masculine self-reliance, while girls expressed concern about reputational judgement. A 17-year-old girl stated:

“If we go to a counsellor, people will think we are broken. Teachers also say we should just concentrate on our studies. Nobody understands.”

At the same time, young participants were receptive to new forms of support. They identified peer groups, school clubs, and trusted teachers as potentially accessible and credible sources of mental health assistance within school settings.

3.7. Emerging Change and Resilience

Despite pervasive stigma, participants identified emerging sources of hope and collective action. Local non-governmental organisations had begun broadcasting non-stigmatising mental health programmes in Maithili and Bhojpuri. Youth groups used street theatre to challenge rumours and ridicule, while WhatsApp networks shared practical advice among wives of migrant workers. One young activist explained:

“We cannot change everything, but if one person listens and feels less alone, it is progress. Slowly, people will learn that mental illness is not shameful.”

Although these initiatives remained fragile and small in scale, they demonstrated the potential of culturally grounded, community-led action to challenge stigma and create safer opportunities for dialogue and support.

4. Discussion

The findings show that mental health stigma in the study settings operated as an interconnected social system rather than as an individual attitude. Household concealment, community labelling, unequal social positions, fragmented care pathways, and limited services mutually reinforced one another. In relation to RQ1, families used silence to manage anticipated reputational harm, although concealment also delayed disclosure and care. RQ2 shows that the risks and resources associated with speaking or remaining silent were distributed unevenly across gender, caste, migration status, and socioeconomic position. RQ3 locates these dynamics within pluralistic help-seeking and a locally experienced gap between policy commitments and service capacity. RQ4 demonstrates that stigma was neither complete nor uncontested, as young people and community initiatives created limited but meaningful spaces for alternative narratives and support. Synthesised across these questions, the findings identify silence as constrained social risk management: it can reduce immediate exposure to sanction while reproducing the social and institutional conditions that make disclosure hazardous.

4.1. Stigma as a Social Process

Goffman’s concept of a “spoiled identity” illuminates how the label “pagal” could eclipse participants’ identities as workers, students, parents, or neighbours. Yet the findings also move beyond the interpersonal moment of labelling. Gossip, exclusion from communal events, anticipated effects on marriageability, and unequal access to privacy made discredit durable across households and institutions. Link and Phelan’s power-sensitive framework helps explain this persistence: labels acquired force because elders, caste leaders, religious figures, neighbours, health workers, and teachers could influence reputation, belonging, and access to support [34]. Schools capture this ambivalence particularly clearly. Young people viewed peers, clubs, and trusted teachers as possible sources of assistance while also fearing ridicule and moral judgement from adults [35]. Stigma was therefore sustained through the interaction of identity devaluation and unequal authority, not through language alone.

4.2. Silence as a Form of Power

Foucault’s account of silence as productive rather than merely absent clarifies how families regulated what could be said, to whom, and in which terms [16]. Avoiding psychiatric language, attributing distress to physical or spiritual causes, and seeking care outside

the locality were not isolated behaviours; together, they formed a household strategy for managing exposure. This strategy was simultaneously protective and reproductive. Concealment could safeguard marriage prospects, kinship reputation, and livelihood security in the short term, yet it also delayed care, intensified caregiver burden, and preserved the association between mental illness and shame. Silence should therefore be understood neither as simple ignorance nor as cultural resistance but as constrained agency within marriage markets, caste relations, migration pressures, gendered obligations, and limited-service options [32]. This synthesis qualifies assumptions that disclosure is inherently emancipatory: when speaking carries substantial social costs and does not lead to credible care, disclosure may increase vulnerability without producing support.

4.3. Intersectionality: Gender, Caste, and Migration

Intersectionality explains why this risk-management strategy was neither equally available nor equally costly. Women experiencing distress could be judged against ideals of wifehood, motherhood, and emotional self-discipline, while women caregivers absorbed stigma by association, unpaid labour, and economic sacrifice [36]. Caste and class shaped families' capacity to manage visibility: participants described how economically advantaged, higher-caste households could seek distant or private care, whereas Dalit families faced greater scrutiny and fewer options for protecting privacy. Migration extended these inequalities across borders. Men abroad were expected to remain employable and financially productive, while women at home managed loneliness, financial strain, caregiving, and reputational surveillance. These dimensions did not simply add separate disadvantages. They interacted to determine who could conceal distress, who bore the work of concealment, and who could convert disclosure into care. Mental health stigma was thus produced through the intersection of cultural expectations, material resources, and political-economic arrangements rather than through identity categories in isolation.

4.4. Policy–Practice Gap

The policy–practice gap formed part of this same system. Nepal's national commitments envisage integrated, decentralised, and rights-oriented care, whereas participants described medicine shortages, weak referral pathways, and reliance on distant or private services. Service scarcity therefore did more than constrain treatment after stigma had occurred; it altered the perceived value of disclosure itself. When formal care was inaccessible, incomplete, or stigmatising, concealment and recourse to informal providers became understandable forms of risk management rather than simple failures of awareness. The local implementation gap consequently linked structural conditions to household practice: limited services reduced the potential benefits of speaking, while silence obscured need and allowed inadequate provision to persist. The evidence supports this local interpretation, but not a comprehensive assessment of national or provincial implementation.

4.5. Pluralism and Pragmatism in Help-Seeking

Pluralistic help-seeking connects household risk management to service scarcity. Families moved among healers, religious sites, pharmacies, private practitioners, and public facilities while weighing cultural legitimacy, affordability, privacy, geographic access, anticipated stigma, and perceived effectiveness. Traditional healers offered socially intelligible explanations, and pharmacies offered rapid, discreet symptom management without the visibility of a psychiatric diagnosis [37]. These pathways were therefore pragmatic as well as culturally meaningful. However, repeated movement across providers could delay comprehensive assessment, increase expenditure, and deepen caregiver exhaustion. The findings do not justify displacing trusted forms of care; rather, they indicate the need to examine how existing providers might connect safely to culturally and linguistically

responsive primary care. Any referral model would require co-design and evaluation because the study did not assess provider readiness, safety, or effectiveness.

4.6. Resilience and Emerging Change

The accounts of street theatre, radio programming in Maithili and Bhojpuri, and WhatsApp exchanges among migrant workers' wives complicate an interpretation of communities as uniformly constrained by stigma. These practices created socially recognisable spaces in which distress could be connected to shared experience and dominant meanings could be questioned. Their significance lies less in demonstrated effectiveness—which this study did not assess—than in their potential to lower the interpersonal risks of speaking and make alternative responses imaginable. They can be understood as forms of everyday resistance: modest, collective practices that challenge the taken-for-granted legitimacy of silence and ridicule without directly overturning established hierarchies. Their reach and durability nevertheless depend on safeguarding, resources, referral options, and institutional support. Community action may open pathways to change, but it cannot substitute for accessible services or structural reform.

4.7. From Individual Pathology to Structural Phenomenon

Viewed together, the findings recast stigma from a private prejudice into a structural process. Community surveillance, marriage markets, caste ordering, gendered care expectations, migration economies, and limited state support shaped both exposures to discredit and the capacity to respond [38–40]. These arrangements distributed the costs of distress unevenly: affected individuals risked exclusion, families managed reputation, women absorbed disproportionate care work, and marginalised caste groups had fewer resources for privacy or treatment. This synthesis changes the logic of intervention. Mental health literacy remains necessary but cannot make disclosure safe when sanctions persist, and credible care is unavailable. Interpersonal change must therefore be linked to feasible care pathways, recognition of caregivers, attention to gendered and caste-based inequalities, and community accountability. Otherwise, awareness may change terminology without redistributing the risks attached to mental illness.

4.8. Implications for Global Mental Health Debates

The Bara and Parsa case makes three bounded contributions to global mental health debates. First, idioms such as “tension” and “dimag kamjor” can function simultaneously as communicative resources and limits: they make distress speakable without immediately invoking psychiatric stigma but may also defer clinical recognition. Second, disclosure has no uniform value; its consequences depend on whether social sanctions can be contained and credible support secured. Silence may therefore represent constrained risk management rather than deficient knowledge. Third, locally credible practices can create openings for resistance, but their potential depends on links to services and institutional support. Together, these contributions connect culture, inequality, and service capacity within a single explanation of stigma. They may be analytically transferable to settings with comparable conditions, but they should not be generalised to Nepal or other low- and middle-income countries without comparative research.

5. Conclusions

This qualitative study shows how mental health stigma in the selected Bara and Parsa settings was sustained through household concealment, community labelling, intersecting inequalities, and constrained care pathways. Its main contribution is to conceptualise silence as a negotiated practice that can protect family reputation while reproducing stigma and delaying support. The accounts also show that gender, caste, migration, and caregiving

position people differently in relation to the risks of disclosure and the resources available for seeking care. Participant accounts of radio programmes, school discussions, support groups, and youth-led activities indicate locally grounded possibilities for change. These examples do not establish intervention effectiveness, but they identify culturally and socially credible entry points for future co-designed and evaluated initiatives.

5.1. Significance and Implications of the Study

The findings identify context-specific priorities, not proven interventions. Each recommendation requires co-design and evaluation for feasibility, safety, cost, and effectiveness.

- Improve primary-care access, medicine availability, and referral pathways. Specific responses should follow local service assessment because workforce and supply systems were not directly examined.
- Assess safe, acceptable referral links with healers, religious sites, and pharmacies. Test whether using “tension” in public communication encourages discussion without minimising distress or delaying care.
- Assess caste- and poverty-related barriers and co-design responses such as transport support, anti-discrimination measures, and community participation in local health decisions.
- Evaluate street theatre, radio, and WhatsApp networks as anti-stigma and peer-support channels, assessing reach, safety, acceptability, and effects.

5.2. Limitations of the Study

Several limitations bound the interpretation of these findings. The purposive, partly snowball sample prioritised depth and diversity rather than representativeness; the findings cannot estimate prevalence or be generalised to Madhesh Province or Nepal. Recall and social-desirability pressures may have shaped self-reports, particularly in focus groups and discussions of sensitive experiences. Translation across Maithili, Bhojpuri, Nepali, and English may have altered culturally embedded meanings despite efforts to retain key idioms. Comparing interviews and focus groups, attending to divergent accounts, and using contextualised quotations strengthened credibility but did not remove these constraints.

5.3. Future Research Directions

Future research should examine how silence, disclosure, and stigma change over time and across generations. Comparative studies could investigate variation within Madhesh and across other provinces, while mixed-methods research could assess how caste, gender, migration, and socioeconomic position shape the distribution of the mechanisms identified here. Implementation research should test the feasibility, safety, and effects of locally grounded referral pathways and community- or school-based initiatives. Research on digital mental health communication is also warranted, particularly in relation to access, privacy, safeguarding, and referral in rural Nepal. Participatory action research could further examine whether community involvement strengthens the relevance and sustainability of anti-stigma responses.

5.4. Final Reflections

Overall, the study suggests that mental health stigma in the study settings is not solely an individual attitude or health-service problem. It is embedded in social relationships, cultural expectations, unequal resources, and institutional arrangements. Reducing stigma therefore requires locally tested strategies that make disclosure safer, strengthen feasible care pathways, recognise caregivers, and address gendered and caste-based inequalities. The findings offer an interpretive framework and directions for future research.

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