The Dividual Self:

Ethno-Psychology, Idioms of Distress and Explanatory Models of Mental Illness in Karachi, Pakistan

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A thesis

submitted in partial fulfillment of the

requirements for the degree of

Master of Public Health

University of Washington

2018

Committee:

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Program Authorized to Offer Degree:

Global Health

University of Washington

Abstract

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Research on cultural manifestations of distress, by examining ethno-psychology, idioms of distress and explanatory models of mental illness in indigenous populations, is essential to develop culturally sensitive mental health screening tools and interventions. This exploratory study used qualitative methods to understand the cultural manifestations of distress in a population of mental health practitioners, patients and laypeople (N=30) in Karachi, Pakistan. We used a phenomenological approach to conduct 30 in-depth interviews followed by thematic analysis. The ethno-psychology revealed a sense of self that is 'dividual'; composed of many parts (physical, mental, emotional, social, and spiritual) and influenced by the external environment. Idioms of distress and explanatory models of mental illness revolved around these parts of the self. Idioms of distress pertaining to the 'heart' and 'mind-brain' constructs were observed, the most salient of which was *tension*. The most common explanatory models were those attributing mental illness to adverse social experiences. Idioms of distress and explanatory models also showed somatization, spiritualization and socialization of distress, as opposed to the psychological manifestation prominent in Western cultures. Significant differences were observed in the use of idioms and

explanatory models between different demographic groups. The younger more educated participants espoused more Western conceptualizations of illness.

Keywords: Idioms of distress, Pakistan, Mental health, Explanatory models, Culture

Introduction

Culture and Mental Health

Contemporary psychiatric nosology is based on the underlying assumption that mental health problems are biomedical in nature, and thus mainstream psychiatric constructs can be universally applicable regardless of cultural differences between diverse populations (Kohrt and Harper 2008; Kohrt, et al. 2014). This approach, however, has come under criticism with some experts contending that symptoms of mental health problems are determined by indigenous conceptions and manifestations of distress and, therefore, mainstream psychiatric nosology may not be applicable to all cultural settings (Bhattacharya, et al. 2010; Kirmayer, et al. 2017).This is even more relevant in the field of global mental health, which encompasses many diverse cultures and populations throughout the world. One expert suggests that the imposition of these constructs of mental illness on other cultures is akin to medical imperialism (Summerfield 2013). In addition, the imposition of these constructs may, in turn, change how distress manifests itself in indigenous populations. This has been described in the book "The Globalization of the American Psyche" as occurring through the process of de-legitimization of indigenous manifestations of distress, by portraying them as ignorant and superstitious, and touting Usonian (people living in the USA) conceptions of distress and illness as scientific truth (Watters 2011).

As a result, there has been increased discussion about the importance of taking into account cultural manifestations of distress. Culture directly affects both individual understanding and trajectories of mental illness through differentiating between normal and abnormal behavior, influencing help seeking behavior and determining the causes and expressions of distress (Bhattacharya, et al. 2010). Anthropologists doing valuable ethnographic work, have captured the

diverse ways in which distress and mental illness manifest and are conceived of in different cultures (Kohrt, et al. 2016b; Krause 1994).

Idioms of Distress and Explanatory Models of Mental Illness

Idioms of distress are socio-culturally appropriate ways of experiencing and expressing distress (Nichter 2010). They are dependent on personal and cultural meaning which is influenced by the values of society (Desai and Chaturvedi 2017). Research on idioms of distress in different cultures has provided several examples that exemplify the diversity of their usage. An example of an idiom of distress is *ataque de nervios,* which is a condition among Caribbean-Latino populations in which distress manifests as biologically unexplainable neurological symptoms (Bagayogo, et al. 2013). A study conducted in Haiti revealed *doulè nan kè* (pain in the heart), which is chest pain associated with distress (Keys, et al. 2012). Some idioms are found in a variety of cultural settings such as 'thinking too much' which has been found in more than a 100 studies in different regions of the world such Haiti, South Africa, Cambodia, Liberia and Nepal (Fabian, et al. 2018; Kaiser, et al. 2015). Other idioms are specific to certain cultural settings such as *Koro* syndrome; a somatic disorder prevalent in Indian men which consists of a fear of the testicles retracting into the body due to some traumatic event (Nichter 2010). Some experts suggest that idioms of distress should be thought of as constantly evolving constructs, rather than highly structured static ones similar to conventional psychiatric nosology (Nichter 2010). Just like mental health problems, the socio-political conditions influencing idioms should also be examined, rather than just focusing on individual psychological processes (Nichter 2008).

In addition to idioms of distress, explanatory models of mental illness also provide an understanding into how distress manifests in different cultures. Explanatory models of mental illness are factors that, are perceived to, lead to mental health problems (Alemi, et al. 2017). These

models provide an opportunity to ascertain the importance of different causal factors across particular cultural settings. Research in Haiti has demonstrated the importance of local Vodou traditions, since spirit possession is considered to be a major cause of mental illness (Hagaman, et al. 2013; Khoury, et al. 2012). Studies on women in India have revealed the importance of social relationships, with interpersonal problems perceived to be one of the major factors leading to mental illness (Pereira, et al. 2007). Explanatory models of mental illness vary across cultures and are dependent on indigenous epistemologies.

Ethno-Psychology

Ethno-psychology is the "study of how individuals within a cultural group conceptualize the self, emotions, human nature, motivation, personality and the interpretation of experience" (Kohrt and Hruschka 2010). The dominant ethno-psychological frameworks of a given population determines the indigenous idioms of distress and explanatory models of mental illness (Kaiser, et al. 2015).

Conventional psychiatric nosology is based on Western European ethno-psychology which is derived from Cartesian dualism (Kohrt, et al. 2016a). This considers human beings to be constituted of tangible physical bodies and intangible abstract minds (Keys, et al. 2012). Physical illnesses are thus considered to be afflictions of the body whereas mental illnesses are thought to be disorders of the mind. Contemporary medical education (including psychiatric training) in most post-colonial states is based on this ethno-psychology that is influenced by Western medicine (Keys, et al. 2012). Therefore, the exportation of Western medicine rarely takes into account that indigenous populations may have different ethno-psychological constructs, based on culturally specific medical or spiritual beliefs (Keys, et al. 2012). Anthropological approaches, however,

offer significant information about the phenomenological differences between the manifestations of distress in cultures with different ethno-psychological frameworks (Kohrt, et al. 2016b).

Study Objectives

The objective of this study was to examine cultural manifestations of distress in Pakistan. While several studies have focused on South Asian populations, very little research has been conducted on Pakistani population groups. Two studies, one conducted on Pakistani populations in the UK and one conducted in northern Pakistan, found that somatization of distress was very common with physical complaints being frequently reported by patients with mental health problems (Bhui, et al. 2002; Minhas and Nizami 2006). These studies also elicited various idioms that revolved around the heart, brain and mind constructs which has also been observed in research conducted on Indian and Nepali populations (Kohrt and Hruschka 2010; Weaver 2017). Some other studies focused on developing or adapting mental health screening tools after understanding local idioms of distress (Ali, et al. 1998; Mumford, et al. 2005). However, most of the studies used quantitative methods and primarily focused on idioms of distress. To the best of our knowledge, no other study has explored ethno-psychological constructs and explanatory models of mental illness on Pakistani populations.

The aims of this study are to (1) identify the ethno-psychological constructs, common idioms of distress and explanatory models of mental illness by interviewing practitioners, patients and laypeople in Karachi, Pakistan; and to (2) evaluate whether there is a difference in the usage of idioms of distress and explanatory models of mental illness between patients, laypeople or different demographic groups. This information would allow us to develop an understanding of how distress manifests in the Pakistani cultural context.

Methodology

Study Setting

Pakistan is a nation of 209 million people in South Asia and has diverse ethno-linguistic and religious groups, with more than 70 languages spoken and 5 religions practiced in different parts of the country (Kachru, et al. 2008; Mohiuddin 2006). Islam is the religion of the majority and the most commonly spoken language is Urdu, which is also the official language (Mohiuddin 2006).

This study was conducted in Karachi, the most populous city of Pakistan, and the financial hub of the country. Karachi has a population of 15 million people and is considered to be the cosmopolitan melting pot of the nation (Mohiuddin 2006; Paracha 2014). The city is reported to be more than 95% Muslim and is mostly constituted of 5 main ethno-linguistic groups; Muhajirs (Urdu, Gujrati and other language speakers), Punjabis (Punjabi, Seraiki and other provincial language speakers), Pashtuns (Pashtu, Farsi and other provincial language speakers), Sindhis (Sindhi, Thari and other provincial language speakers) and Balochis (Makrani, Balochi, and other provincial languages speakers) (Kachru, et al. 2008).

Study Design and Population

We used qualitative methods and a phenomenological approach to fulfill the specific aims of the study. Phenomenology, as compared to quantitative positivist approaches, is better suited in mental health research aiming to study the lived experience of people (Aho 2008; Nakayama 1994; Picton, et al. 2017). We used this approach because this study sought to understand how the participants experienced the phenomenon of distress and what they considered to be the primary causes of mental illness. Before initiating the data collection phase, the lead author and data

collector conducted a bracketing exercise and identified his positionality per phenomenological methodologies (Bernard and Ryan 2010).

The target population was divided into three groups consisting of: (1) practitioners (professionals providing some form of mental health care including conventional, alternative and traditional providers such as psychiatrists, psychologists, counsellors, homeopaths and spiritual healers); (2) patients (individuals who had been diagnosed with a mental illness by a certified psychiatrist or psychologist); and (3) laypeople (individuals who had never been diagnosed with a mental health condition by a mental health professional and had never sought mental health services from any provider).

An ethical review of the methods was conducted in June 2017 by the University of Washington Institutional Review Board and the study was approved.

Sampling, Recruitment and Data Collection

We used a variety of sampling strategies to recruit a total of 30 individuals into the study (11 practitioners, 11 patients and 8 laypeople). A sample of this size has previously been identified to be sufficient for a phenomenological study (Bernard and Ryan 2010). The lead author conducted 30 in-depth interviews conducted by the lead author, with each participant completing one audio-recorded interview. Most of the interviews were conducted in Urdu, but English was also used in some, depending on the interviewee preference. The interviews ranged from 15 minutes to 90 minutes in length. We developed interview guides specific to each participant group to elicit responses related to our research aims.

Some themes explored with the practitioners included common idioms of distress and explanatory models of mental illness they had observed, similarities and differences of idioms and explanatory models between different demographic groups and ethno-psychological constructs

they had identified. The interviews with the patients revolved around their experience with mental illness, their understanding of the causes of their illness and their stream of consciousness during a period of distress. Some topics that were addressed with the laypeople included their experience with a distressful event, their stream of consciousness during that event and their understanding about the causes of mental illness.

We used purposive sampling to recruit practitioners who fulfilled the inclusion criteria which was: (1) being an accredited professional providing some sort of mental health service; and (2) having been practicing in Karachi for at least 5 years. The catchment areas for the psychologists and psychiatrists were the Department of Psychiatry at Aga Khan University Hospital, and the outpatient mental health clinic of the Pakistan Association for Mental Health. The other practitioners were working in private practice. An introductory meeting was conducted in which the lead author introduced the study to the practitioners and obtained their verbal consent. The characteristics of the recruited practitioners have been given in table 1.

Table 1: Characteristics of Practitioners

Practitioner	Quantity	Gender	Qualifications	Institutions
Psychiatrist	4	2 Female, 2 Male	3 trained in the UK, 1 trained in the USA	Aga Khan University Hospital Pakistan Association for Mental Health
Psychologist	3	3 Female	1 trained in the USA and 2 locally trained	Aga Khan University Hospital Pakistan Association for Mental Health
Counsellor	1	Female	Locally trained	Private
Homeopath	1	Female	Locally trained	Private
Spiritual healer	1	Male	Locally trained	Private
Alternative practitioner	1	Female	Locally trained	Private

Based on initial analysis of the data from practitioners, we developed a theoretical sampling frame for the recruitment of patients and laypeople. The three most important factors influencing idioms of distress and explanatory models of mental illness were identified by practitioners to be age, gender and education level. As a result, we used stratified sampling to recruit the sample of patients and laypeople, maximizing variation across these three variables.

The inclusion criteria for the patients included: (1) being diagnosed with an anxiety, mood or psychotic disorder (according to the DSM-5 or ICD-10) for at least 5 years; (2) having been in treatment for at least 5 years; (3) having been a resident of Karachi for at least 10 years; (4) being lucid at the time of the interview (determined through a mini mental status exam with a score of 25 used as a cut off); (5) being a Muslim; and (6) belonging to one of the 5 main ethno-linguistic groups in the city (Muhajir, Punjabi, Sindhi, Pashtun or Baloch).

We then used this sampling frame, inclusion criteria and snowball sampling to recruit patients through practitioners, who had previously participated in the study. We asked them to identify patients fulfilling this criteria, briefly describe the purpose of the study to them and ask them whether they would be willing to participate. If consent was given, the practitioners connected the patients with the research team who then took informed consent for participation in the study. Through this process 12 patients were identified, with 11 of them agreeing to participate in the study.

After recruitment of patients, purposive sampling was used to select laypeople participants with the inclusion criteria including: (1) being residents of Karachi for at least 10 years; (2) not ever having been diagnosed with any mental illness; (3) not having utilized any mental health services; (4) being a Muslim; and (5) belonging to one of the 5 main ethno-linguistic group in the

city (Muhajir, Punjabi, Sindhi, Pashtun or Baloch). Through this process 8 laypeople were recruited. The characteristics of the participating patients and laypeople can be found in table 2.

Table 2: Characteristics of Patients and Laypeople

Characteristic	Number of Patients	Number of Laypeople	Total
Total	11 (100%)	8 (100%)	19 (100%)
Age			
20-35 years	4 (36%)	2 (26%)	6 (32%)
36-50 years	5 (45%)	3 (37%)	8 (42%)
51-65 years	2 (19%)	3 (37%)	5 (26%)
Gender			
Male	6 (55%)	4 (50%)	10 (53%)
Female	5 (45 %)	4 (50%)	9 (47%)
Education level			
Less than High School	5 (46%)	3 (37%)	8 (42%)
At least High School	3 (27%)	2 (26%)	5 (26%)
At least Bachelors	3 (27%)	3 (37%)	6 (32%)
Ethnicity			
Muhajir	6 (55%)	5 (61%)	11 (58%)
Pashtun	2 (18%)	0 (0%)	2 (11%)
Punjabi	1 (9%)	2 (26%)	3 (15%)
Sindhi	1 (9%)	0 (0%)	1 (5%)
Balochi	1 (9%)	1 (13%)	2 (11%)
Diagnoses			
Anxiety disorder	4 (36%)	Not applicable	Not applicable
Mood disorder	4 (36%)		
Psychotic disorder	3 (28%)		

Data Management and Analysis

Interviews were transcribed verbatim in the original interview language and imported into ATLAS.ti for coding and analysis. The lead author conducted analysis in two phases. The first phase occurred after the completion of the practitioner interviews and involved analyses of these interviews on the basis of which theoretical sampling for patients and laypeople was conducted. A

code-book was developed after the first round of analyses using primarily inductive means since this was an exploratory study. The second phase was conducted after the conclusion of the patient and laypeople interviews. The development of the code-book continued into the second phase of analyses and at the end a total of 32 codes were identified (see appendix 1).

We conducted thematic analyses in order to identify the relevant themes around: (1) idioms of distress commonly used across all groups; (2) types of idioms; (3) similarities and differences in idioms between different groups; (4) explanatory models of mental illness commonly used across all groups; (5) types of explanatory models; (6) similarities and differences in explanatory models between different groups; and (7) ethno-psychological constructs.

Findings

Ethno-psychology and Distress

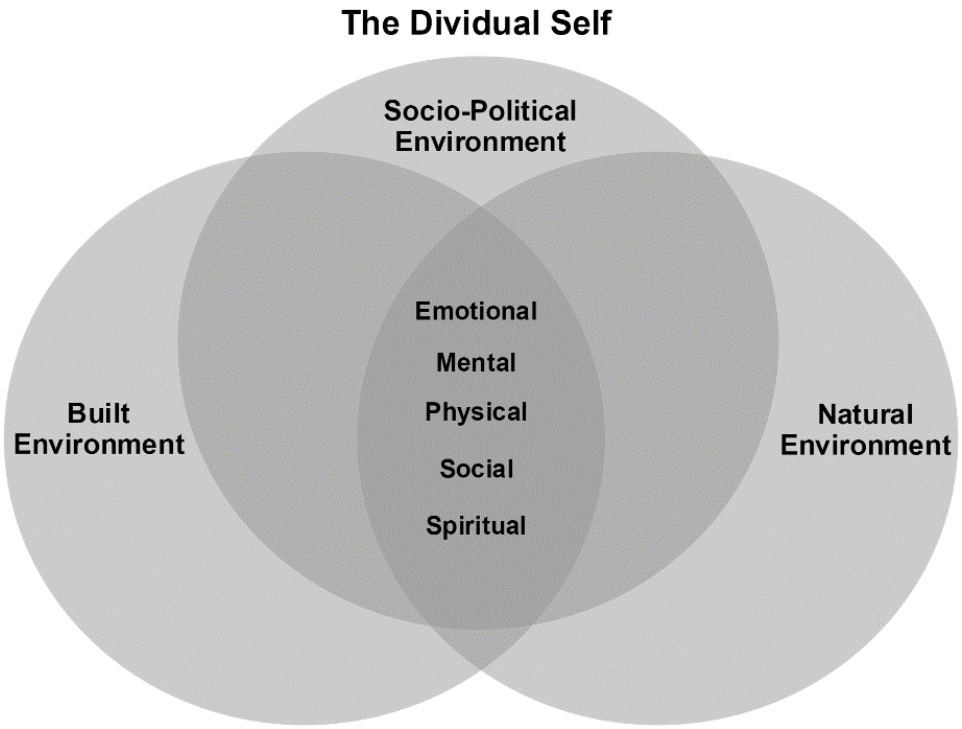
According to the mental health practitioners, the sense of self of patients constituted 5 components: (1) the physical self which is related to physical health and is represented by the *jism* (body); (2) the mental self which is related to cognition and other mental processes and is represented by the *zehn/dimagh* (mind/brain); (3) the emotional self which is related to emotional experiences and is represented by the *dil* (heart); (4) the social self which is related to the social world (relationships, socio-economic class, occupation and social status); and (5) the spiritual self which is related to the spiritual connection with the divine. One practitioner stated:

> "In order to develop a sense of self in the local context which is of Pakistan, it's really important to keep three or four domains in your mind when you see a patient in the clinics. It's the physical self and the mental self and the spiritual self and the religious and cultural self, all those selves, different aspects of the self, they bear equal weightage" (male, psychiatrist).

This 'dividual self' has multiple interconnected components, and is influenced by the surrounding built, natural, and socio-political environment. The various components of the self

perform different functions and some of them are represented by specific constructs; *jism* (body) for the physical self, *zehn/dimagh* (mind/brain) for the mental self and *dil* (heart) for the emotional self. According to the practitioners, distress then is not only experienced through the mental or emotional selves, but is also influenced by and expressed through the other components of the self. A conceptual model capturing this ethno-psychological framework can be seen in figure 1.

Figure 1: Ethno-psychological framework



We also discussed the interplay of these components to formulate the sense of self, with the practitioners. In this sense of self, the *dil* (heart) was the construct most commonly associated with emotions. As one practitioner stated, "Emotions in our culture are understood as coming from the heart" (female, alternative practitioner). Conversely, the *zehn/dimagh* (mind/brain) construct was associated with cognition and was seen "as a more tangible, physical structure, rather than an abstract [one]" (male, psychiatrist). This denotes a clear differentiation between emotions and

cognition with both faculties associated with distinct constructs. However, as compared to the emotional self, the mental self wasn't as frequently used to express distress as patients "will consider themselves as such that their feelings are all related to the heart; sadness, worry, emotions are related to heart. You will find very little reference to the mind or brain" (female, psychologist).

Compared to the mental self, the physical self was also more frequently used to express distress as patients "tend to focus more on the physical aspect - they have less concept of the mind being disturbed and causing all these symptoms in the body. So they approach these symptoms that they may have through the avenue of the body" (male, psychiatrist).

The social self was also prominent in this ethno-psychological framework which may be an indication of the collectivistic nature of Pakistani society:

> "Our culture or society is not a very individualistic society, it's more of a social and communal or collective society, where people mostly perceive themselves in relation to other people. With respect to certain roles that they must play. A lot of times….attention to their own self.….may not be considered a priority as compared to a lot of Western cultures" (female, psychiatrist).

Another practitioner added that, "I think the sense of self here is firstly very [much] enmeshed with your family and larger community so your sense of self, a good part of it relates to: if I do this what will other people think" (Female, psychologist). In fact, the social self was reported to be one of the most important components of the self with patients more likely to express distress in social terms and associate it with their social world (relationships, socio-economic class, social status, occupation). The spiritual self is also very significant in this conception of the self with one practitioner explaining:

> "In our culture meaning and purpose are closely linked with our faith and religion, although even atheists can have meaning and purpose, but in our culture and even for me, meaning and purpose is linked with the hereafter. If there is injustice here, we will get justice there" (female, alternative practitioner).

The significance of the spiritual self may be due to the highly religious nature of Pakistani society and the use of spirituality as a way to relieve distress. Thus, the relationship between distress and the spiritual self should be closely examined because "when you devise interventions, then you have to be very mindful that as much as it's important to alleviate physical and mental distress, it's also sometimes as important to alleviate spiritual distress" (male, psychiatrist). The importance of the physical, social and spiritual self in this ethno-psychological framework may also explain the phenomenon of socialization, spiritualization and somatization of distress which is apparent in the idioms of distress and explanatory models elicited by this study.

Idioms of Distress

Participants identified 72 idioms of distress (see appendix 2) that can be divided into 7 main categories: (1) physical (idioms related to the physical body); (2) social (idioms related to the social world); (3) emotional (idioms related to the emotional aspects of the self and often involving the heart); (4) mental (idioms related to cognition and mental processes and involving the mind/brain); (5) spiritual (idioms related to religious beliefs or spiritual connection with the divine); (6) environmental (idioms related to the external environment of the participant which could be natural, built or socio-political); and (7) other (idioms that don't fit in one category but are part of multiple).

Out of these 72 idioms, 28 of the most common ones (mentioned by at least 4 people) have been outlined in table 3.

Table 3: Common Idioms of Distress

Category	Idiom	Translation	Total mentions	Mentioned by

Emotional	*Pareshani*	Worry	8	6 practitioners, 1 patient, 1 layperson
	Bechaini	Uneasiness	8	4 practitioners, 4 patients
	Dil nahi lagraha	My heart is not in it	7	6 practitioners, 1 patient
	Dil doobna/tootna	My heart is sinking/breaking	4	4 practitioners
	Udaasi/Mayoosi	Intense sadness	6	3 practitioners, 3 patients
	Ghusa ziyada aana/Chircharapan	Becoming more angry than usual/ Irritability	9	4 practitioners, 4 patients, 1 layperson
	Dar/Khauf	Fearfulness	6	3 practitioners, 2 patients, 1 layperson
	Rona aana	Feel like crying	4	2 practitioners, 2 patients
Physical	*Ghabrahat*	Restlessness	8	7 practitioners, 1 patient
	Kamzoori	Weakness/Lethargy	11	5 practitioners, 6 patients
	Neend mein masla	Sleep problems	7	4 practitioners, 3 patients
	Jism mein dard	Pain in the body	8	5 practitioners, 3 patients
	Sar mein dard	Pain in the head	9	6 practitioners, 3 patients
	Bhook mein masla	Appetite problems	4	1 practitioner, 3 patients
	Pait mein gas/dard	Pain/gas in the stomach	5	5 practitioners
Social	*Akela rehna pasand hai*	I prefer being alone	5	2 practitioners, 3 patients
	Taluqaat mein masle	Relationship problems	5	2 practitioners, 2 patients, 1 layperson
	Tanhai	Loneliness	5	2 practitioners, 3 patients
	Shak-o-shubaat	Paranoia/Lack of trust	7	3 practitioners, 4 patients
Mental	*Awazein aana*	Hearing voices	4	1 practitioner, 3 patients
	Samajh nahi aarahi	Confusion	8	4 practitioners, 3 patients, 1 layperson

	Zehn/Dimagh kaam nahi karna	Mind/brain is not working	8	4 practitioners, 3 patients, 1 layperson
	Zindagi khatam ho gayi hai	My life is finished (nihilistic thoughts)	7	4 practitioners, 2 patients, 1 layperson
	Khudkush khayalat	Suicidal thoughts	5	2 practitioners, 3 patients
Environmental	*Andhera hai*	There is darkness all around me	4	4 practitioners
	Shehr mujhay pagal kar raha hai	This city is driving me crazy	5	4 practitioners, 1 patient
Spiritual	*Gunaoon ki saza*	Punishment for my sins	5	2 practitioners, 2 patients, 1 layperson
Other	*Tension*	Feeling very stressed, pressure in the head	16	7 practitioners, 5 patients, 4 laypeople

The most commonly mentioned idiom was the English word *tension*. One practitioner noted that, "some English words have seeped into Urdu" (female psychiatrist). *Tension* could not be encapsulated in one singular category because it was associated with physical, mental and emotional phenomenon:

> "A lot of the time people will complain of feeling a lot of pressure, as if they're under a lot of pressure. They often use the word 'pressure' and 'tension' is another term that is more specific but people will complain of feeling as if their brain is under a lot of pressure, or they may feel as if they're trapped, or they're being pulled in several different directions, or they're being pushed into a corner" (female psychiatrist)

The use of *tension* cuts across different demographic groups and was mentioned by practitioners, laypeople and patients. In fact, *tension* is "so commonly used that it's being overused and quite often people have to be psycho-educated that there is a difference between stress and tension and distress and depression and quite often they sort of mix it up altogether" (male psychiatrist).

The emotional idioms, identified by participants, revolved around the heart construct with some common ones including *dil doobna/tootna* (my heart is sinking/breaking) and *dil nahi lag raha* (my heart isn't in it). Other idioms in the emotional category were often used with the heart construct; the idiom *bechaini* (uneasiness) could also be stated as *dil bechain hai* (my heart is uneasy). This supports the finding in the ethno-psychological framework of the heart being considered to be the seat of emotions.

Participants cited mental idioms including impaired cognition such as *zehn/dimagh kaam nahi kar raha* (mind/brain not working), suicidality like *khudkhush khayalat* (suicidal thoughts) and nihilistic thoughts such as *zindagi khatam ho gayi hai* (my life is finished). This supports the ethno-psychological construct of the mental self being associated with cognition.

While some physical idioms, such as sleep and appetite problems, are commonly established expressions of distress, some unique examples were also observed. These mostly related to body pains (*jism mein dard)* and physical weakness *(kamzoori)*. *Pait mein gas* (gas in the stomach) is another idiom that seems unique to this sample since the patients "feel as if their distress is related to gastrointestinal [system] - there is this concept that there's gas which is rising up into their body and going into the brain and affecting the brain" (female, psychiatrist).

Social idioms demonstrated the significance of the social self, and were primarily related to interpersonal issues and a lack of connection with society. Some prominent ones were *taluqaat mein masle* (relationship issues) and *tanhai* (loneliness). Spiritual idioms, reflecting the spiritual self, were also present with the most prominent one being *gunaoon ki saza* (punishment for my sins). Environmental idioms revolved around the natural, built and socio-political environment with one prominent one being *shehr mujhay pagal kar raha hai* (this city is driving me crazy).

This is probably a reference to the infrastructural and security problems plaguing Karachi and demonstrates how the self is enmeshed in and influenced by the environment.

According to the psychiatrists, out of these idioms, some were used more commonly among different types of patients presenting to the clinics (see table 4). Since these correspond with the symptomology of psychiatric disorders, this may indicate that psychiatrists usually focus on symptoms they have been trained to identify.

Table 4: Idioms used more commonly by patients diagnosed with particular conditions.

Diagnoses	Idioms	Translation
No diagnosable condition	*Pareshani* *Tension* *Neend nahi aarahi* *Kuch samajh nahi aaraha*	Worry Feeling very stressed Sleep problems Confusion
Depressive disorder	*Dil nahi lag raha* *Zehn/Dimagh kaam nahi kar raha* *Akela rehna pasand hai* *Khudkush khayalaat* *Tanhai* *Zindagi khatam ho gai hai* *Mayoosi/Udaasi*	My heart isn't in it Mind/brain is not working I want to be alone Suicidal thoughts Loneliness My life is over Intense sadness
Anxiety disorder	*Ghabrahat* *Sar mein dard* *Kamzoori* *Pait mein gas/dard* *Bechaini*	Restlessness Pain in the head Weakness/lethargy Pain/gas in the stomach Uneasiness
Psychotic disorder	*Shak-o-shubaat* *Awazein aana*	Paranoia/Lack of trust Hearing voices

According to the participants, in the different demographic groups the most significant factor that seemed to influence idioms of distress was the intersection of education and age. The younger more educated group seemed to "use the more modern lingo which is common for that age. It comes from their schools and their colleges depending on where they are studying. They

are more westernized and influenced more by American and British culture" (female counsellor). Potentially due to this exposure to Usonian culture, younger more educated participants tended to use mental idioms more frequently whereas physical, social and spiritual idioms were more common in other groups. As one practitioner stated:

> "I think the younger people tend to be more direct, they probably describe psychological symptoms more, the ones in the older groups tend to - what I would call - somatize their symptoms much more, as opposed to the psychological symptoms. Again, that would depend on their educational background and those who are much more [educated] would tend to lean more towards the psychological symptoms than the physical ones" (male psychiatrist).

According to a practitioner, in Pakistan education level is closely linked with socio-economic class with the more affluent groups acquiring Western education. This may be one of the reasons that they are more likely to use Western idioms of distress:

> "The upper classes are more educated and can use terminology that is perhaps more westernized and more specific to their symptoms. If they're feeling depressed or sad, they'll say that they're feeling depressed or sad. They may actually present with that complaint. They've probably read more about it or heard more about it or maybe through the media, so they've been more exposed to this kind of language and they're more familiar with it therefore they will use that language" (female psychiatrist).

In contrast, "in the lower socioeconomic class, somatization is very common. We quite often see patients with either convergence symptoms, somatization disorder, sometimes hypochondriac symptoms too" (male psychiatrist). Participant responses suggest that mental idioms are more common in groups exposed to Western systems while physical idioms are more frequently used by the other groups.

Participants also reported differences in the use of idioms between different genders, since "for women it's often physical symptoms like headache, or gas, or weakness and shortness of breath. Those might be more common symptoms. Whereas amongst men it may be anger, irritability, lack of concentration, sleep disturbances" (female psychiatrist). In addition, "men don't

want to tell you about their symptoms, but when you actually ask them some close-ended questions quite often they relate their stress to aches and pains at the back of their shoulders or the neck, and they're having problems concentrating at work" (male, psychiatrist).

According to a practitioner, this may be due to the traditional nature of Pakistani society with gender roles exerting more work related pressures on men as compared to women. Notions of masculinity may also make men more likely to externalize their distress through aggression. In contrast, the 'passive female' construct may make women more likely to internalize their distress through somatization.

There were no differences observed in the idioms of distress between different ethnic groups.

Explanatory Models for Mental Illness

Participants identified several explanatory models for mental illness present in the sample. They can be divided into 5 main groups including: (1) biological (related to some form of biological problem); (2) social (related to social issues); (3) supernatural (related to supernatural causes); (4) environmental (revolve around the natural, built and socio-political environment of Karachi); and (5) spiritual (focused on spirituality and religion). The explanatory models are outlined in table 5.

Table 5: Common Explanatory Models for Mental Illness

Category	Explanatory Model	Explanation
Biological	Physical illness	Mental illness was considered to be result of some physical illness with the participant being unable to distinguish between the two.
	Genetic	Mental illness was considered to be passed down from parents to children.
	Neurochemical imbalance	Mental illness was thought to be a result of neuro-chemical imbalances.

Social	Family problems	Mental illness was attributed to problems in relationships.
	Financial problems	Mental illness was attributed to financial problems.
	Loss of a loved one	Mental illness was thought to be due to the loss of a loved one through death, separation or divorce.
Environmental	State of the city	Mental illness was thought to be caused by the built and socio-political environment of Karachi.
Supernatural	Persecution by Jinn	Mental illness was thought to be caused by persecution by malignant Jinn (Hidden beings made of smokeless fire based on Islamic cosmology)
	Black magic	Mental illness was attributed to black magic by someone who was jealous or angry with the affected.
Spiritual	Divine punishment	Mental illness was attributed to punishment for sins.
	Lack of spiritual connection	Mental illness was thought to be due to a lack of connection with or distance from God.

Out of these, the most commonly mentioned were social models which were repeatedly observed across the demographic groups. Death of a loved one was one of the most common models and seemed to be frequently mentioned by both men and women. Family problems were highlighted more by women, than men, with one patient saying, “I had lots of family problems which is why I became sick” (25, female, less than high school education). For men, financial issues seemed to be the main cause with a layperson saying, “If a man doesn’t have enough money that’s why it happens. He keeps on thinking where do I get it from. That causes tension and takes him towards mental illness” (30, male, high school degree). This supports the earlier findings of this study and provides further evidence of the impact of gender roles in the manifestation of distress.

In the biological category, physical illness was mentioned more by the less educated lower socio-economic class. Some practitioners reported that they are unable to distinguish it from the psychological. Genetic and neurochemical imbalances as an explanatory model seemed to be

present more in the younger more educated demographic groups with one practitioner explaining the reason to be "the younger age group is accessing the internet and that sort of information more" (female counsellor). Another patient stated, "[Mental illness] happens due to a decrease in chemical substances in the brain and due to genes. My doctor told me about this" (41, female, bachelors degree). Participant responses suggest that exposure to Western schooling and media is influencing the explanatory models of mental illness.

The supernatural models that were observed revolved around persecution by *jinn* and black magic. In Islamic cosmology *jinn* are supernatural beings composed of smokeless fire who live among humans but are usually invisible. *Jinn* can be benevolent or malevolent. Malevolent *jinn* are thought to persecute individuals leading to mental illness. While the less educated lower socio-economic class "say 'yes it's to do with *jinn*', the educated don't speak of *jinn* but they believe in black magic and refer to the Quran regarding it" (female, psychologist). This suggests that even though supernatural models are present in all demographics, the less educated lower socio-economic group is more likely to use the *jinn* model while the more educated higher socio-economic group is more likely to use the black magic model.

There was no difference observed in the occurrence of the spiritual or environmental models across different demographic groups.

Discussion

This exploratory qualitative study was one of the first of its kind to study the cultural manifestations of distress and mental illness in Pakistan. The ethno-psychological framework established by the study finds striking similarities to studies conducted in other parts of South Asia. According to a study, Nepalese ethno-psychology is "considered an assemblage of the *man* (heart-

mind), *dimaag* (brain-mind), *jiu/saarir* (corporeal body), *saato/atma* (spirit/soul) and *ijjat* (social status/honor), all of which are connected with *samaaj* (the social world)" (Kohrt and Hruschka 2010). Studies conducted in India have revealed an ethno-psychological framework very similar to that identified in Nepalese populations (Weaver 2017). An important aspect of this is that "Indian notions of personhood are 'dividual' (rather than individual)—that is, permeable, constituted by and from the substances and other people with which they come into contact" (Smith 2012). The differentiation of the mental and emotional selves with their association with the mind/brain and the heart constructs respectively is also significant. Aside from South Asia, this phenomenon has also been observed in studies conducted in Haiti, Cambodia and other regions of the world (Hinton, et al. 2016; Keys, et al. 2012). The Pakistani ethno-psychology unveiled by this study shows similar features with a 'dividual self' having multiple components (physical, mental, emotional, social and spiritual), enmeshed in the external environment. The idioms and explanatory models seem to support this as they are expressions of some aspect of the self.

The dividual self is very different to the individual self of the Western world. The individual self is a discrete, autonomous and independent self clearly demarcated from the external environment (McHugh 1989). The dividual self, in contrast, doesn't conceive of itself as a sovereign entity but as a dynamic extension of the people and society around it, continuously influenced by the external environment (Smith 2012). The aspirations of the dividual self are to sacrifice self-interest in order to ensure the harmony of the social whole, rather than striving to fulfill personal aspirations which is the hallmark of the individual self (Smith 2012). This may also be an indication of the differences between individualistic and collectivistic cultures as has been reported in literature (Gorodnichenko and Roland 2012). Some experts suggest that this ethno-psychological framework is influenced by indigenous medical epistemologies, comprising of

Ayurvedic and Greco-Islamic traditions, as well as religious beliefs (Safdar, et al. 2017). The importance of the social and spiritual selves in the Pakistani ethno-psychology may be strongly influenced by the emphasis on communal relations in Islam and the spiritual beliefs of Muslims (Sabry and Vohra 2013). However, similar findings in non-Muslim South Asian communities in Nepal and India seem to suggest that there is more at play than just religion (Kohrt and Hruschka 2010; Weaver 2017).

The idioms of distress elicited by this study are similar to idioms observed in studies in Pakistani and other South Asian populations. Frequent association of emotional distress with the heart has been seen in research conducted on Pakistani, Bangladeshi and Nepali populations (Bhui, et al. 2002; Kohrt and Hruschka 2010; Minhas and Nizami 2006). In fact, the centrality of the heart to Nepalese ethno-psychology is so important that the Nepalese term for counsellor is *manobimarshakarta* (person who advises on matters of the heart) (Kohrt and Harper 2008). Another idiom that is significant is *tension* which despite being an English word was the most commonly used idiom. A study conducted in India found similar results with 'tension syndrome' being reported that consists of a "broad cultural syndrome that comes on quickly and involuntarily, involving feelings of anger, irritation, and being upset" (Weaver 2017). Another study conducted in Northern Pakistan also mentioned *sar pe tension* (tension on my head) as a common idiom (Minhas and Nizami 2006).

The differences in the idioms used between various demographic groups was also important, in that the younger more educated group was more likely to use Western idioms, like depression and anxiety, to describe their distress. According to the practitioners this is due to the exposure of these individuals to Western media. This also supports the theory that globalization is causing the Westernization of distress and changing the way it is expressed in non-Western

cultures (Watters 2011). The differences in the idioms between men and women is also significant in that men are less likely to open up about their emotions. Studies have shown that the nature of the gender roles in Pakistani society may lead to emotional suppression in men (Ramzan and Amjad 2017). The effects of this on their mental health merits further exploration.

While no significant difference was observed in the use of idioms between different ethno-linguistic groups, it may have been because the sample was primarily Muhajir and the interviews were all conducted in Urdu which, despite being the national language, is not the first language of over 90% of the Pakistani population (Mohiuddin 2006).

With regard to the explanatory models, the most prominent category were social models with the understanding that distress caused by adverse social experiences can lead to mental illness. This may be an indication of the importance of the social self in the ethno-psychological framework of the Pakistani and has been supported by another study conducted on Pakistani populations in the UK (Bhui, et al. 2002). Within the social category the differences observed in the use of models between men and women was also significant with women mentioning family problems (such as issues with parents, siblings, husbands or in-laws) more while men were more likely to attribute their distress to financial or employment issues. This may be due to the traditional gender roles, with men being the breadwinners and women being the home makers, and has been seen in studies conducted on other Pakistani populations (Bhui, et al. 2002). Similar differences have been observed in research on Indian and Bangladeshi populations (Bhui, et al. 2002).

The biological category was also frequently mentioned, and has been supported in other studies on Pakistani populations (Bhui, et al. 2002) with the specific models differing among groups with different educational levels. Individuals from the less educated group were more likely to consider the distress causing mental illness to be a manifestation of some underlying physical

illness. In contrast individuals from the more educated group were more likely to support the genetic and neurochemical imbalance model propagated by Western medicine. This may be because the educated group may be more exposed to Western media and are more likely to discuss their condition with practitioners as compared to the less educated group, providing further credence to the theory that Westernization is changing the way distress manifests in non-Western cultures (Watters 2011).

The supernatural category is also significant in that the *jinn* and black magic models were present in all demographic groups regardless of education, gender or age group. This may be because of the existence of these concepts in Islamic cosmology (Sabry and Vohra 2013). The presence of the spiritual models indicates that more research needs to be conducted in order to understand the role of religion in the conceptualization of distress and mental illness, and the development of effective prevention and treatment approaches.

Limitations

Since this was an exploratory study, the findings need to be validated through further research. In addition, the study sample was recruited from Karachi, which has its own cosmopolitan culture, and primarily belonged to the Muhajir ethnic group which despite forming 40% of Karachi's population only forms around 8% of Pakistan's population and is largely present in the urban centers (Mohiuddin 2006). Therefore, it may not be possible to generalize the findings of the study to all of the Pakistani population without conducting similar studies in other regions of the country.

Implications for Future Practice

Research on cultural manifestations of distress offers a way for global mental health to address several criticisms leveled against it, for being too Euro-centric and being a form of medical

imperialism. The evidence provided by this study raises important questions about the applicability of Western constructs of mental illness to the Pakistani cultural context. If the ethno-psychological framework, on which mainstream psychiatric practice is based, is dissimilar to the Pakistani one, it is unclear the extent to which Western psychiatric practices for prevention, diagnosis, and treatment will be effective.

The idioms of distress elicited by this study should be analyzed and incorporated into screening tools to make them more culturally resonant, effective and valid. Idioms revolving around the social and spiritual selves are particularly important since these constructs are usually absent from mainstream psychiatric nosology and screening tools. The explanatory models of mental illness can inform mental health promotion and mental illness prevention programs, to enable the development of effective health behaviour change interventions. The ethno-psychological framework can be used for the development of indigenous psychoanalytic theories that are more applicable to the local cultural setting.

Conclusion

Very little research has been done on the cultural manifestations of distress in Pakistani populations. This study has established an ethno-psychological framework that is dividual; composed of many parts (physical, social, emotional, mental, and spiritual) and influenced by the external environment. The idioms of distress and explanatory models of mental illness have demonstrated socialization, spiritualization and somatization of distress.

By taking indigenous understandings and manifestations of distress into account, culturally sensitive mental health screening tools and interventions can be devised that are more likely to be effective. This exploratory study offers valuable information that, after being validated through further research, can help achieve this task in the Pakistani context.

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