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The Role of Family Dynamics, Health Literacy, and Community Support in Shaping Mental Well-Being: The Mediating Effect of Social Stigma in Urban Pakistan

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ABSTRACT

This study explores the role of family dynamics, health literacy, and community support in shaping mental well-being, with social stigma examined as a mediating factor in the urban context of Pakistan. Mental health remains an under-addressed dimension of public health, particularly in developing countries where social stigma creates barriers to seeking care. The primary objectives of the research are to assess the direct influence of family dynamics, health literacy, and community support on mental well-being, and to determine the mediating effect of social stigma in this relationship. A quantitative cross-sectional survey design was employed, targeting urban populations across major cities in Pakistan, with data collected from 300 respondents through a structured questionnaire using a five-point Likert scale. Statistical analyses, including regression and mediation tests, were conducted to establish relationships among the variables. Findings indicate that supportive family dynamics, higher health literacy, and strong community networks significantly contribute to better mental well-being, while social stigma partially mediates these relationships by weakening the positive effects of these factors. The study highlights that reducing stigma is crucial for enhancing the effectiveness of family and community-based interventions. These insights provide valuable implications for public health policy and urban mental health programs in Pakistan, underscoring the need for integrated strategies that combine awareness, literacy, and social inclusion initiatives to strengthen mental well-being.

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1.0 Introduction

Although mental health is acknowledged to be a vital component to the health of a nation, the issue is largely unexplored in developing countries, one of which is Pakistan. Mental health in urban inhabitants is particularly influenced by the acceleration of urbanization, rising economic disparity, evolving family systems, and increased vulnerability to psychosocial stressors. The juxtaposition of conservatively modern Pakistan, poses the unique problem of complex mental health stigma, which adversely and intricately relates to one's attitude toward mental illness, and treatment dependency, lack of advocacy and awareness, as well as the approach toward health by the family, society, and the individual (Noorullah et al., 2024). Mental health stigma, in particular, is well-documented to be the primary obstacle to receiving clinical intervention, the ramifications of which in Pakistan are influenced by family software and mental health Illiteracy, community integration, and overall psychosocial wellness, with the latter being particularly neglected in the region (Mashhood et al., 2025).

In the context of this and many other similar studies, the present study shifts its focus towards the realization of the fact that mental well-being is tied not to the individual psychological fortitude alone. It is tied to the family network, the level of community literacy, and the support mechanisms in place interwoven with the existing social stigma (Graber et al., 2025).

Family dynamics involve the individual connections, integration, flexibility, and communication styles present in family systems. It is well known that positive family dynamics contribute to mental well-being by providing positive family mental ers support, direction, and resources to manage stress and adversity. In contrast, dysfunctional family systems with conflict and neglect, or loose connections, tend to aggravate emotional suffering and increase risk for mental disorders. Family systems in collectivist societies like Pakistan tend to be even more critical in mental health because the family is the primary socializing and supportive unit(Ayub, 2025). In addition to family systems, health literacy the ability to acquire, process, and understand basic health information and services to make appropriate health decisions needs to Mit is fundamentally important in determining how people regard and manage their mental health. In Pakistan, the pervasive and low levels of health literacy have led to the high assumptions of mental illness, and reliance on non-medical, spiritual, and detrimental treatment avoidance. Higher health literacy increases the possibility of better mental health by faster recognition of symptoms and readiness to receive professional help, along with managing stigma (Yeo et al., 2024).

In the same manner, the pillars of community support, such as social trust and engagement, as well as the availability of local resources, acts as a buffer to the stressors of urban life. Douglass & Flanagan (2019) argue that community support enhances social ties and shields its members against acute forms of social alienation. Strong community ties created

feelings of protection and support, while inadequate community support often worsened feelings of isolation and despair (Manchana, 2025).

Although family relations, health literacy, and community support are each individually interconnected to mental well-being, the relationship between them is often conditioned by the additional factor of social stigma, which acts as a psychological and sociological barrier. social stigma is defined as the sociocultural framework of negative stereotypes, prejudices, and discriminatory attitudes which surrounds a given mental health condition. Stigma prevents discourse and help seeking behavior. In Pakistan, and other urbanized cities, stigma has additional forms. These include the labeling of persons as weak, the attribution of mental illness as a mystical or moral failing and mentally disordered persons as a source of social disgrace to the entire family (Fenderico, 2024). Stigma does not simply encumber the health literacy family and community structures and support are able to provide, it also hinders the actions the knowledgeable individual could take. Stigma and the other determinants of mental well-being do not simply coexist. Rather, stigma mediates the extent the other determinants are able to operate positively. This mediating role is important in explaining the paradox of why family support, community literacy, and structure do not in practice result in ameliorating the mental health of the people in Pakistan, even though it is theoretically plausible (Allen, 2023).

The study describes its components' context using both the social-ecological model of health and the theory of stigma. The social-ecological model outlines the health and wellbeing of individuals consider, an individual, interpersonal, community, and societal factors. Family and community connections are in the interpersonal and community. Health literacy sits between the individual and societal domains, based on its production and availability. Stigma, on the other hand, permeates these and any other domains, sculpting attitudes and actions at every level and serving as a meditative filter. The Goffman Stigma and the other models of health behavior stigma show that while stigma has its primary effects on individual through the self and the psyche, its effects are also secondary on the systemic and societal dimensions (Nguyen & Li, 2020). Thus, stigma theory, in this case, creates a framework through which the proposed mediating role of stigma on the independent variables (family dynamics, health literacy, community support) and the dependent variable (mental well–being) can be rationalized. Drawing from the social-ecological model of stigma, this study views stigma as an important analytical tool that both demonstrates and reproduces systemic structural inadequacies, therefore, complicating the pathways to mental health in urban Pakistan(Coombs et al., 2022).

There remains a deficiency in research focus even as the world pays more attention to these relationships in the context of Pakistan. To begin with, the influence of family support and community participation on mental wellness has been documented in the literature, yet how these relationships function in the context of urban Pakistan has been modernized and transformed the support systems. Secondly, the role of health literacy in mental health and its

associated outcomes remains unexplored, as most studies in Pakistan focus on health literacy in the context of physical health. Thirdly, most of the research in Pakistan on stigma has been qualitative in nature, examining attitudes and the cultural stories around stigma (Shah et al., 2020). There have been empirical studies on stigma as a mediating variable, however, these are limited. Lastly, research conducted in Pakistan on these issues tends to explore them in isolation rather than as part of a broader interconnected framework, resulting in a disjointed understanding. This particular research is a response to such scholarly neglect, attempting to establish the nexus between family health literacy and community support and the mental well-being of individuals, with a focus on social stigma as a mediating variable (Fakhari et al., 2023).

The research problem, then, is discerning the absence of mental well-being, considering the abundance of family ties and social connections in the towns and cities of Pakistan. Why paradoxically do mental health and well-being remain unprotected and neglected? It is possible that, the alleged social support systems in place do not result in the much needed mental health and psychological assistance, perhaps because of the stigma surrounding mental health. The same can be said of the attempts to improve mental health. Even with the widespread educational campaigns in cities, mental health and mental illness still suffers stigma. Evidence of this is the lack of proportionate attention given to mental health (Lindell et al., 2025). It is clear that, absence of stigma, mental wellness and mental health improvement is highly probable and facilitative. Therefore, any stigma that the public health industry fails to tackle will stultify the anti-stigma campaigns, and result in incomplete, unsuccessful public health strategies. The needed research that this study attempts to address is to elucidate the role of stigma in family, health literacy, community, and mental well-being interactions in the unique socio-cultural context of urban Pakistan (Khan et al., 2020).

In summary, this study has both academic and practical significance. It contributes to the body of knowledge by framing the interplay of family relationships, health literacy, and community support within the stigma model. The study also exemplifies application of the social-ecological model and stigma theory to a South Asian urban setting (Jahan et al., 2024).

This study operates at the crossroads of public health, social psychology, and cultural sociology and aims to describe and explain the mental health complexities of urban Pakistan. Ascertain the direct, and family, health literacy, and community nexus and social stigma processes to advance both the theory and the practice. Attend urgent and emerging literature and policy discussions about the "whispering" mental health crisis of urbanizing Pakistan where social stigma continues to muffle expressions, deter help seeking, and undermine the supportive mechanisms that should, in principle, be protective in nature. This study could advance the relevant body of knowledge and aid practitioners, policymakers and community leaders in the formulation of culturally appropriate, stigma attuned, and systems oriented mental health policies in urban Pakistan.

2.0 Literature Review

This study builds upon the social-ecological model and stigma theory within the same breath to form the basis for understanding the use of a stigmatic social-ecological approach for mental health and well-being. Social-ecological model suggests that the health of an individual is the result of the intersection of many levels of influence including the individual, relationships, community, and broader society. Within the community and interpersonal levels, the family and the community are situated, while health literacy is an individual and societal determinant that affects the health knowledge and behavior of the people (Organization, 2022). In contrast, stigma theory explains the social perceptions and biases, which are described as the 'gaze', and then the discrimination that is directed towards people, which affects the way an individual goes through the process of illness and recovery. The combination of these two theories explain how social stigma operates as a cross-cutting determinant of family and community literacy on mental well-being. Hence, these two theories explain how an individual's mental health and well-being is affected by these two theories and how stigma is the reason for the suppression of these two theories to achieve the mental well-being and mental health of people residing in urban Pakistan (Noorullah et al., 2024).

Having established a theoretical framework, previous empirical studies have highlighted the crucial role of familial relationships on mental health. Research on collectivist societies shows that psychological resources, such as strong family ties, positive communication patterns, and supportive emotional relationships, lessen stress and promote resilience. On the other hand, family environments that support neglect, foster conflict, and offer little encouragement amplify feelings of anxiety, depression, and social isolation. The mental health consequences of these conflicts become amplified in urban settings in which families experience economic hardship, migration, and generational disconnect (Dabrinze, 2025). Studies conducted in various Asian and Middle Eastern countries reveal that a strong family support system is associated with high self-esteem, low stress, and improved general wellness. The absence of protective effects speaks to the role of stigma associated with mental illness, as families tend to avoid discussing the matter, even if supportive help is available internally (Nguyen et al., 2025).

In today's society, there are a lot of misconceptions about mental illness, and health literacy has been identified as a critical component of an individual's mental health. People who are more health literate understand psychological problems and seek help. They are also able to understand more about treatment options. In addition, they are more likely attempt to combat stigma, and the negative impact of stigma and stereotypes. On the other hand, a lack of mental health literacy leads to longer periods of undiagnosed illness, non-medical explanations, and poor treatment compliance (Mobashery et al., 2024). Research in developing countries suggests that mental health literacy is a precondition for awareness and a positive attitude towards help-seeking, and for a reduction in self-stigma. In Pakistan, there is a lack of mental health literacy,

and awareness campaigns have been effective, but the ability to act on the knowledge is inhibited by stigma (Mashhood et al., 2025).

The importance of community support for mental wellness becomes even more apparent when taking working and living conditions in metropolitan areas into account and considering the effects of overcrowding and unemployment as well as the negative effects of social inequality. This means, even though there is a high degree of communal support, the benefits that can be derived from it are determined by the enduring cultural factors and the level of stigma associated with mental health problems (McKenzie et al., 2022).

Notably, the attention given to the social stigma associated with mental health issues has intensified in the last few years. Researchers in the field have begun to appreciate the negative impact social stigma, in particular, has on the positive mental health of the individual. This is the form of self-stigma as well as part of auxiliary stigma at the family, community, and society levels. There is an absence of psychosocial well-being, as well as absence of social integration because stigmamatizing people makes family psychosocial support ineffective. Obliterably, mental illness stigma is an integral part of socio-cultural structures, such as in Pakistan, where issues of social and family pride and virtue, as well as mystical reasoning, govern the social conception of mental illness (Omurbekov, 2025). Thus, the result is a treatment gap as a result of stigma, symptoms of mental illness are concealed and society withdraws, as family support, and literacy, and community psychosocial support, are rendered ineffective. Interventions to reduce stigma have been shown to improve the effectiveness of family-centered and community-centered approaches, and thereby the importance of addressing stigma as an outcome is reflected in the importance of addressing stigma as a mediator (Sandhu et al., 2025).

Bridging on the body of work, the current study hypothesizes that family dynamics, health literacy, and community support have positive impacts on mental well-being, albeit weakened by the effect of social stigma. The first hypothesis deals with family dynamics and posits that supportive family structures do more to enhance mental well-being, but stigma is a mediating factor that reduces the degree to which families are able or willing to attend to mental health issues. The second hypothesis deals with health literacy and suggests that individuals with a higher degree of health literacy do better with mental well-being, but stigma is a negative mediating factor that literate individuals by dissuading them from care or reinforcing feeling of shame (Nadal, 2020). The third hypothesis concerns community support and argues that there is a higher mental well-being among individuals who are part of supportive communities, but stigma is a mediating factor that lowers mental health support and discourages participation in support. Lastly, it is hypothesized that stigma does partially mediate the total effect of the predictive variables on mental well-being, meaning that there are positive effects, but the effects are significantly weaker in the presence of stigma (Paleari et al., 2021).

3.0 Methodology

The approach of the study sets out to rigorously analyze family structure, health literacy, community assistance, and the impact of social stigma on mental well-being in an urban setting in Pakistan. It relies on quantitative research which investigates measurable connections among given constructs and the mediation effects within, producing substantive evidence to support both practice and theory. In this study the cross-sectional approach works best since it allows the collection of data from a large urban population in a single point in time and tests relationships among variables with adequate statistical precision. Such an approach works best in estimating the mental well-being of an individual and the social determinants of rapidly changing urban mentalilty of Pakistan.

From a philosophical perspective, this study was grounded on objectivity and measurement within a positive paradigm because it sought to prove facts, and knowledge rigorally tested defined hypotheses, principles, or theories capable of being generalized. Just as the positive paradigm was constructed on a framework of modular family systems being stigmatized, the study was operationalized as family dynamics, health literacy and community support, family centered stigma, and mental wellbeing all being operationalized to stigma constructable and quantitative. This philosophical approach to the study was designed within boundary conditions using rigid tools and PLS-SEM evidence to pre allocate the domains to which subjective frameworks and PLS parameters are reserved. Given the evidence based approach adopted the study aimed to prove its findings through observation not subjective frame works. This approach demonstrated that this study sought to uphold credibility and rigorous scientific merit grounded on considering mental health issues in Pakistan.

Out of the entire population, the sample of 300 respondents was selected and thought to be adequate for the statistical power requirements of structural equation modeling. PLS-SEM, for example, adopted and at a minimum, the sample of 300 respondents was sufficient for complex mediation effect testing, with path modeling guidelines met. The sampling strategy was designed to achieve diversity across age, gender, education and income demographics and employed purposive sampling with elements of stratified random sampling. Purposive sampling was used for targeting urban residents and stratification improved the external validity of the research by ensuring different subgroups within the targeted population were represented. Respondents were urban dwellers who were 18 and above, ensuring adequate exposure to family, community and other social structures pertaining to the study variables.

The information for this study was gathered using a structured questionnaire survey. For this study, the questionnaires were designed using previous validated studies, tailored for the culture of Pakistan. With a five-point Likert scale, the respondents were asked the extent to which they agree with the statements under the construct of family dynamics, health literacy, community, social stigma, mental, and overall mental health as family health. In order to

accommodate all respondents, the data collection instrument was translated to and printed in Urdu. For ease of access and in consideration of the varying levels of digital literacy among respondents, the data was collected in both online and offline formats. To increase response accuracy, collected data was kept anonymous, and the participants were educated on the fact that there are no correct or false answers. Analysis was done in two distinct stages. The first assessed the measurement model in the context of internal consistency, reliability and validity, as well as convergent and discriminant validity. The second tested the structural model against the proposed links between mental well-being, and family dynamics, community stigma, and support and health literacy. Evidence regarding the significance of path coefficients and mediation effects was assessed through bootstrapping procedures to ensure validity of the findings. This method of analysis sharpened the focus of the research questions and enhanced the understanding of the direct and indirect relationships between the variables.

Results

4.1 Reliability and Convergent Validity (Outer Loadings, CR, AVE)

Table 4.1 Reliability and Convergent Validity

Construct	Item	Loading	Cronbach's Alpha	Composite Reliability (CR)	AVE
Family Dynamics (FD)	FD1	0.812	0.871	0.905	0.657
	FD2	0.844			
	FD3	0.798			
	FD4	0.821			
Health Literacy (HL)	HL1	0.803	0.884	0.916	0.685
	HL2	0.851			
	HL3	0.841			
	HL4	0.826			
Community Support (CS)	CS1	0.832	0.861	0.901	0.648
	CS2	0.793			
	CS3	0.821			
	CS4	0.804			
Social Stigma (SS)	SS1	0.847	0.873	0.908	0.666
	SS2	0.826			
	SS3	0.803			
	SS4	0.797			
Mental Well-Being (MWB)	MWB1	0.835	0.889	0.922	0.701
	MWB2	0.856			
	MWB3	0.841			
	MWB4	0.823			

Bearing in mind the results on the reliability and validity, the absence of the psychometric properties of the constructs does not call into question the strength of the measurement model. With every factor loading exceeding the basic limit of .70, it is safe to argue that every indicator touches the measure of the corresponding construct. The values of Cronbach's alpha fall within the boundaries of .861 and .889, and the values of composite reliability (CR) .901 to .922, both governed by the threshold of .70. the measures also in turn ensure that there is a fundamental degree of internal consistency across constructs.

Discriminant Validity – HTMT (Heterotrait-Monotrait Ratio)

Table 4.2 Discriminant Validity – HTMT

Construct	FD	HL	CS	SS	MWB
FD	–				
HL	0.624	–			
CS	0.571	0.598	–		
SS	0.411	0.437	0.452	–	
MWB	0.652	0.681	0.667	0.498	–

The correlation table indicates that the constructs of the study have strong associations with relationships as the correlation between the family, health, and community in the cross-construct mental health wellness. Literacy, community and wellness is enhanced with the help of supportive family structures positive, strongly correlated, meaning community support (CS, r = 0.571) and family dynamics (FD) mental well-being (MWB, r = 0.652) and health literacy (HL, r = 0.624). The people with better and more health-related knowledge MWB (r = 0.681) is correlated with health literacy. There is positive relationship MWB Community support positive relationship (r = 0.667), and stress and resilience mental health are applied using social networks. All variables Social stigma positively related (0.411 to 0.498), moderated to the positive impacts of family, health, and community support, added, considered, and nuanced intervened of mediator the role of. As a whole, these results reinforce that even though family relationships, health literacy, and community support strengthen one another in enhancing mental health, stigma acts as a barrier that withholds access to the full benefits of their synergistic impact.

4.3 Collinearity Assessment (VIF Values)

Table 4.3 Collinearity Assessment

Construct → Endogenous	VIF Range
FD → MWB	1.822
HL → MWB	1.931
CS → MWB	1.746
SS (Mediator)	1.687

The model fit statistics all show the structural model to be adequate, when compared to the accepted PLS-SEM standards. The Standardized Root Mean Square Residual (SRMR) was 0.059, well within the suggested ceiling of 0.08, and this means that the difference between the observed and the estimated correlation matrices was very small. Normed Fit Index (NFI) was 0.912, which is above the standard of 0.90, and therefore, it is valid to say that the overall fit between the hypothesized model and empirical data is strong. Also, the RMS_theta of 0.09 was lower than the 0.12 threshold, which further proves the correctness of the model and its predictive ability in relation to theoretical predictions. Although the Chi-Square statistic was found to be 1325.56, the interpretation of the statistic is not very important in PLS-SEM where absolute fit is not as important as it is in covariance-based SEM.

4.4 Model Fit Indices (PLS-SEM)

Table 4.4 Model Fit Indices

Index	Value	Threshold
SRMR	0.061	< 0.08 (acceptable)
NFI	0.911	> 0.90 (good)
RMS_theta	0.087	< 0.12 (acceptable)
R^2 (MWB)	0.542	Moderate
R^2 (SS)	0.437	Moderate

The lack of concern multicollinearity within the model is further confirmed by the VIF results which show all values are well under the threshold of five. Specifically, the predictors of mental well-being, family dynamics (1.822), health literacy (1.931), and community support (1.746), all demonstrate moderate and acceptable levels of collinearity, indicating that each construct explains variance in mental well-being without excessive overlap. The same is true for the mediator, social stigma (1.687), which further confirms its model-independent status. The structural paths can be trusted and the explanatory power of each construct is not diminished by overlap between predictors

4.5 Structural Model – Path Coefficients and Hypothesis Testing

Table 4.5 Structural Model – Path Coefficients and Hypothesis Testing

Path	β	t-value	p-value	Decision
FD → MWB	0.284	5.102	0.000	Supported
HL → MWB	0.261	4.879	0.000	Supported
CS → MWB	0.223	4.342	0.000	Supported
FD → SS→ MWB	-0.198	3.621	0.000	Supported
HL → SS→ MWB	-0.214	3.954	0.000	Supported
CS → SS→ MWB	-0.176	3.248	0.001	Supported
SS → MWB	-0.193	3.785	0.000	Supported

The structural model results provide strong evidence for each of the relationships hypothesized and confirmed the important input for family dynamics, health literacy, and community support towards mental well-being and the social stigma they mediate as well. The direct effects of family dynamics (β = 0.284, t = 5.102, p = 0.000), health literacy (β = 0.261, t = 4.879, p = 0.000), and community support (β = 0.223, t = 4.342, p = 0.000) demonstrate that all three have a significant positive effect on mental well-being, which shows that family support, health education, and community involvement all result in better mental health outcomes. At the same time, these predictors have a social stigma negatively and family dynamics (β = –0.198, t = 3.621, p = 0.000), health literacy (β = –0.214, t = 3.954, p = 0.000) and community support (β = –0.176, t = 3.248, p = 0.001) all significantly contribute to stigma

reduction. Social stigma, in turn, has a significant negative effect on mental well-being (β = –0.193, t = 3.785, p = 0.000), thus, serves to confirm its status as a partial mediator which attenuates the positive effects of the other constructs.

5.0 Discussion

The results of the study in urban Pakistan present new inputs into the complex interrelationships of family system, health literacy, and health resources and community available and accessible, and the social stigma of a victim and his family impacted by the mental health. The research results reinforce the idea that family system, health literacy and the presence of the best community resource and support has has strong and positive relationships to the mental health which is coherent with the fact that family interactions, health practices and knowledge and Community relations contribute to positive mental health. This also applies in the urban setting of Pakistan which is set more as collectivist where instrumental and supportive roles of the family unit and community matter. The most available source is the family in terms of offering emotional support and coping mechanisms that the individual goes through with mental health. Some knowledge and awareness of health problems in the individual population are also a significant obstacle. Either, the person with a higher health literacy level identifies their mental health problems and is able to use positive coping strategies and access mental health services. In conjunction with this, neighborhood positive social interaction, support, and care through urban social structures, neighborhoods, peer groups, and religious groups also serve as an added protective factor in relation to mental health.

These implications of these findings have logistical and policy implications. The implications of the findings on mental health professionals and policy makers in the Pakistan region are that regardless of efforts, intervention strategies that prioritize psychotherapy or pharmacotherapy will not be effective. Instead, they need extensive strategies that enhance family involvement, create community involvement, increase health literacy, and directly deal with the issue of stigma. A mental health victimization campaign is required on the approach of destigmatizing mental illness by mobilizing mental health outreachs including religious heads, educators, and the mass media. The method to help families create an emotionally supportive climate should involve training to recognize and address the mental health issues of all members of the family members and to encourage them to seek help. Similarly, community-based initiatives can also be created to facilitate through supportive platforms that can facilitate the open acknowledgement of mental health problems.

Much as the distortion of the reality should reside under the equal priority anchors of pitching service delivery and tackling stigma. Societal attitudes can also be changed by policy policies that are intended to fund awareness programmes, mental health literacy school based initiatives and health promotion activities within the work place. Most of all, the policies must

be relevant to the religious, cultural, and social conditions of Pakistani cities. As an example, the negative images can be excluded, and the positive attitudes toward mental health can be formed with the help of Islamic methods of treating each other and caring about each other and taking responsibility. More chances of acceptance and success of mental health interventions are likely to be attained in the event of incorporation with culturally applicable practices.

The stigma construct is an important aspect in which the research covers the gap in the literature. In the studies which considered stigma in urban Pakist, none of them tested mediation of stigma. Such criteria as wealth and social capital, where family and family literacy are re-used, just proves the high importance of those determinants. As a major paper in the stigma literature, these investigations focus on the example of the ability of social stigma to entirely prevent entry into the kinds of capacities of a mental health. It is these informal networks which are more common in developing countries which are offering most easily available social support. The puzzle is, as this paper demonstrates the progressive contradiction of the dual role to life represented by social networks as both enabler and restrainer to mental health.

The results reaffirm that high levels of health literacy, positive community resources, and supportive family relation have positive effects on the mental health of urban Pakistan. Nevertheless, stigma is rife and this effect is suppressed. Stigmatization also represents the most important barrier to the achievement of optimal outcomes of mental health strategies based on families and communities. To change mental health attitude, the use of stigma reduction efforts, including families and community-oriented applications set in the local context, should be use. Reducing stigma is not a scholarly topic but is converted into measures that are practical on multi-layered approaches of community general health, health workers, and local governments.

Considering such findings, the following are the courses of recommendation in this essay. In the first place, the policymakers must come up with national-level policies on mental health promotion exercise to overcome the stigma of mental illness. Mental health literacy and resource activities should be divided to these activities. Second, health professionals are to use family-centered and community-centered approaches in their practice and acknowledge the role of interdependence which is relevant to Pakistani society. Third, the mental health education must be incorporated in the training of teachers and school mental health sectors to enable this to be done so as to point areas of mental health literacy gaps in the young generation. Last, mass media, faith-based organizations and other sectors in the community should include stigma reduction and encouragement of mental health practices in their programs.

This paper is of national and international interest and it demonstrates that there is a necessity to think in a holistic way. The problem of urban mental wellbeing will not simply be solved by means of the delivery of clinical assistance. The society, communities, and families will have to be integrated. Addressing stigma along with enhancing literacy and psychosocial service will bring Pakistan one step further to a place where mental health challenges cease to be covered up, but are instead integrated and talked about in community and societal health and social promotion

Contributions

Haya Zainab: Problem Identification, Literature search

Ayesha Kashif: Results and Discussion

Hamid Bilal: Results, Revisions and Litrature Writing

Conflict of Interests/Disclosures

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