An exploration of social construction of mental health: perspectives of Pakistani diaspora in Aotearoa

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Abstract

The ‘Asian’ population in Aotearoa is growing significantly. Quantitatively, an increase of 26 per cent by the year 2043 is projected (Stats, 2022). Despite this increase, Asian health in Aotearoa is a neglected area of research (Chiang et al., 2021). Research suggests an urgent need to address the mental health concerns among Asian communities (Xia, 2021) but Asian mental health remains absent from the mainstream discourse. Research has also identified that Asian communities have unique ways of understanding and managing mental health, but these almost always are explained through Western constructs and conceptualisations. The purpose of this thesis is to move beyond western conceptualisations of health and well-being to examine the social construction of mental health among the Muslim Pakistani diaspora in Aotearoa – one subset of the Asian communities. Using a qualitative methodology of in-depth interviews with ten participants, this research examines how the Pakistani diaspora constructs mental health and how these constructions are influenced by culture and gender.

This research showed that the Pakistani diaspora has a complex and nuanced way of socially constructing mental health that are tied to the dominant discourses prevalent in both Pakistan and Aotearoa. Participants predominantly drew on the biomedical discourse, the contemporary well-being discourse, and the religious-spiritual discourse. The research also shows that the concept of mental health is not static for Pakistani diaspora but instead it is constantly being navigated, negotiated and in some instances resisted. The research raises important questions about the dynamic social constructions of mental health among Asian communities in Aotearoa and its implications.

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“Ehara taku toa i te toa takitahi, engari he toa takitini”

Success is not the work of an individual, but the work of many.

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Chapter one: Introduction

A researcher always has a story about their choice of topic. I, too, have a story. This research is about the Pakistani diaspora in Tāmaki Makaurau, Aotearoa, and their understanding, social constructions, and cultural, social, and religious practices of mental health. My drive to do this research was born out of my personal experiences of/with mental illness as a diasporic Pakistani woman in Aotearoa, coupled with personal interactions with several other people of colour and their mental health experiences, including the suicide of a close friend.

When I was 16 (I am now in my early thirties), I migrated with my three younger sisters and father to Aotearoa from Karachi, Pakistan. I did not have a choice in the decision to migrate, and I left behind my mother and two other siblings. I was grieved to have been made to leave my mother and had not even begun to recover from this grief when myself and my sisters were faced with family violence in our new home. Being the firstborn in the family, the protection of my younger siblings rested on my shoulders. Within one and a half years of moving to Aotearoa, my sisters and I had escaped the violence perpetrated on us by our father. By the age of 17, and still in high school, I was in family court, trying to assure a New Zealand judge that I could look after three younger sisters. The judge believed me, and I became a guardian parent to my sisters (15, 14, and 14). As a Pakistani Muslim, I was born and raised within a collectivist culture and family background, which places immense importance on family honour. Defying my father's authority and leaving his home tarnished our family honour; it meant that my sisters and I were ostracised from our family both in Pakistan and Aotearoa and received no family support. We were placed in a safe house in an undisclosed location, and while there, a relative close to my father warned us that if we were his daughters, he would have beheaded us. We knew our father was looking for us, and we had a death threat looming over our heads.

Becoming a legal guardian at seventeen placed considerable pressure on me – looking after my siblings, attending school, and working in paid employment. These everyday pressures were coupled with the constant fear of being located by our family and regularly watching my back when out in public - on the bus, on the road, in the supermarket. The trauma of family violence, the lack of adult guidance, the responsibilities, and the fear resulted in extreme paranoia, self-harm, and several suicide attempts. I was in and out of respite, never saw the same doctor or psychiatrist more than once, and was never asked by medical

professionals where all of this was coming from. I was clueless about what was happening to me, and in one session with a psychiatrist, I gathered the courage and asked, “What is wrong with me?”. He said, “You have borderline personality disorder”. I had a label, my first label. I researched about it, believed it, and lived the next eight years with it, but the underlying cause of my distress was never talked about in the multiple counselling and psychiatric consultations. I felt like I was a mere label, a medical condition rather than a human being with a very personal and unique set of life experiences. From 18 to 24 years of age, I would attempt suicide, wind up in the hospital, a psych team would assess me, and a “professional” decision would be made as to whether I would go into respite or if I was deemed safe to go back home. And repeat.

My undergraduate years at university were devoid of any understanding of what was happening to me. No one was willing to understand, including medical professionals, family, employers, and friends, and I did not have the knowledge or understanding to explain to anyone. My education, work opportunities and social relationships were severely impacted. I moved from house to house, from job to job, from degree to degree. Unsettled and scared. When I faced rejections, I would return to my self-harming behaviours.

The tensions around how I should perform my mental health issues were apparent. On the one hand, I felt I was expected to hide my mental health issues from prospective employers and at university. On the other hand, in order to receive financial support from the Government, I was expected to prove that I had mental health issues. The cycle continued. Over the years, I was prescribed medication and engaged in one-on-one and group therapy. Over the years, the labels given to me changed. Sometimes it was clinical depression, sometimes borderline personality disorder, sometimes bipolar disorder. I was considered a lazy student at the university by the dean, lecturers and tutors, and my absence from work for bouts of severe depression meant I was considered an unproductive worker. Despite explaining (to lecturers and employers) my ins and outs of hospital and respite, and my struggles with mental health issues, I was made to feel useless and a burden on society.

In 2012, at the age of 25, I had my first breakthrough. I discovered the power of reading. I read around 100 books a year, from science to religion and everything in between. I found comfort and consolation in the books and the knowledge. Around the same time, I found a community, those who showed up, those who were willing to give me a chance and welcomed me, both socially and professionally. For the first time, I openly talked about my

journey with mental health issues with these people. Sadly, my healing journey never included support from my family, mental health services, welfare system or education institutions.

The emphasis that we see today around mental health awareness in Aotearoa was largely absent while I was struggling. It was not until my last year of undergraduate studies that mental health awareness became more prominent. At the University where I worked, emails from Human Resources on well-being and self-care were frequent. A shift was occurring, and it was most noticeable at the workplace. I openly allowed myself to be positively influenced and changed by these messages.

My struggles and journey with mental health issues led me to start thinking about my community – the Pakistani diaspora in Aotearoa, and how we understand and deal with mental health issues. I wanted to raise awareness of mental health issues in my community and, at the time, believed it needed to be dealt with within the realm of psychiatry bereft of context and nuance. But I also recognised that the Pakistani diaspora was hesitant to seek medical support for mental health issues. This position was my point of entry into this research, but it wasn't how I exited it. Like my own journey of mental health, this research and the construction of this thesis has been a journey of discovery and change: personally and in terms of the research objectives and aims.

When I reflect back on my story, it raises a number of themes and ideas, which I explore throughout this thesis. My story shows the deficit in the dominant biomedical approach to mental health, which blatantly ignores the social determinants that impact mental health. It highlights how "well-being", the new buzzword in Aotearoa's political and health landscape, fails to fulfil its promise. It shows how awareness of mental health issues alone will not be able to eradicate 'stigma'. It shows that mental health is much more than stigma. It demonstrates my cultural and gendered position, but it also shows the way my multiple identities intersected. As a survivor of family violence, as a Pakistani woman in a highly patriarchal society, as a migrant, as mentally ill, as an unproductive worker in a neoliberal capitalist society, and as a lazy student in educational systems that privilege a certain kind of student. It shows how the systems, NGOs, health care, state welfare, and education systems speak different languages. It shows the insidious nature of discrimination in institutions in Aotearoa. All these fragments and progression of my story come together to show that mental

health is a social construction – fluctuating and fluid, political and that there is no single way to understand it.

The aim of this thesis is to explore and understand how ideas and practices of mental health are socially constructed among the [Muslim] Pakistani diaspora. Two key research questions drive this study. The first is concerned with how the Pakistani diaspora in Aotearoa construct mental health, the discourses they draw upon and how they negotiate the dominant discourses of mental health when bridging constructed ideas and practices of mental health? The second is concerned with how these constructions are influenced by the intersection of culture and gender.

Discourses and framings of "mental health"

Mental health issues, mental health problems, mental ill-health, mental unwellness, mental distress, and mental disorders are some words used to describe what is commonly understood as mental illness. The meanings of these terms vary and are contextual, suggesting "allegiance to a particular set of ideas" (Warner, 2009, p. 631). Some terms such as mental ill-health and mental disorders demonstrate allegiance to a biomedical understanding of mental health, and others terms such as mental health issues, mental distress are argued to imply "a more problematised stance" on mental health (Warner, 2009, p. 631). Throughout this thesis, I use the phrase mental health issues instead of mental illness or distress. I chose this term for two reasons: 1) as a Pakistani, I am aware of the stigma and taboo associated with "mental illness" in Pakistani culture and felt that reference to "mental illness" might be confrontational for my participants and 2) to demonstrate my positioning as resisting biomedical construction of mental health. The choice not to align with "distress" (the language used in Aotearoa) is personal because distress fails to capture the implications of living with mental health issues.

Mental 'distress' is common in Aotearoa, with four in five individuals having experienced it or know someone who has (Kvalsvig, 2018). Mental 'distress' is more than biomedically diagnosed conditions; it includes social factors that impact mental health (Kvalsvig, 2018). In Aotearoa, the term mental distress is used in official Government reports and by mental health services rather than mental illness to "better capture the broader range of peoples' experiences, demonstrate respect of those with lived experience, and better reflect Māori and Pasifika views of health and well-being" (Flett et al., 2020, p. 4). The shift in language from

mental illness to mental distress in Aotearoa is also due to the stigma attached to mental health issues, as outlined by Kvalsvig (2018):

> …by pathologising lived experience of mental health problems, there is an increase in associated stigma as those who discriminate seek to distance themselves from those with 'mental illness'. Not referencing 'mental illness' also makes it easier for people experiencing distress to talk about their difficulties (Kvalsvig, 2018, p. 8)

Undoubtedly, many people are reticent about sharing their experiences of mental health issues because of the associated stigma with the term mental illness. Language and terminology of mental health play an important role, as demonstrated in a study of 1,646 people in Aotearoa. The report found that mental distress was seen as different from mental illness among the participants. However, the experience under the categories of mental illness and mental distress showed little difference in the responses (Kvalsvig, 2018). The change in terminology is indeed justified; 'mental distress' relieves some of the stigma inherent in the loaded term 'mental illness'. What it fails to bring to attention is that changing terminology does not change the power structures and relations that produce stigma.

Foucauldian discourse analysis is considered an influential framework for questioning such power relations. Discourse is more than language, described by Foucault (1969) as:

> practices that systematically form the objects of which they speak. Of course, discourses are composed of signs ["signifying elements referring to contents or representations"]; but what they do is more than use these signs to designate things. It is this more that renders them irreducible to the language (langue) and to speech. It is this 'more' that we must reveal and describe (Foucault, 1969, p. 54).

Khan and MacEachen (2021) further explain discourse analysis as a process that begins with an idea that becomes practice by sharing this knowledge with wider groups. These ideas and knowledges "enter into the social world" and become "into a kind of factual existence of truth, as a natural, objective feature of the world… Finally, they internalize or make it part of their everyday practices and future generations are born into a world where these ideas already exist" (p. 2). These form the dominant discourses which are presented as truths about the world, constantly being influenced and influencing social systems and practices.

The dominant discourse of mental health issues in Aotearoa is a biomedical discourse framework. Within this discourse, mental health issues are constructed as "conceptually analogous to physical ill-health...amenable to a scientific, positivistic line of enquiry" (Giacaman et al., 2011, p. 547). Inherent in the construction of mental health issues as ill-health, as a disease or pathology is the subjugation to the same kind of "investigation, [medical] treatment, and elimination..that diseases of the body do" (Kopua et al., 2019, p. 376). In this way, the individual with mental health issues is constructed as a "patient" who requires adherence to a medical treatment plan (Speed, 2006). A biomedical discourse serves "the interests of the pharmaceutical industry and powerful professional elites" (Thomas et al., 2005, p. 27), highlighting the implications for power relations where psychiatrists are constructed in a position of power.

The biomedical discourse locates mental health issues within the individual manageable by consuming medication. In this way, the individual is held responsible for managing their 'illness'. The individualising discourse of mental health absolves the power structures from their responsibility to consider inequalities in society such as poverty, lack of opportunities and racism. Cohen (2020) further problematises the depoliticisation of individual suffering, interrogating the role of western psychiatry in individualising "socio-economic and political issues" and argues that the agenda of such a discourse is to neutralise "the effects of globalization", the exploitation of Global South and capitalism (p. 40). This evaluation that troubles the efficacy of an individualising discourse remains absent from the global discussion of mental health. One example of the individualisation of mental health issues is the rise of mindfulness in the West. Mindfulness is a tool to alleviate suffering and does not promote medication. Purser (2019), in a critical analysis, argued that mindfulness is a profitable industry that operates by "deflecting attention from social, political and economic structures" (p. 29). Thus, mental health issues become an individual problem when the structural, cultural, and historical context is neglected.

It has been said that the mental health system in Aotearoa is in crisis (McClure, 2021). Several studies in Aotearoa shed light on the burden of mental health issues on the health system and its failure to provide adequate care (Elliot & Cloet, 2017; Paterson et al., 2018). This crisis has led to a shift in the understanding of mental health issues. This is evident in recent government reports, where the current mental health system is critiqued for relying on a psychiatric response to mental health issues. For example, The *He Ara Oranga* report, an

inquiry from the Aotearoa Government into mental health and addiction, argued for a paradigm shift from psychiatry to the community. The report highlighted that mental health issues are currently viewed as a "health deficit" with "a health entry point led by medicine". A paradigm shift with a focus on the community would mean that mental health issues are viewed as "a recoverable social, psychological, spiritual or health disruption" with "multiple entry points led by multiple sectors and communities" (Paterson et al., 2018, p. 36). The report also highlighted several social and economic determinants of mental health issues, including "poverty, social exclusion", access to "affordable and safe housing, quality education, meaningful employment, adequate income, social connectedness, freedom from violence and reliable social support" (Paterson et al., 2018, p. 42). In other words, the report recognizes the impact of structural inequality. Similarly, several other reports, such as the People's Mental Health report produced by Action Station, highlighted the social determinants of mental health issues and recommended a more community-based approach (Elliot & Cloet, 2017).

Associated with this shift to a holistic community-based understanding is the growing focus on raising awareness around mental health issues and fighting the associated stigma. Several nationwide public campaigns focus on normalising and destigmatising mental health issues by promoting open conversations around mental health. Examples of such campaigns include Like Minds, Like Mine, Mental Health Awareness Week, and depression.org. Besides these national campaigns (with celebrity endorsements), there are many digital resources to self-manage mental health issues (for example, Melon, Mentemia, Small steps). Some have argued that these campaigns have changed "the way people with experience of mental illness are viewed and changed the New Zealand social environment for the better" (Cunningham et al., 2017, p.285). Others have argued that the focus should be on action rather than awareness. The emphasis on awareness without considering the structures that produce stigma is evident in studies that continue to report a high degree of stigmatisation and discrimination around mental health issues in Aotearoa (Peterson et al., 2008; Peterson et al., 2007).

However, despite the growing advocacy for a shift in how Aotearoa responds to mental health issues, the biomedical approach to mental health issues remains dominant. There has been a 50% increase in prescriptions for mental health issues in the last decade, and that growth has continued at about 5% per year (The Government Inquiry into Mental Health and

Addiction, 2018). One of the primary reasons for this continual reliance and increase in medical intervention stems from underfunding of alternative mental health services (Elliot & Cloet, 2017). Issues about mental health and access to mental health services are important in the Aotearoa context. However, this thesis is about the construction and practices of mental health issues among the Pakistani diaspora in Aotearoa, which raises a different, arguably more complex, contextual backdrop.

As in Aotearoa, there is growing attention to the socioeconomic conditions which impact mental health issues in Pakistan. It has been estimated that fifty million people in Pakistan suffer from mental health issues (Mumtaz, 2021), and these high rates have been attributed to the "exposure of Pakistanis to serious bouts of sociopolitical instability, economic uncertainty, violence, regional conflict and dislocation" (Sohail, 2017, p. 28). However, similar to Aotearoa, mental health issues in Pakistan are still largely framed within the biomedical model, which is prioritized in both academic literature and government policy. Unlike Aotearoa, in addition to the biomedical medical, spiritual and religious discourses are also prominent. Many people in Pakistan explain mental health issues through reference to spirituality/religion. Yusuf (2020) argues that there is a firm belief in mental health issues being attributed to a punishment from God, and yet despite this, "Western and medical approaches, in particular psychiatry, are the preferred treatment approaches" for those who have access to resources, and "including those who describe Islam as being central to their lives and worldviews" (p. 439). This reference to religion and spirituality is underpinned by class. People who do not have the resources to afford (bio)medical mental health services are more likely to turn to religion or spiritual methods (Farooqi, 2006), such as seeking support from faith and religious healers. This underlines that in Pakistan, understandings and practices around mental health are structural as well as spiritual/religious ideological. A person's pathway to treatment is highly dependent on social class, which in the Pakistan context is also tied to geography (i.e., rural versus urban and associated education levels).

These two dominant discourses and practices in Pakistan: the medicalised discourse and the religious discourse, are framed as competing in the literature. Recommendations by researchers have been on educating the public to move away from spiritual/religious methods of dealing with mental health issues to seeking biomedical intervention. One of the reasons put forward for shifting public thinking from religious to medical intervention has been concern around individuals with mental health issues not getting the support they require.

Furthermore, it has been argued that traditional beliefs about mental health issues hinder the timely intervention and recovery of individuals (Shah et al., 2019). Despite this attempt to pull away from spiritual and religious understandings and practices around mental health issues, a number of researchers in psychology, sociology, and public health are also calling to incorporate the religious elements of Islam into the [formal] treatment modalities available in Pakistan (Farooqi, 2006; Khan, 2016). Privileging religious explanations address the absence of cultural discourse in general and provide a culturally competent model to deal with mental health issues. However, it is also a form of co-option, furthering a psychiatric agenda as problematised by Williams (2020), "the problem that appears to be perceivable, recognizable, discussable and actionable in the sphere of culture and mental health is the need to render cultural differences into a form that can be expropriated by Western-based mental health knowledge" (p. 143).

This thesis is not, however, about Pakistani people living in Pakistan. Or specifically about the state of mental health discourses and services in Aotearoa. Instead, the focus is on the Pakistani diaspora in Aotearoa, who as I will show later in the thesis, straddle and negotiate what is often considered competing and uncomplimentary discourses and practices of mental health issues: biomedical/religious & spiritual, and individual /collective.

Significance of this study

This study is significant and timely for a number of reasons. First, while there is a greater acknowledgement of the impact of social and contextual factors on mental health issues in Aotearoa, research on 'Asian' mental health (in which the Pakistani diaspora is included) in Aotearoa is scant (Kumar et al., 2006). Second, Aotearoa's Asian community is largely neglected in the Aotearoa health policies (DeSouza, 2006), despite Asian people comprising over 15% of the Aotearoa population (Statistics New Zealand, 2020). It has been projected that the Asian population will continue to increase, reaching up to 26% of the total population by 2043 (Statistics New Zealand, 2021). Like diasporic communities worldwide, the Asian population in Aotearoa is argued to underutilise mental health services (Chow & Mulder, 2017). One explanation for the underrepresentation of Asian people utilising the health system is the failure to account for cultural explanations of mental health issues that do not align with western mental health concepts, including shame and stigma (Chow & Mulder, 2017). This failure to account for a significant population gives rise to growing inequity in

service provision which would undoubtedly have implications on the Asian community's mental health.

Third, there is no disaggregated data on health, including the mental health of different Asian populations in Aotearoa. The term 'Asian' encompasses a large number of ethnicities and has been argued to be "merely an expedient construct that potentially provides benefits but disguises disparities within groups" (DeSouza, 2006, p. 2). This emphasises how Asian communities are framed as homogenous and in doing so, eradicates cultural complexity. These differences have ramifications, they "can influence access to health information, health maintenance opportunities, health care, and health outcomes" (Sadler et al., 2003, p. 1). In this thesis, I seek to dehomogenise the label "Asian", specifically in mental health, by demonstrating the wide array of discourses available in one specific Asian community – the Pakistani diaspora in Aotearoa.

Roadmap of the thesis

In this introductory chapter, I began with my personal experiences of mental health as a member of the Pakistani diaspora in Aotearoa. This established my motivations for the study and raised important sociological themes. I introduced the objectives and the key research questions and discussed the dominant discourses of mental health in Aotearoa and Pakistan. This sets the scene for the research, highlighting the complexity of how diasporic communities straddle various ways in which mental health issues are understood and practised in different "homes" (Pakistan and Aotearoa).

In Chapter two, I explore the literature around the social construction of mental health. I specifically consider stigma, culture and gender. I discuss the theorisation of stigma and highlight the absence of structural contributions that produce stigma. I take into account the cultural values that influence the construction of mental health. In the last section, I consider the way that gender is a key feature of dominant constructions of mental health discourse and through a brief historical overview of the construction of gender in psychiatric discourse, explain how it produces gendered positions. This is followed by a focus on gendered ideologies in Pakistan that influence mental health.

Chapter three discusses the methodology employed in this study, describing social constructionism as the methodological approach, and explaining the research design and data analysis. It also discusses the ethical considerations in the study. Here I stress my reflexive

stance and the benefits of my role as both an insider and an outsider – an insider in terms of understanding culture and an outsider in terms of someone who is a non-practising Muslim.

Chapters four and five comprise the results of this research. Chapter four explores the intersection of culture and mental health. This chapter discusses the participants' discursive constructions of mental health.

Chapter five explores how mental health constructions among the Pakistani diaspora are gendered as they intersect with Pakistani culture and in particular the socio-cultural concept of *izzat* and its implications for mental health.

Chapter six discusses the conclusion.

Chapter 2 - Literature Review

Introduction

Mental health and well-being has generated much attention in the last decade, which is visible nationally and internationally in the growing body of work around advocacy, prevention, and intervention of mental health issues. The Movement for Global Mental Health, established in 2008, is a coalition of a large body of individuals, institutions, and countries to seek solutions for people living with mental health problems globally (Patel et al., 2011). This movement has identified that the grand challenges in mental health can be answered within the realm of psychiatry (Kopua et al., 2020) and are partly due to the lack of dissemination of "effective [medical and psychiatric] treatments" to everyone in the world (Collins et al., 2011, p. 27). This position, however, is somewhat limited. It fails to account for "a growing counter-discourse", which highlights other ways of thinking about and responding to mental health issues (Kopua et al., 2020, p. 2). For example, medical or psychiatric treatments fail to account for "indigenous knowledge and healing traditions" that counter the hegemony of the psychiatric discourse (Kopua et al., 2020, p. 3). Undoubtedly these different positions reflect different epistemologies and ways of thinking about the world. Indeed, where one is located in the world influences the dominant discourses of mental health one might be exposed to. Although medical and indigenous understandings do not map simply and readily onto different nations, various cultural perspectives and practices certainly shape mental health constructions in different places.

In this chapter, I first briefly introduce the concept of mental health by reviewing the major epistemological positions in conceptualising mental health. I argue that mental health and mental health issues are socially constructed. To forward this argument, I bring together three fields of scholarship: 1) stigma, 2) culture and 3) gender. I first explore the various conceptualisations of stigma, including the influence of culture in shaping ideas of stigma. Here I build on the work of Goffman (1963) to demonstrate that stigma is a relational concept and then move beyond his work to critically examine the power dynamics that operate through the processes of stigmatisation while emphasising that more attention is needed on the intersection of individual and structural contributors to stigma. I conclude this discussion by drawing upon research outside the mental health field by showing that stigma is not a static concept; rather, it is negotiated, denied and sometimes reversed.

These ideas raise important questions about the cultural context in which ideas of mental health are generated. This leads to my second section, which contextualises mental health through culture and religion. I argue that cultural values play a significant role in understanding and managing mental health for Asian communities. I also critically examine the role of the western biomedical model in marginalising religious traditions of conceptualising mental health. The third part extends these ideas further by considering the gendered nature of mental health. I show this by examining the global history of mental health, where women are disproportionately pathologised. In the last section, I examine the patriarchy in Pakistan and its role in mental health.

Social construction of mental health

According to World Health Organisation (2004, p.10), mental health is "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". This definition is widely accepted and used in Aotearoa when discussing mental health or mental health issues. However, mental health is a difficult concept to define. Some scholars have called it an elusive, "unspecified" term, mainly presented as a euphemism for mental health issues (Bondi & Burman, 2001, p. 7). While others have pointed out that the sociological inquiry into mental health is problematic because mental health is a "misnomer", and the real interest is almost always in mental health issues (Warner, 2009, p. 631).

The debate around defining mental health or mental health issues gets further complicated when the question of whether it exists is considered. This debate has been referred to "as one of the most contentious metaphysical disputes in the area of mental illness" (Wrigley, 2016, pp. 374-375). The realist perspective argues that mental health issues are "genuine" illnesses that "individuals may exhibit" and can be discovered "through a better medical knowledge" (Wrigley, 2007, p. 375). While scholars belonging to the anti-psychiatry movement have questioned the existence of mental illness, critiquing the medicalisation of "problems in living" (Szasz, 1979, p. 122). To argue against the binaries of whether mental health issues exist or not, Foucault (1985) urges us to look at the social process in which mental health issues are defined and produced:

> …for when I say that I am studying the "problematization" of madness, crime, or sexuality, it is not a way of denying the reality of such phenomena. On the contrary, I

> have tried to show that it was precisely some real existent in the world which was the target of social regulation at a given moment. The question I raise is this one: How and why were very different things in the world gathered together, characterized, analyzed, and treated as, for example, "mental illness"? What are the elements which are relevant for a given "problematization"? And even if I won't say that what is characterized as "schizophrenia" corresponds to something real in the world, this has nothing to do with idealism. For I think there is a relation between the thing which is problematized and the process of problematization. The problematization is an "answer" to a concrete situation which is real (Foucault, 1985, pp. 171 – 172).

Within sociology, two major epistemological positions incorporate these debates about mental health: Social constructionism and realism. A Social constructionist perspective emphasises that mental health is understood through the social and cultural processes and that "there is no direct access to reality because all versions of reality are mediated through discourse or text" (Warner, 2009, p. 632). The realist position assumes that mental health is a truth and a "general aspect of (human) illness" (Wrigley, 2007, p. 375). Drawing upon these epistemological positions, I argue that mental health is a social construct that manifests in ways that have real and material consequences. To this end, I apply a social constructionist approach in this thesis to demonstrate that perceptions and practices of mental health issues are socially constructed, grounded in contextual experiences, and influenced by cultural, historical, and social structures.

Conceptualising Stigma of Mental health

> "There's definitely a huge stigma around how [Asian] people see those with mental illnesses that also leads to people not coming out to seek help or openly speak about their mental health issues,"… (Chen, 2021).

Mental health stigma is given quite a lot of attention in the literature concerning Asian communities in Aotearoa (and globally). Several studies and media reports in the Aotearoa context have highlighted that stigma in Asian communities acts as a barrier to seeking mental health support (Asian Family Services, 2021; Ho et al., 2003; Shah & McGuinness, 2011). The preoccupation with stigma in public and academic domains while contextualising Asian communities in a specific way within these spaces shows that stigma is central to the question of mental health.

Sociologist Erving Goffman (1963) lays the foundation for conceptualising stigma in his seminal work, 'Stigma: Notes on the Management of Spoiled Identity'. He describes stigma as "the situation of the individual who is disqualified from full social acceptance" (p. 3). He argues that stigma comes into effect in social settings when an individual's attributes are different from the acceptable social norm and recognisable as a "less desirable kind" (p. 3). This is caused by the discrepancy between what he describes as a "virtual social identity" based on societal assumptions and "actual social identity", which is the true attribute of an individual (p.2). Thus, stigma is the consequence of an attribute that an individual possesses which is different from the prescribed assumptions of a particular society. This gap discredits the individual, resulting in discrimination because the person is "reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p.11).

Goffman offers three types of attributes to explain the devaluation and stigmatising of the individual. The first is "abominations of the body" based on what he describes as physical "deformities", the second is "tribal stigma", which discredits an individual based on negative attitudes towards perceived attributes of race, religion or socioeconomic class, and the third category is the "blemishes of the individual character perceived as weak will", which include non-visible things such as mental illness, addictions, homosexuality, alcoholism or unemployment (p. 13-14). Goffman maintains that some discredited attributes are immediately visible, whereas others are not immediately obvious but are discreditable upon being revealed. Mental health issues are a non-obvious discreditable attribute. These various types of stigma are useful because they indicate the different areas in which stigma takes effect.

Even though Goffman's work is grounded in visible stigma and mental health stigma is categorised as invisible, the critical point in Goffman's theorisation of stigma is related to the idea of the social constructionism of stigma. Following Goffman, no attribute in and of itself is stigmatising. Instead, stigma comes into effect in social settings through social interactions. Goffman recognised that stigma has social consequences on individuals who are constructed as stigmatised, and those individuals find ways to rectify the stigma by correcting their stigmatised identity.

Whereas Goffman's conceptualisation of stigma has been and continues to be a source of inspiration for research on stigma (Tyler & Slater, 2018), there have been several critiques of

his work and the succeeding conceptualisations of stigma influenced by his work (Sayce 1998; Link & Phelan, 2013). Tyler and Slater (2018), for example, problematise his neglect of "structural questions about the social and political function of stigma as a form of power" (p. 729). They point out that although Goffman acknowledges the historical, social and individual contexts in which stigma processes occur, no further attention is given to it. Thus, there continues to be a focus on identity management, in educating people about the implications of stigma or "schooling the stigmatised to better manage their stigmatised differences" (p. 729) rather than analysing the structures that produce stigma in the first instance – a theme which is also prevalent in stigma studies in Asian communities.

Despite this criticism, research on stigma since Goffman's work has been described by Link and Phelan (2001) as "incredibly productive, leading to elaborations, conceptual refinements, and repeated demonstrations of the negative impact of stigma on the lives of the stigmatised" (p. 363). However, these authors comment that the definition of stigma remains variable regardless of an acceleration in stigma studies since Goffman. They propose two reasons for this: 1) the concept of stigma "is applied to an enormous array of circumstances" such as leprosy, mental illness, and homosexuality, and 2) that stigma research is "multidisciplinary" (Link & Phelan, 2001, p. 365). Echoing Link and Phelan (2001), Smith (2002) affirms that "there is no generally accepted 'unitary theory' of stigma" and points toward the complexity of stigma being multifaceted, "represent[ing] a complex interaction between social science, politics, history, psychology, medicine and the factors that perpetuate it" (p. 317).

Responding to the failure to account for the multifaceted nature of stigma, Link and Phelan (2013) provide a framework of stigma that includes both interpersonal and structural contributors to stigma. Their definition identifies that "undesirable characteristics" create negative stereotypes and, subsequently, produce the perception of differences between those who are stigmatised and those who are not. Once distinguished, these differences perpetuate the experience of discrimination for the stigmatised. While similar to Goffman's theorisation of stigma, the point of difference is their emphasis on the structural context in which stigma emerges. Link and Phelan (2013) advance that:

> Stigmatisation is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination (p. 367).

The value of this conceptualisation of stigma is that it shifts the conventional understanding of stigma from an individual problem. It also emphasises and demands exposure of a complex interrelationship between interpersonal and powerful structural factors. To further elaborate on this, Link and Phelan (2014) developed the concept of stigma power. Stigma power suggests the marginalisation of people by those who are in power. It functions through "exploitation, control or exclusion" or keeping "people [stigmatised individuals] down, in or away" (Link & Phelan, 2014, p. 24). The stigmatised individuals are kept down through denial of resources such as status and wealth or are kept in through social pressures to hide the condition or away to avoid any contamination either socially or physically. Similarly, Kelly (2006) argues that people with mental health issues are systematically excluded from "participation in civic, social and political life" (Kelly, 2006, p. 2118) and the organisations and groups that support people with mental health issues only have limited power. A survey conducted in The United Kingdom (U.K.) reported that people with mental health issues have fewer social resources than those without mental health issues (Webber et al., 2014), confirming the above assumptions.

Tyler and Slater (2018) address the inequalities through the concept of the political economy of stigmatisation, explicitly questioning why and how the experience of stigma affects groups and people differently. Riessman (2000) conducted a study in South India among childless women in which she demonstrated the intersection of class and gender that produce the experience of stigma. She found that childless women from the upper and middle classes can reject and resist stigma when compared to childless women from the lower class. The ability to resist stigma for women from higher socioeconomic backgrounds demonstrates that the context in which stigma operates is essential to understanding how it is constructed. Reissman writes,

> Childless women in India cannot "pass"; on a daily basis, they encounter beliefs about the "ordinary and natural" family. They resist normative definitions differently depending on the resources they can bring to bear, particularly their subjective and material positions in South Indian society (p. 131).

In addition to class, other ways of actively resisting stigma include altogether rejecting the existence of mental health issues. Several studies on perceptions of mental health among migrant communities have suggested that denial of mental health issues results from stigma (Dow & Woolley, 2011; Mantovani et al., 2017; Mosher et al., 2015; Rastogi et al., 2014)

and is considered a coping strategy (Kleinman & Lin, 1980; Ng, 1997). Somatising mental health issues is another response to resisting stigma (Khan & Reza, 1998). Somatisatisation is the presentation of physical symptoms to explain mental distress, argued to be common among South Asian communities (Bhui et al., 2001). It allows for mental health issues to be treated without stigma. Many studies have reported this association between the presentation of somatic symptoms to describe mental health issues (Sheikh & Furnham, 2012; Bhui et al., 2004).

It has also been demonstrated that groups and people not only resist stigma by challenging it but also actively reverse it. Kusow (2004) advances that there is "no coherent theoretical perspective accounts for the ways in which certain groups not only disavow the stigma enforced on them but also impose their own stigma on the dominant group" (p. 194). Kusow shows this resistance through his research with Somali Canadians. His research showed that participants reject racial stigma through strongly identifying with their own culture and traditions, rejecting Canadian identity, and limiting their social interactions with mainstream Canadian society. Kusow's research on how stigma can be resisted and challenged is particularly relevant to this study, given the cross-cultural approach to understanding the influence of stigma on people's lives.

Impact of Mental health Stigma

Despite variability in the conceptualisation of stigma, there is a consensus that stigmatisation negatively impacts the stigmatised individual (Kelly, 2006). This is evident in the area of mental health, where stigmatisation has a deleterious impact at multiple levels, including individual, societal, and community (Corrigan et al., 2005). O'Reilly and Lester (2017) highlight that stigma of mental health issues is not only apparent in the daily experiences of people with mental health issues but is also present in "implicit and explicit ways, as everyday institutionalised practices, discourses, and structures function to position some as 'normal' and others as 'abnormal'" (p. 150).

People living with mental health issues may experience public stigma, internalised stigma or self-stigma, structural stigma, and/or courtesy stigma. Public stigma of mental health issues occurs through public attitudes of prejudice and discrimination towards people with mental health issues (O'Reilly & Lester, 2017). It can have an impact on employment, housing, education, social relationships (Corrigan et al., 2001), social welfare and civic participation (Stuart et al., 2019). According to the Mental Health Foundation (2021), in the U.K., people

with mental health issues are least likely to "find work, be in a long-term relationship, live in decent housing, [and] be socially included in mainstream society" compared to people without mental illness diagnoses.

Internalised or self-stigma is stigma directed toward the self through internalising public stereotypes and prejudices (O'Reilly & Lester, 2017). The process of self-stigmatisation shapes how a person with mental health issues perceive themselves. Self-stigmatisation impacts self-esteem and self-worth (Corrigan et al., 2011; Shah et al., 2020), results in increased levels of symptoms of depression (Grant et al., 2016) and decreased life satisfaction (Read et al., 2006), and leads to feelings of shame, hopelessness, and increased suicidality (Oexle et al., 2017). While public stigma materialises in discrimination, self-stigma is turned inwards, acting as a barrier to seeking help (Hartman et al., 2013).

In contrast to public stigma and self-stigma, structural stigma is defined as the "societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and well-being for stigmatised populations" (Hatzenbuehler & Link, 2014, p. 2). It refers to the inequalities inherent in social structures that undermine the freedom and power of individuals (Kelly, 2006). For example, in Aotearoa, until recently, individuals who were on anti-depressants were not considered for police recruitment (Ryan, 2017). This demonstrates the egregious impact of stigma perpetuated through social structures, in this case, the law, and illustrates the compounding impact of stigmatisation.

The presence of shame and stigma attached to mental health issues acts as a burden not just for the individual but those who "assume major roles in supporting relatives with mental illness" (Larson & Corrigan, 2008, p. 90). The negative impact of stigma on close friends and family is a process described by Goffman (1963) as courtesy stigma. Phelan et al. (1998) explained the impact of stigma on close friends and family by examining perceptions of stigma among the parents and spouses of 156 people with mental health issues. They reported that half of the family members concealed their relative's illness because of shame and fear of stigma. This raises important questions about diaspora communities with roots in cultural values where family and community play a significant role in shaping the response to mental health.

This section has discussed the role of stigma and mental health; however, attitudes towards mental health are culturally specific, a point I turn to in the next section.

Cultural constructions of mental health

The conceptualisation and social construction of mental health and illness have varied through culture and history. In distinguishing between normality and madness, each culture has its own set of rules and worldviews. For example, hallucinations are typically associated with symptoms of schizophrenia in a western psychiatric context. While in some cultures, hallucinations are deeply embedded in religious discourse, attributing it to *jinn* possession or black magic (Dein et al., 2008). Similarly, in some cultures, illness is considered a divine intervention to reflect on one's actions (Selekman, 1998). These constructions are almost always framed as "markers of peculiarity" or are ignored within the western context of mental health (Williams, 2020, p. 141). In this section, I discuss the cultural values that influence mental health from the lens of collectivism-individualism paradigm.

Individualism and collectivism are frequently used to explain cultural differences when discussing mental health (Tse & Ng, 2014). Individualist cultures are described as autonomous with loose ties between individuals (Hofstede, 1991). They are considered "independent from their in-groups", and priority is given to "personal goals over goals of their in-group" (Triandis, 2001, p. 909). In contrast, collectivist societies emphasise extended family structure and "tend to see themselves and their life goals as an inseparable part of a family, community or tribe" (Tse & Ng, 2014, p. 8). In a collectivist setting, the needs of the family superimpose the needs of the individual (Huisman, 1996). Pakistan, the focus of this study, is generally associated with cultural values that emphasise collectivism (Karasz et al., 2019), while the culture of Aotearoa is considered to emphasise individualism.

It has repeatedly emerged in mental health studies focused on Asian communities that collectivist cultural values of interdependence on the family and community play a vital role in shaping the response to mental health issues (Karasz et al., 2019; Leong & Lau, 2001). Due to this high familial dependency, social status and perceived image are of paramount importance (Weston, 2003). This can have a significant negative effect for a person experiencing mental health issues. Research has shown, for example, that people in India often prioritise family honour, resulting in families tending to hide family members with severe mental health issues to maintain that honour status (Marrow & Luhrmann, 2012).

Likewise, Papadopoulos et al. (2013) showed that more stigmatising attitudes around mental health issues were reflected in collectivist cultures. The authors argue that this is explained by

collectivist cultures' higher interdependence, where the society sets the social code and norms, and any deviance from these codes is sanctioned. In comparison, they found that individualistic cultures tend to have more positive attitudes towards people with mental health issues because there is more tolerance for deviation from the norm (Papadopoulos et al., 2013).

Thinking about cultural differences in how mental health is socially constructed through a collectivism-individualism paradigm has its merits. However, this conceptualisation of culture, derived from Hofstede (1984), is an overly simplistic mapping of culture onto a binary system. It is problematic because it "polarise[s] the differences rather than appreciate the intricacies and heterogeneity within and across people and cultures" (Tse & Ng, 2014, p. 7), and is considered by some to be a "reductionist approach to studying culture" (Voronov & Singer, 2002, p. 476).

The Pakistani diaspora in Aotearoa is a good example of how culture shifts through processes of mobility, moving from a place that values collectivism (Triandis, 1995) to a society that largely prioritises individualism (Brougham & Haar, 2013). Despite the problematic nature of the binary and the inherent tension, when trying to understand a diasporic community, the dynamics of collectivism/individualism is a useful starting point for this study because it concerns the cultural value placed on family and community to situate participants' discussion around mental health as they shift across time and place. Relating these ideas specifically to mental health issues, Shafiq (2020), in a systematic literature review on perceptions of Pakistanis in Pakistan and the Pakistani diaspora around mental health issues, highlighted that "even though living in a different country, at some level, the Pakistani community tends to hold the same values/attitudes as if they were in Pakistan" (p. 30). This raises questions about how ideas, attitudes and perceptions travel and transform from place to place and across time; questions which I discuss in chapters four and five.

An important aspect of a traditionally collectivist culture is honour. The cultural role of maintaining public honour describes the value imposed on how people socially construct the perceptions of mental health issues. The fear of losing public honour in South Asian culture, including Pakistani communities, has been reiterated in the literature as a factor influencing the perceptions and response to mental health issues, including stigma. In a study of people's attitudes towards mental health issues among the Pakistani diaspora in the United Kingdom, Tabassum et al. (2000) found that participants were willing to interact with people with

mental health issues, but only on a superficial level. They would not "consider marriage with these individuals and less than a quarter would consider a close relationship and less than half would be prepared to socialise" (p. 175). The authors argue that "the honour of the family and adherence to cultural norms emphasise the stigmatising effect" of mental health issues (p. 179). This study highlights that cultural beliefs travel with diasporic communities and that these values are equally important in the diaspora as they are in the country of origin.

The role of family and community in response to mental health issues is paradoxical. While it has been shown that high dependency on family and community results in stigmatising of mental health issues (Papadopoulos et al., 2013), it has also been demonstrated that dependency on family and community can be a source of support for individuals with mental health issues (Fellmeth et al., 2015). For example, a US-based study on Albanian immigrants' perceptions of mental health reported that family was an important source of help for individuals. However, the study also showed that when it comes to coping with mental health issues, the family played a negative role. The authors argued that in some instances, families limited access or did not permit access to support services for family members with mental health issues due to stigma and shame directed towards the family, which causes further distress to the family member concerned (Dow & Woolley, 2011). In addition, when resources are scarce, family and community become the only support. This is demonstrated by Alhariri et al. (2021), who argued that with a failing health system, people heavily rely on "social solidarity" or support from family, community and friends to cope with mental health issues (p. 49).

An extreme practice of mitigating potential shame and stigma is through shackling practices when families do not have the resources to support or cope with family with mental health issues adequately. Alhariri et al. (2021) A report by Human Rights Watch released in 2020 found "evidence of shackling across 60 countries across Asia, Africa, Europe, the Middle East, and the Americas". The individuals who were confined against their will lived in poor conditions, were chained, ridiculed, suffered physical abuse in some rehabilitation centres, and were visibly malnourished. The report revealed that a lack of mental health services infrastructure, neglect from the government and religious and cultural beliefs are some of the main reasons people with mental health issues are shackled in these countries (Human Rights Watch, 2020).

While cultural ideas on “honour” and “stigma” enable extreme responses, Tesemma and Coetzee (2022) draw our attention to laws and policies in some countries with collectivist cultural values that allow for the institutionalisation of people with mental health issues in prisons. They highlight that people with mental health issues are detained in “police custody” to relieve the burden on the families. In some cases, ambiguous laws that do not formally sentence “civil lunatics” mean people can remain in prison indefinitely (p. 14). This highlights that shackling practice is more than the influence of cultural values but also a result of failing health care systems and government policies.

Collectivist values such as maintaining family honour and high dependency on family influence potential responses to mental health issues. In addition to collectivist values, the biomedical model of science and ideas about religion or spirituality are also influential in the social construction and practices associated with mental health issues.

Biomedical and religious paradigms

The psychiatric biomedical model generally dominates the understanding of mental health (Deacon, 2013). It approaches mental health issues from the same positivist framework used to address physical health problems (Lake et al., 2012) and promotes pharmaceutical treatments (Thachuk, 2011). Despite limited evidence on biological causes for mental health issues, psychiatry and medicine continues to be the leading voice on how mental health issues are explained, understood, and managed in the West (Wyatt & Midkiff, 2006).

The Movement for Global Mental Health that upholds the dominance of the psychiatric biomedical model consistently highlights the lack of biomedical infrastructures in the Global South. This psychiatrically driven agenda is often used to suggest that low uptake of medical treatment coupled with a high incidence of mental health issues for non-western communities is due to lack of awareness, lack of knowledge and the beliefs in repressive ideologies such as evil eye or possession.

Cohen (2020) explains that this contemporary idea of “populations of the Global South” described as “inherently less stable and more prone to mental disorder” (p. 40) is not new but a reinvented discourse from colonial times. He argues that the racist trope was inherent in how indigenous people in colonies were described when mental health issues were concerned. First, indigenous people were presented as primitive, lacking intellectual

complexity and “therefore, unburdened by the demands and complexities of modern ‘civilisation’” (p. 37) and when a rise of indigenous people was seen in asylums, it was attributed to becoming “mad due to their inability to adapt to the new environment [acculturation to civilisation]” (p. 38).

The dominance of psychiatric approach in the colonial Indian sub-continent (now Pakistan, Bangladesh and India) was reflected in the rapid establishment of several psychiatric asylums (Sohail et al., 2017). Consequentially, it also “moved to extinguish local spiritual and health practices through pressing for legislation to outlaw Indigenous healers” (Cohen, 2020, p. 38). This Eurocentric view dismissing the “indigenous medical systems and religious healing” can be traced back to when psychiatric institutionalisation was imposed on the people (Fernando, 2014, p. 553) for “medicalising dissent and resistance” to the colonial rule as a form of social control (Cohen, 2020, p. 37). Thus, the contemporary emphasis on the biomedical model and dismissive attitudes toward alternative understandings of mental health issues is in part, rooted in colonial ideologies and western imperialism.

King (2009) explains the discomfort with non-western discourse and argues that modern knowledge production requires these non-dominant discourses to let go of their cultural and religious baggage:

> Before being allowed to enter the public space of western intellectual discourse, such systems of thought must either give up much of their foreign goods (that is, render themselves amenable to assimilation according to western intellectual paradigms), or enter as an object of rather than as a subject engaged in debate. Through this process of cultural and ideological segregation, African, Australian aboriginal, native American, Buddhist, Confucian, Daoist, Hindu, Islamic and Sikh traditions enter the public space of academic discussion but only once they have been purified of much of their “foreignness” (p. 45)

Such discomfort is visible in how non-western approaches to mental health issues have been constructed within the mental health literature. For example, in a study exploring the assumptions of mental health professionals in the U.K. about South Asian women and their experiences, Burr (2002) found that the professionals operated from a place of division between East and West, where East was described as repressive, and the West as enlightened. Health professionals in this study believed South Asian communities had more stigma

attached to mental health issues and that spiritual or religious explanations of mental health issues were exotic and created a barrier to successfully treating the mental health issues (Burr, 2002).

Despite this prominence of the psychiatric biomedical model, the religious/spiritual understandings of mental health dominate in certain cultures. Symptoms generally attributed to conventional psychiatric disorders, such as hallucinations and changes in behaviours, are often perceived as having spiritual or religious explanations. Some of the conceptualisations of mental health issues identified in the literature have been attributed to spirit possession, the wrath of God for sinful behaviour, curses (Choudhry et al., 2016), black magic, evil eye (Nisar et al., 2019) and infidel ghosts (Tabassum et al., 2000).

In a critical review of the mental health among Muslim communities in Muslim countries and Western countries, Ciftci et al. (2013) showed that mental health issues are generally understood from the lens of Islam. Muslim communities adhere strictly to Islam, and one of the fundamental tenets of Islam is the belief in Allah and the understanding that "Allah causes everything, including illnesses" (p.23). Any disease or suffering is given by Allah and should be accepted and not be "considered as alien" (p. 23). It is also observed that some may believe mental health issues to be "a test or punishment from God" (p. 23).

The strong association with religion when conceptualising mental health also influences the management of mental health issues. Mirza et al. (2006), in research conducted in Pakistan, identified several types of experts that people with mental health issues generally seek out, such as general practitioners, homoeopathic practitioners, faith healers (*Amil*) and religious healers (*imams, fakir, peer)*. The authors found that these practitioners used a variety of treatments, including medications, psychotherapy, and spirituality. For example, if spirits involuntarily possess a person, exorcism of the spirit from the body is conducted by religious or spiritual healers. Other ways of managing mental health issues are praying and recitation of Qura'an (Sohail et al., 2017). Diasporic Pakistanis have also been reported to use alternative methods to biomedical treatment for mental health issues. Tabassum et al. (2000) found that faith healers and homoeopaths were a popular preference for Pakistanis living in the U.K. Another study in the U.K. reported that Muslims rely on faith healers who use guidance from the Qura'an to treat mental health issues (Khalifa & Hardie, 2005). Some studies have also suggested that religious or spiritual treatment is favoured over medical

treatment for mental health issues because people believe that "their religious values will not be taken seriously" (Johansen, 2005, p. 181).

It is important to note that it is not only the Western academic literature that upholds the medicalisation thesis of mental health that reveals discomfort with ideas such as possession or healers. Non-Western literature reproduces and regurgitates similar ideas. For example, Kishore et al. (2011), in an India-based study exploring the perceptions of mental health, argue that non-medicalised explanations of mental health as discussed by their participants were a myth. They claim that religious explanations are a "denial of reality"; therefore, these beliefs are "harmful to health" (p. 325). Using terms such as 'harmful to health' to describe religious explanations is a way scholars participate in reproducing hegemonic discourses of biomedical understanding of mental health and vilifying cultural explanations.

While religious and biomedical discourses are often positioned as irreconcilable, I show (in chapter four) that among the Pakistani diaspora, these social constructions, traditions and practices can be held at the same time.

Gendered construction of mental health

Ideas about mental health are not only informed by culture, science, and faith. They are also informed by a patriarchal society that produces gendered ways of thinking about and experiencing mental health issues. In this section, I discuss how the social construct of gender has been situated in influencing the conceptualisation of mental health and its implications.

Patriarchy is entrenched in the fabric of both western and eastern societies: reinforced through various political and social structures and strengthened through avenues such as the portrayal of gender in media, religious doctrines and cultural norms. bell hooks (2010) describes patriarchy as a "political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule" (p.1). She argues that patriarchy disproportionately favours men, but both men and women are socialised in gendered ways.

Ideas about mental health have emerged in gendered ways under the dominance of patriarchy. Under patriarchal systems of power and dominance, women's health has regularly been pathologised. It begins with the hysteric woman described in the literature as "difficult, narcissistic, impressionable, suggestible, egocentric and labile" (Ussher, 2013, p. 63). This

presentation of women as hysteric served to fulfil the purpose of controlling and confining women to keep them domesticated and away from the workplace (Bondi & Burman, 2001)

While women are no longer formally labelled as hysterics (Cohen, 2016), pathologising women has only "become more systematic and more sophisticated" (p. 148). Cohen maintains that the label of hysteria "has in fact fragmented and morphed into many more "feminised" categories of pathology" (p. 156). This is evident in the Diagnostic and Statistical Manual of Mental disorders Version 5 (DSM-V), in which a total of 3096 words or phrases are considered to be gendered (Cohen, 2016). This number has increased from 105 words or phrases in DSM -1. The proliferation of feminising of mental disorders, such as HPD (Histrionic personality disorder) and BPD (borderline personality disorder), paints a very bleak picture. It reveals the gendered medicalisation of mental health issues in psychiatric discourse to control female behaviour while "both policing the boundaries of acceptable gender roles as well as reinforcing heteronormativity" (Cohen, 2016, p. 154-155). The construction of women's mental health issues as such demonstrates the continued control of women through regulating acceptable and unacceptable behaviour. Thus, if women deviate from the socially prescribed gendered norms, then she is labelled as mentally ill (Vindhya, 2001)

When mental health is constructed through a medical lens that subsequently requires medical intervention, women lose control over their experiences such as sexuality, ageing and fertility (Oakley, 1984) while the power is transferred to the health practitioners (Neiterman, 2013). The medicalisation of menstruation as a mental disorder is one of the often-cited examples in literature that explains this legitimisation of control and exclusion of women from positions of power by framing them as emotionally unstable and irrational (Vindhya, 2001). Thus, women's health issues became an outcome of the patriarchal structures, and such reproduction of patriarchal ideologies continues to dominate through the discourse of psychiatry.

In contrast, Men are generally and historically absent from the mental health discourse. Prior (1999) argues that the reason for such absence in the past is because of the structuring of health care from a patriarchal perspective where problems concerning women were related to health issues, and men's problems such as alcohol and drug dependence were attributed to deviance. Boysen et al. (2014) show that these gendered differences are often explained through externalising and internalising symptoms. Alcohol and drug dependency are

examples of externalising symptoms associated with men. In contrast, internalising symptoms refer to "disturbance in feelings" associated with women's anxiety and mood disorders (p. 548). Such distinction sheds light on how the mental health discourse has been shaped to perpetuate gender differences. The selective pathologising reinforces and maintains hierarchical gendered ways of thinking about mental health.

The history of the gendering of mental health in colonial India took a different shape from the West because of the implications of race, class, coloniser and colonised. Ernst (1996) illustrates that the treatment of mental health issues in colonial India perpetuated gendered stereotypes. For example, women were allowed to engage in stereotypical women's activities such as sewing in the asylums. In contrast, men were allowed to engage in what was perceived as "'male' pursuits (such as playing at cards)" (p. 366). In terms of native Indians, women were overrepresented in the asylums (Ernst, 1997). The gendered history of mental health in colonial India subsequently had an impact on how mental health is viewed in postcolonial India.

Gender and patriarchy in Pakistan

The gendered dimension of mental health issues and the beliefs and practices surrounding them is important for understanding how gender dynamics play out among Aotearoa's Pakistani diaspora. Pakistan is a postcolonial, patriarchal society where privilege and power are in the hands of men (albeit playing out differently). In Pakistan, patriarchy is visible at all levels, from home to community to institutions. Practices such as family violence, forced marriage, the underage marriage of girl children, honour killing, selling brides, bride burning, female foeticide, dowry-related deaths, acid attacks and Haq Bakshish (marriage to the Qura'an to avoid giving property to the women in the family) are some of the horrendous ways in which women are controlled and subjugated in Pakistan (Bhattacharya, 2014). These issues of gender-based violence have implications for mental health. Women in Pakistan are argued to be at a greater risk for developing mental health issues because of their social standing in society (Niaz, 2004).

On a family level, women are perceived as inferior to men and socialised from a young age that a daughter does not have any status in the family (Bhattacharya, 2014). The birth of a boy is celebrated, whereas the girl is perceived as a burden because of dowry payment to her husband's family and as an outsider who leaves the house after marriage. Therefore, the male

child is favoured and is given access to education, better food and care (Niaz, 2004, p. 60). Such treatment of girl children from a young age as unwanted has been argued to have deleterious effects on their mental health, such as "low self-esteem, personality problems, and weak sense of self-worth" (Khan et al., 2020, p. 131). Studies of mental health reporting among Pakistani and Indian diaspora in Britain similarly found a higher rate of women reporting psychological distress. Women reported higher psychological distress due to the emphasis on the value bestowed in families on sons more than daughters (Furnham & Shiekh, 1993), which is evident through the patrilineal and patrilocal family structures. The patrilineal family structure describes the male head and the continuity of lineage through the male heir, and patrilocal describes the system where the woman lives with the husband's family after marriage (Habiba et al., 2016, p.212).

Collectivist family and community values and traditions affect social and gender relationships in Pakistan (Aziz et al., 2011). Social relationships, particularly with in-laws and husbands, in a patrilocal family structure have been found to cause higher rates of mental health issues among women in Pakistan. A systematic literature review reported that the depression rate was higher for women than men because of women's problematic relationships with in-laws, verbal abuse from in-laws, marital disputes, lack of autonomy and lack of support network (Mirza & Jenkins, 2004). Gender socialisation and the organisational family structure reproduce patriarchal ideologies where women remain socially, emotionally and economically dependent on men.

The two premises on which gender relationships in Pakistan are based are "that women are subordinate to men, and that a man's honour resides in the actions of the women of his family" (Blood, 1996, p. 118). *Izzat* is a socially constructed cultural and gendered concept in South Asian cultures. *Izzat* roughly translates to honour, but it is more than honour (Gill & Brah, 2014), it is a way of life. *Izzat,* in a collectivist society, dictates the morally correct forms of behaviour, controls the sexuality of individuals, determines the "obligations of women in particular social roles" (Gunasinghe et al. 2018, p. 748) and is disproportionately a burden for women to bear (Bhopal, 1999; Gilbert et al., 2004). A UK-based study explored the role of *izzat* and the experience of mental health issues among Pakistani women born in the U.K. The authors concluded that upholding the izzat has deleterious effects on women and their help-seeking behaviour for mental health issues (Gunasinghe et al., 2018). Deviation from the prescribed norms of upholding or maintaining honour has consequences.

It results in shame, ostracisation from the community and family, honour-based violence such as threats of death, and in extreme cases, murder (honour-killing). Fear of tarnishing family integrity and izzat has been shown to cause mental distress and severe psychological distress (Naved & Akhtar, 2008).

Women's subordination to men also means that some women in South Asian cultures, including Pakistan, do not have decision-making power. For example, in a study to investigate urban women's reproduction health decisions in Lahore, Pakistan, Zafar and Malik (2016) reported that women had to seek permission for basic necessities such as going to the market (for grocery shopping) or even medical checkups (Zafar & Malik, 2016). The study found that while working women had more freedom and autonomy to make decisions, the husbands or the mothers-in-law still made health care decisions. On the other hand, women who did not have paid employment fared worse because of their dependency on their husbands and had almost no freedom or autonomy to make health care decisions. The lack of autonomy and decision-making power caused women mental distress (Zafar & Malik, 2016).

As discussed, one common finding in Pakistan's epidemiological research on gender and mental health is that women experience and present with more mental health issues than men (Husain, 2018). The differential treatment in girl children and boy children, the family organisational structure where women are dependent and subordinate to men, a burden on women to uphold izzat, navigating social relationships, and lack of decision-making power are some of the factors discussed in the literature that contribute to disproportionate gender representation in mental health. While it has been argued that men's lack of representation in mental health is due to upholding masculine identities and being socialised not to show emotions (Nisar et al., 2019).

Conclusion

In this chapter, I have interrogated the concept of stigma itself highlighting the important role of structures that perpetuate stigma which is largely absent from stigma studies. Despite the difficulty and variability in how stigma is described, the literature review established the undisputed impact on people with mental health issues. I critically examined the ways that ideas about collectivist and individualist societies can be mapped onto ideas about mental health. I specifically discuss collectivist elements of honour and social relationships and their implications for mental health. I discussed two dominant paradigms, biomedical discourse

and religion/spirituality discourse that offered insight into the construction of mental health and how they are positioned in cultural contexts as competing with each other. I considered the multiple ways in which mental health is gendered through medical practices of diagnosis, overrepresentation of women in mental health history and contemporary literature. I further discuss the intersection of culture and gender and its implications for mental health issues.

This chapter has shown how there are multiple constructions of mental health issues and multiple aspects that contribute to the social constructions of mental health issues i.e., collectivist/individualist values, shame, stigma, religion and biomedical models, family structures, patriarchy and ideas and practices of honour.

The next chapter (three) provides a detail of the research process and the rationale for selecting the methodological approach.

Chapter 3 – Methodology

So far, I have outlined that understandings and practices associated with mental health and mental health issues is socially constructed. Social constructionism informs my methodological approach to this research. The purpose of this chapter is twofold. First, the purpose is to outline the methodological approach underlying the research. This is followed by the research design, including the recruitment process, data collection through semi-structured interviews and thematic analysis as a tool to analyse the interviews. Second, I also discuss ethical considerations while conducting fieldwork, drawing particular attention to my positionality that had ethical implications for my research.

Methodological approach

In this study, I adopt a social constructionist methodology to understand how the Pakistani diaspora in Aotearoa makes sense of mental health issues and their practices around mental health. Burr and Dick (2017) summarise social constructionism as an epistemology that:

> problematises all truth claims, the familiar ideal of objectivity becomes inappropriate; there is no single 'truth' to be revealed by taking an objective stance to the world. Furthermore, we must all encounter the world from our particular location in the social world; our questions, theories and hypotheses, must therefore stem from the assumptions embedded in our perspective (p. 70).

The epistemological position of social constructionism asserts that knowledge is socially constructed rather than a "truth" that is found or discovered. It argues that knowledge is not static but fluid, fluctuating, context-dependent, and a negotiable element of reality (Burr, 2015). When considering perceptions of mental health, social constructionism provides a foundation to understand the changing conceptualisations over time, geographical boundaries, and political and social influence in an ever-changing world. As Corbin and Strauss (2008) highlight, understanding perspectives means considering the social, political and cultural context in which they are situated. An important aspect of this approach posits that knowledge is historically and culturally specific, contextual and situated (Yang & Gergen, 2012). A part of this is through critically evaluating "taken-for-granted ways of understanding the world and ourselves" (Burr, 2015, p. 2). It challenges the positivist

paradigm that claims knowledge is an objective and singular truth (Gergen, 2001) and emphasises multiple contextually based perspectives.

Dominant discourses of social phenomena such as mental health are a consequence of power relations. Power relations describe the positions held by some people that give them more authority to speak for and about others and hold power over other groups and people. The people in power "set the standards and norms" of a given social phenomenon to which others are expected to adhere (Burr & Dick, 2017, p. 62). Such normative standards define issues and fields of inquiry such as mental health and are translated into policies and practices. Through these relations, the resultant dominant discourses protect and serve those in a privileged position (Burr, 2015). For example, the western biomedical model dominates the knowledge about mental health globally while equally and continually legitimising the need for psychiatry.

Importantly, dominant discourses produce and sustain knowledge of the world (Hjelm, 2014) through shared meanings in social interactions and language. Discourses are differentiated from ideas through their "productive power", which Burr and Dick (2017) describe as "influenc[ing] what we do and how we act" (p. 61). In other words, discourses are not simply words. Rather they have material implications. For instance, discourses of mental health produce ideas about what is deemed normal in society and consequently what is deemed abnormal.

To sum up, the social constructionist approach in this study was important because it complements the aim of the study. It provides a foundation for exploring how mental health is constructed among the Pakistani diaspora that transcends the boundaries of biomedical psychiatric explanations

Research design

I employed a qualitative methodology because its explorative nature sits easily alongside a social constructionist approach. The usefulness of the qualitative approach lies in examining the "underlying meaning and patterns of social relationships" (Kendall, 2014, p. 21), and it allows us to elucidate how people make sense of the world (Midgley, 2004). Qualitative research with a social constructionist approach was appropriate for this study because I

wanted to understand better how participants construct ideas of mental health in the context of their own lives as migrants. A qualitative social constructionist approach allows me to explore how discourses of mental health influence them both in Pakistan and Aotearoa and, importantly, how they contribute to those discourses and negotiate these ideas.

The research was comprised of semi-structured interviews with ten Pakistani migrants. In the following section, I outline how participants were recruited, what was involved in the interview process, and how I analysed the data using thematic analysis.

Recruitment

I utilised two methods of recruitment, first, through posting on Facebook and second, by putting up posters in community spaces (See Appendix A). Recruiting participants was a potential challenge because, in order to access prospective participants, I first had to negotiate access through gatekeepers of the Pakistani community. I messaged some leaders in the community on Facebook, describing the research and my motivation for carrying it out. I received positive responses and was guided to several Facebook groups such as 'Pakistanis in Auckland', 'Pakistanis in New Zealand' and 'Pakistani Ladies in New Zealand'. With the approval of the elders in the community, I was able to advertise for prospective participants on the suggested Facebook sites. Even though the community leaders were very welcoming and supported my call for research, unfortunately, when asked if they would like to participate, none of them took up my invitation to speak to them directly. I speculated this could be either because of the topic of mental health, which is taboo in Pakistani culture, or because I was a woman. I was unable to seek clarification.

The Facebook page, 'Pakistanis in Auckland', is a closed group largely populated by Pakistani men. Very few women post on the site, and an unspoken rule dictates that women must reach out to a male member if she wishes to post. In order to reach prospective participants and have legitimacy as a female researcher, I had to ask one of the respected community leaders to make a post on my behalf, providing a reach of about 2700 people. The Pakistani Ladies in Auckland group is an open community group, and I was able to post directly on the site.

The second method of putting up posters was relatively simple. I first sought permission from a few Imams before putting the printed posters on the mosques' noticeboards. I also reached

out to a few friends and some community support organisations who circulated the posters and shared the email invitation to participate on their respective Instagram and Facebook accounts. I also reached out to the Pakistani people through my own social networks and shared the poster and the research details.

I Initially received calls from eight individuals interested in participating in the research. Five of them chose not to proceed primarily because they wanted to be assured of anonymity, given the stigma and taboo around mental health issues. Interestingly, these five people were less concerned to talk about mental health issues in a research capacity and were more interested in securing advice on their current mental health issues. The openness to discuss these issues with a Pakistani woman took me by surprise but equally surprising was their perception that I was a mental health professional, an assumption they made after not reading the full post on Facebook.

In total, I recruited ten participants (three participants via phone calls and three via email). The initial six participants responded directly either to the advertisement on Facebook or the poster. The remaining participants were recruited using the snowball method (Naderifar et al., 2017) and were a contact of one of the original six participants.

Of my ten participants, four were women (Amanda, Alia, Fatima and Eliza) [1], and six were men (Max, H, Raza, Waqar, Ali and Sahil)[2] between the ages of 24 to 45 years. Amanda and H were second-generation Pakistanis born and brought up in Aotearoa, whereas the rest migrated to Aotearoa in the last five years. Out of these ten participants, two of them were professionals in the mental health sector in Aotearoa (Max, a psychiatrist and Amanda, a counsellor), one participant was a social worker (Fatima), and one had experience working in the mental health sector in Pakistan (Alia) and was a stay at home mum. One worked in the health sector (Ali). Five out of the ten participants were affiliated with the health industry. The other 5 participants' professions were Engineers (Raza and Waqar), a PhD student (Sahil), an undergraduate student (H) and a housewife (Eliza). All the participants identified as Muslims.

[1] Pseudonyms: Selected by the participants
[2] Pseudonyms: Selected by the participants

Participant's name	Occupation
Max	Psychiatrist
Amanda	Counsellor
Fatima	Social worker
Alia	Counsellor
Ali	General practitioner
Raza	Engineer
Waqar	Engineer
Sahil	PhD Student
H	Undergraduate student
Eliza	Housewife

All the participants were provided with an information sheet (See Appendix B). They were given an opportunity to ask questions about the research either via phone conversation or email. After providing the information, the participants were given time to think about participation. The participants determined the locations and times of the interviews, which took place in a variety of locations: the participants' houses, cafes, university meeting rooms, and workplaces. Some of the interviews took place in participants' homes in areas I was unfamiliar with. Because I had no connection with the participants prior to the interviews, I adopted a check-in check-out system to ensure my own safety. I communicated my location to my supervisors on arrival at an interview and once I left. Before the interview, the participants were asked to sign a Participant consent form (See Appendix C). These were in English, and an Urdu translation was available as required. All Participants chose the English translation to sign.

Data collection

The data collection method was semi-structured interviews. The interview schedule (See Appendix D) was developed alongside the identified research aim and was written in both English and Urdu. The aim was to understand the perceptions of participants rather than their personal experiences of mental health issues, which meant that I had to be very careful in developing questions and executing the interviews. The questions were open-ended and semi-structured. I chose a semi-structured instead of a structured or unstructured interview schedule for two reasons. First, semi-structured interview schedules are useful in guiding the interview, especially for a first-time researcher (instead of unstructured). Second, it also allows for exploring topics that arise as the discussion takes place (Smith & Shinebourne, 2012). For example, the gendered aspect of mental health (discussed in chapter five) would not have emerged for me if I had followed a strictly structured interview schedule.

I completed interviews in the preferred language of each participant. I am fluent in both Urdu and English, which enabled me to speak their preferred language. All the interviews were predominantly conducted in Urdu, with some shifting between Urdu and English. I mirrored my participants in my language interchange. Despite being fluent in Urdu, I faced a few hiccups when translating words that were not part of the interview schedule or my language repository, such as *maashra* (society). Being in Aotearoa for more than a decade with English being the everyday language, I know society (*maashra*), superstition (*weham parasti*), livelihood (*rozgar*), and influence (*asr*)[3] in English. However, when used by my participants, I had to ask them to translate.

The questions put to the participants were piloted on two Pakistani friends, but as described above, when the interview's language was changed, some adjustments were made for future interviews. The pilot interviews also gave me an idea of how well the questions worked and, to some extent, helped me remove the expectations for answers I had preconceived in my mind. The interview began with a broad question:

> "What does the term mental health mean to you?"

Despite piloting the interview schedule, for the first participant, the interview turned out to be a very formal question and answer session because I relied on the interview schedule and

[3] Some of the words that I translated for this study

launched into the first question without understanding the complexity of what that question entailed. It felt confrontational and appeared to be testing the participants' knowledge. I felt that such a way of interviewing came across as a barrier to fully appreciating and engaging in the topic. I significantly changed my interview prompts after the first interview. I roughly began with the question,

> "Mental health is such a vast topic to begin talking about. What comes to your mind when I say mental health?"

Other questions included, "Do people in Pakistan talk about mental health issues?", "What areas of life are impacted for someone who is experiencing mental health issues?"

A slight change of approach in the subsequent interviews meant that the conversation resembled more of an in-depth conversation than an interview. The length of the interviews varied from one to two hours. However, before the interview, I spent a fair bit of time getting to know the participants by discussing our shared history as Pakistanis, our lives as diasporic communities and our lives in general. My ability to speak Urdu was welcomed, and I believe it helped build rapport with the participants. After the interview, I stayed for another couple of hours to discuss anything the participants wanted, from politics to how Pakistanis could be better supported in Aotearoa. These were not analysed but "formed part of the relational fabric of the researcher-participant interaction" (Furness et al., 2016, p. 83)

I had wanted to audio record each interview but suspected that participants would not be comfortable with the prospect of getting their voices recorded. Only one participant openly accepted the idea of audio recording. This meant I had to take notes throughout the interview in a notebook. After the first interview, I listened to the recording and compared it to the handwritten notes. Even though the interview was recorded, after comparison, I still managed to take a lot of details, including direct quotes. The following offers an example of how well I could record participants' responses. In this example, I asked the participant how they thought the family would respond to someone with mental health issues.

Transcription of audio recording	**Notes taken from the same interview**
"In Pakistan, people are quite confused about things. And, I think society is responsible to some extent for this one.	"In Pak ppl r quite confused abt things. I think society is responsible to some extent. Illiteracy is antr reason. When smbdy is

Illiteracy is another reason. When somebody is affected or someone [has] mental issues in Pakistan, their family members are quite confused that what has happened to them and where we should go to get the proper treatment. Identification of mental problem and then to find the remedy, to find the solution of that problem, it is quite confusing for them. They don't understand, or they don't have option of how to address that thing."	affected -w/ MH issues, family members are quite confused – what hapnd to them and where shud we go for prpr treatment. Identification of problm then find remedy, find solution to the problm, it is quite confusing 4 them. They don't undst/nt hv option of how to address that thing"

The notetaking was still very challenging as I was trying to hold the conversations while ensuring that I was taking notes. After each interview, while on the bus or train or the side of the road, I sat down for 30 minutes to review the notes again and audio record myself reiterating the main points I had heard during the interview. After each interview, I listened to my recordings, reviewed my notes, and detailed the interview in Microsoft OneNote.

The nature of this method also meant that I had to go back to all but two of the participants to ask clarifying questions, either by email or phone. I felt more at ease after I had done this exercise and felt that I had captured the conversations to the best of my ability and was able to appreciate the "limits of my understanding that may occur so as to avoid distorted claims" (Furness et al., 2016, p. 84)

Data analysis

Thematic analysis, influenced by Braun and Clarke's (2006) six-step method, was used to analyse and interpret the data collected from the interviews. As noted, the data was collected using notes with the exception of one interview, which was transcribed. The first step involved familiarising myself with the data. I read my notes, listened to my own recordings, typed up my notes and formulated follow-up questions for the participants immediately. This process was routine for all ten interviews.

The second step involved generating initial codes. After going through the interviews, I used charts and created boxes with each participant's name and added the main points in each box. It allowed me to visualise all the data in one place. Simultaneously, I highlighted the data on OneNote and wrote some ideas evident in the first readings in the columns.

The third step in the process involved searching for themes. I examined the codes further, and with every reading, more important points were highlighted, and new codes were generated. I used NVivo software to identify patterns across the data and categorise the data into 11 initial themes and four over-arching subthemes. The high-level themes were: Stigma, religion, collectivism, and gendered perceptions. I also utilised mind maps to visualize the themes and how they were related to one another. The fourth and fifth steps involved reviewing and refining the themes, describing the theme in a way that captured its essence, and the final step was to write them. This process was iterative as I worked with the data, reviewed scholarship in the field, and discussed preliminary findings with supervisors.

Ethical considerations of being an insider/outsider researcher

Researching sensitive topics such as mental health raise fundamental questions about research ethics, especially in an in-depth qualitative research setting. The importance of considering ethical issues for research has been well established in the literature (Reid et al., 2018) but, despite this, some researchers' experiences around the formal ethics process is that of a daunting journey resulting in a perception that formal ethics review is a "hurdle to be surmounted" (Reid et al., 2018, p. 70). My own experience with the ethics process at Massey University was quite different. The Ethics process was rigorous and consuming but highly beneficial.

The formal ethics review process had two discrete parts. The first involved discussing the research with my supervisors and an external reviewer in an in-house peer-review conversation. Through these conversations, I had the opportunity to think about the project in ways I had not considered before. For example, one of the recruitment methods required access to participants through community leaders. The ethical consideration here was would a participant have the freedom to decline the invitation to participate had it come from a community leader.

The second part involved submitting a full Human Ethics application and attending the committee meeting, together with one of my supervisors, where I responded to questions

about my research and application. This process emphasised the confidentiality of the participants and dealing sensitively with the disclosure of mental health issues. Ethical approval was received on December 2018 from MUHEC prior to data collection.

Although formal ethical approval had been sought and granted by the MUHEC, numerous unanticipated ethical dilemmas and challenges still arose throughout the duration of the project due to the intersectional nature (female/Pakistani) of my insider/outsider positionality. Reflexivity in qualitative research is considered good practice. Qualitative research focuses on interpreting the worldviews, perceptions and meanings people hold, which are subjective in nature. Reflexivity, as described by Haynes (2012), "is an awareness of the researcher's role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects both the research processed and outcomes" (p. 72).

A key issue I faced was my ontological position as a diasporic Pakistani who has resided in Aotearoa for more than 16 years. The subject position of the researcher is essential for thinking through the ethics of carrying out qualitative research (Unluer, 2012). In the context of this study, I was an insider researcher, generally defined as belonging to the same group as the participants or "someone who shares a particular characteristic such as gender, ethnicity or culture" (Saidin, 2016, p. 849-850). Being an insider researcher has advantages and disadvantages. In terms of advantages, it meant that I was able to speak in Urdu and understand the unspoken rules by which Pakistani communities organise themselves such as reaching out to the community leaders before advertising for recruitment of participants. I was an insider with the women participants in particular because I shared not only the same culture but also the same gender. Because of this, women participants were very trusting, open and intimate about their experiences. These experiences ranged from mental health concerns to family problems.

Sharing the same gender with the women participants meant I was perceived as harmless and was allowed to have conversations with them in the absence of their husbands. This potentially would not have been possible if I was a man. The disadvantage of an insider position is a projection of my perspective onto the participants' worldviews (Dwyer & Buckle, 2009). In this instance, a social constructionist approach has been extremely valuable, as it allowed me to keep at the forefront that my participants' construction of ideas around mental health drive this research.

Similarly, with men participants, I was an insider because I shared the cultural identity but was an outsider in their social networks because of my gender. Having the inside position meant I was aware of the gender dynamics between men and women in Pakistan. Therefore, from the beginning, when interviewing men, I ensured that my body language was conservative and that I was not directly looking into their eyes throughout the interview process. While my outsider status meant that some of the male participants spoke to me in an authoritative tone, and when they spoke, it felt like I was receiving a lecture on one or the other aspect of the Pakistani community. It also signalled to me that I was not being taken seriously. Despite using the conservative posture, I realised that some male participants continued to dominate and steer the conversation in whichever direction they wanted, despite how I presented myself. I quickly learned and adjusted and, without being rude, would steer the conversation back to the topic, for example, by saying, "your analysis is very interesting. Do you have anything more to say about this?"

Sometimes, I found it hard to maintain my distance from the participants, especially those who shared experiences of challenging relationships with their families or mental health issues which invoked strong feelings in me, persuading me to take action or support them better. This has been particularly hard because as a survivor of family violence and someone who has suffered with mental health issues, I felt like an insider who needed to take action. However, after leaving the interview, I would again remind myself that I am a researcher, not a mental health professional. My obligation, in this context, is to provide the supporting information in case of disclosure but not get involved.

Setting boundaries was complex because of familiarity with the cultural context. For example, I was always in a dilemma about whether to accept or reject the offer of food from the participants. I was aware that hospitality is crucial in Pakistani culture, and guests cannot leave without being served food. If I had accepted, as an outsider researcher, I felt I was not only taking my participants' time without returning anything to them but also indebted by the food. As an insider Pakistani, I was aware that offering of food or tea was part of the culture, and it has more connotation for the host than the guest and is not considered a debt. I always kindly accepted the offer. One male participant also offered to give me a lift home in his car despite politely advising that I would be fine taking the bus. I was aware of my position as a Pakistani woman at that moment. I understood that the perspective communicated was that

the participant was looking after his guest, i.e., me, but the unsaid expectation from a man is also protection of the women.

Another concern raised as a consequence of my insider status is what I might do with the knowledge I gained through the research. Participants were often concerned that I might show the Pakistani community negatively, and I had to spend some time explaining that criticising the Pakistani community was not my intention. Nonetheless, it is an ongoing challenge and responsibility to be respectful of participants' viewpoints while telling the story of the research.

It was equally rewarding and challenging to navigate and perform insider and outsider roles in the data collection. Nonetheless, it helped me understand how the participants were introducing me to their conceptualisations. The process allowed me to be uniquely positioned to situate myself in the research better.

On 15th March 2019, the Christchurch massacre shook the foundations of Aotearoa as a peaceful country. I started to receive calls from friends and family as the incident unfolded. Everyone I knew was checking on each other. Amid all the chaos, I received two messages from two different participants. I responded to them and decided to get in touch with all my participants. I got through to 8 out of the 10 participants. I had long conversations on the phone about how they were, about the attack itself and shared my grief. One participant was unsure about what was happening with one of their family members in Christchurch who frequented the mosque. Later I found out that the family member had died in the attacks. Many other participants knew the people directly or knew of people who knew people who died in the attack.

The following two weeks after the attack, I was at the participants' houses, either sharing their grief, participating in religious gatherings or just talking on the phone. I did not think about what this meant for my research, but at that particular moment, I was not a researcher but a Pakistani member of the community who was mourning with the community. This act of grieving changed my perspective about the participant/researcher relationship and expectations that I ought not to get involved. Instead, I sat alongside my participants in recognition of our shared humanity.

Conclusion

The purpose of this chapter was to outline the methodological approach to the research. The chapter outlined the rationale for adopting a social constructionist, qualitative methodology that resides within a recognition that social phenomena, including mental health, are socially constructed. I also provided a detailed account of the research process, including how the data was analysed. I examined the various ethical considerations that I had to consider throughout the research process with a particular focus on my subject position as an insider and an outsider researcher.

Next, I turn to the results of this research. In chapter four, I examine the participants' multiple social constructions of mental health.

Chapter 4 - The social and cultural construction of mental health

Introduction

As discussed in chapter two (literature review), mental health and mental health issues are socially constructed and contingent upon social, historical and cultural contexts. In this chapter, I explore discourses of mental health issues among the Pakistani diaspora in Aotearoa that emerged from the analysis of interview data. I show that mental health issues are constructed in several ways, but some discourses are more dominant in specific contexts than others. I argue that the ideas and responses to mental health issues constructed by participants simultaneously reflect culturally specific notions of stigma and shame, and the dynamics of collective values, at the same time reflecting the influence of the western paradigm of biomedical psychiatric discourse and religious/spiritual beliefs about mental health. What emerges in the discussion is a constant navigation, negotiation and fusion of the multiple discourses in which participants are situated.

To begin this chapter, I examine various discursive constructions of mental health that emerged during the interviews. Specifically, how the participants construct meanings of mental health through various discourses that are available to them in Aotearoa and Pakistan. In doing so, new subject positions and tensions are also revealed. This is followed by a discussion of the culturally specific constructions of mental health through the lens of collective social relationships, stigma and shame. In this discussion, I also highlight the cultural consequences of stigma and participants' own contradictory positions in relation to stigma discourse. In the final section, I discuss how the participants draw on religious discourse to articulate meaning of mental health. Specifically, how they fuse the religious with a western biomedical discourse.

Participants' constructions of mental health

Constructing mental health through a well-being discourse

In Aotearoa, a well-being discourse of mental health is promoted and guided by the principle that "well-being is more than simply the absence of distress" (Cunningham et al., 2018, p. iii). The well-being discourse is reflected in the World Health Organisation (WHO) definition of mental health; "a state of well-being in which the individual realises his or her own abilities, can cope with the general stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organisation, 2004, p. 10). The WHO assumes a lead role in conceptualising, setting the direction and standards, advocating,

and treatment pathways for mental health issues globally. The dominance of WHO in directing the overall goals for mental health is evident in Aotearoa's uptake of framing mental health within a well-being discourse.

A point of difference in Aotearoa from the WHO's definition is the inclusion of social and economic determinants of mental health issues (Paterson et al., 2018). The He Ara Oranga report (2018) produced in Aotearoa calls well-being a new approach that is community-oriented, holistic, contextually focused (Paterson et al., 2018, p. 36) and a positive approach to health (Ganesh & McAllum, 2010).

During interviews, a well-being discourse emerged strongly in the way participants discussed and constructed their understanding of mental health. Some of the participants' descriptions of mental health reflected aspects of the WHO definition, which focuses on the individual capabilities that impact a person's well-being and mental health.

> Psychological well-being of yourself. I feel like it is the holistic part of you and who you are, of your well-being, because your mind is the main thing that you carry in your life, and it determines how you live your life and how you keep yourself healthy. It is a holistic part of you (Amanda, counsellor).

> How well you are able to cope with the stresses of society. Able to flourish, are happy in every aspect of life (H, undergraduate student).

> Mental health is a balance of everything, work, diet, exercise, social, personal life (Max, psychiatrist).

> Well-being of a person, this is the basic grounding of whole well-being of a person…If the mental well-being is not good, nothing else is good. Your physical well-being is affected, your social life is affected, your family life is affected. You come in an overall problem if your mental health is affected. It is basic that if your mental well-being is affected, everything else is affected; if this is okay, everything else is okay (Fatima, social worker).

Participants put forward a holistic account of well-being in which balance is centred. Implicit in these constructions by the participants is the individual's control over their mental health. This is evident in the emphasis on the word "you", "how well you are able to cope" (H), and

"how you live your life" (Amanda). Within this construction of mental health and well-being lies an individualisation discourse, which places the responsibility of mental health on the individual. Simultaneously reflective in this construction of mental health was the absence of the structural issues and the role of the state and institutions that can contribute to and produce mental health issues.

While Max does not explicitly place the responsibility on the individual to maintain a balance between the various facets of their lives, he implicitly highlights the individual factors that impact mental health. For example, if a person does not exercise or does not have a proper diet, it creates an imbalance in mental health, reflecting individual responsibility through poor personal choices. This again fails to account for health inequalities, poverty, unemployment, and lack of resources.

Importantly, these participants (Max, Amanda and Fatima) are mental health or social work professionals and assumed a professional subject position that demonstrates their membership to the institutions in which they are trained and located. These professionals are embedded in a field where an individual well-being narrative is most prominent in how mental health is currently discussed. One participant, Ali, who also works in the health sector, did, however, discuss psychosocial stressors when conceptualising mental health:

> Could be number of reasons [that cause mental health issues] but most probably are the psychosocial stressors in life like in our culture people are suffering from a lot of issues like they have financial issues, family issues. These contribute to psychosocial stress in their life, and that leads to anxiety and depression (Ali, General Practitioner).

Although the well-being narrative has been promoted in the health sector and backed by recommendations from health experts (Allan, 2018; O'Hagan, 2017; The Government Inquiry into Mental Health and Addiction, 2018), mental health in Aotearoa remains underpinned by a biomedical discourse (Health and Disability Commissioner, 2018a). Similarly, the participants who constructed mental health within a well-being framework reflected this tension between discourses which is embroiled in the wider Aotearoa mental health sector, as discussed in the following section.

Constructing mental health through a biomedical approach

Health care, in which the mental health field is located, emphasises a "positivist paradigm based on rules of logic and measurement, truth, objectivity and denial of the unobservable" (Zeeman & Simons, 2011, p. 715). This positivist biomedical paradigm posits that the cause of mental health issues is primarily due to a "faulty physiological, emotional and information processing mechanism" (Grant, 2015, p. e50). The framing of mental health in a biomedical discourse of objectivity ignores the subjective experiences and contextual factors that are increasingly recognised as essential in understanding mental health issues.

In Aotearoa, despite the shifting narrative to well-being, a biomedical psychiatric discourse is still privileged in mental health services and apparent in the wider social understanding of mental health issues. The rise in medication use for mental health issues (Brown, 2018) exemplifies the continuing reliance and structuring of mental health issues within the biomedical framework. The Ministry of Health argues that the rise in medication signals a positive move because it demonstrates that people are getting support (Broughton & Newton, 2021). In this way, the Ministry of Health's framing that medication equals support is an empiricist account that assumes mental health issues are objective entities treated through medication. Similarly, the uncritical acceptance of biomedical explanations of mental health remains dominant in Pakistan.

Several studies have highlighted that biomedical discourse is one of the ways people construct explanations of mental health issues in Pakistan (Choudhry et al., 2018; Choudhry & Bokharey, 2013). Consistent with the literature, some participants, including the health sector professionals, constructed mental health through a biomedical discourse. Some of the references to medical terminology used by participants to refer to mental health issues included "chemical imbalance" (Fatima), "genetic disposition" (Max), "patient" (Ali), and according to Amanda:

> An imbalance of your mental health. When your mental health is not okay, it becomes a disease (Amanda, counsellor).

Mental health as an illness is a discourse situated in the biomedical approach. The basic tenet of the mental health as illness discourse is that "mental illness has a biological basis just like other medical illnesses" and should be treated as such (Malla et al., 2015, p. 147). This view is presented for the public to accept the "mentally ill" in a bid to eradicate stigma (Malla et al.,

2015, p. 147). It legitimises and validates mental health issues as medically diagnosed diseases shown in some literature to be liberating for those who have been diagnosed (Karp, 1994). Drawing examples from physical health, Ali stated:

> [Pakistani] People know what heart attack is, people know what stroke is, paralysis is, but people don't understand what's the meaning of depression (Ali, General Practitioner).

Ali draws parallels between physical and mental health to explain that it is easier for people to understand physical illnesses but not mental health issues. He emphasises the prevailing biomedical discourse that favours medical explanations of mental health issues. In other words, mental health as analogous to illness. Similarly, in the following short interview excerpt Alia who works as a counsellor reflects on mental health issues as an illness by arguing that the implications of mental health issues and physical health are the same:

> Alia: Like any other illness, it is an illness. The only difference is that you cannot see it. It has the same effects on you as any other effects of a disease.
>
> Interviewer: Would you describe mental health differently?
>
> Alia: Same point I will say. It is there in everybody, but what extent depends. Mental health issues are in everybody. It is a vast thing. Everybody is suffering one way or the other.

A paradox emerges when we unpack Alia's comments. On the one hand, she echoes the biomedical discourse that argues that mental health issues can be understood as an illness in the same way as a physical illness. On the other hand, she refers to mental health issues as suffering that exists in everyone to some extent which implies an attempt to normalise mental health issues. In both these cases, she argues for the normalisation of mental health issues but through two different positions. One position is her expert position as a mental health professional located in a biomedical discourse. The other implies that through normalisation, she also rejects mental health issues as a disease by saying that it exists in everyone.

While the biomedical framework focuses solely on conceptualising mental health issues as a disease, the well-being narrative challenges it and calls for a focus on multiple explanations for mental health issues. The participants constructed mental health within both well-being

and biomedical discourses. Within a well-being discourse, they discussed mental health as holistic with multiple determinants, but throughout the discussions, they also situated mental health issues within a biomedical discourse. This suggests that they are drawing on multiple discourses that reflect their positions in two different geographical locations.

Both the well-being and biomedical discourses as drawn by the participants are similar in some ways. A biomedical discourse locates the problem in the individual's faulty physiological system. In doing so, the mental health professional becomes the expert and authority over the management of mental health issues. A well-being model, in theory, acknowledges the social and economic determinants of mental health by shifting away from biological explanations of individual physiology as the problem. In practice, the well-being discourse embedded in individualising discourse fails to consider the social and economic factors while still locating the problem in the individual's personal choices rather than individual physiology. In doing so, it transfers the responsibility of the management of mental health issues from the expert to the individual by way of self-managing.

Both these discourses have implications for how participants, in some instances, chose to not engage with the subject position of someone with mental health issues. This is evident through the discussion on stigma later in the chapter.

Constructing mental health through a stress discourse

A third way that participants constructed mental health was through a discourse of stress. Stress is considered to be embedded in the biomedical discourse of mental health issues (Donnelly & Long, 2003). The medical discourse of stress posits that stress is part of the aetiology of several mental health diagnoses (Donnelly & Long, 2003) or stress exacerbates mental health issues (Esch et al., 2002; Cohen, 2000), while the lay discourse constructs stress as "an inevitable part of modern living with its multiple demands, little time for relaxation and pressure to achieve" (Donnelly & Long, 2003, p. 399). Within the literature on the Pakistani community, stress has been constructed as an explanation for mental health issues (Hussain et al., 2017; Choudhry et al., 2018; Tabassum et al., 2000). Similarly, participants constructed stress as a factor that contributes to mental health issues and stress as analogous to mental health issues:

> When the stress becomes significant long term, it might become anxiety; it might affect mental and physical health badly. So, I guess consistent or long-term stress can affect

> negatively the mental or physical health of a person. Multiple factors [cause mental health issues]. My own study, being a PhD Student. Study gives me stress when I do not have a very good feedback from the supervisors. Sometimes the family issues. I have a wife and two kids. Sometimes kids are very aggressive. They don't listen, they don't study… Being a member of the family or the head of the family [cause mental health issues] (Sahil, PhD student).

> Stress related to study, job, family matter, some issues that are not getting solved all these things contribute to the mental health issues. (Waqar, Engineer)

The "prolonged activation of stress" has negative consequences for mental health (Cohen, 2000, p. 199). This is echoed in Sahil's distinction between general everyday stress and significant long-term stress. Furthermore, both Sahil and Waqar talk about external pressures that cause mental health issues.

Sahil gives personal examples emphasising the responsibilities of various roles and relationships in his life, including with his supervisors, his children and his wife while referring to mental health issues analogous to stress. Stress as mental health issues reflects the somatisation thesis. This thesis argues that South Asian communities rely on somatic symptoms or somatisation to explain mental health issues (Lai & Surood, 2008) and for several reasons, such as translation difficulties in diaspora communities (Fenton & Sadiq-Sangster, 1996), language equivalence to the medical terminology of mental health issues (Tabassum et al., 2000) and as a way to subvert stigma (Devapriam et al., 2008). While Waqar talked about external pressures in the previous quote when talking about his own well-being, when talking about others he drew on factors internal to the individual:

> Some people take stress more, they take personally stress more, they get attached emotionally more and they want to take stress more. They want something to happen. I remember one friend at Uni would always say that a lot of days have passed and there hasn't been any problem. Some people are like that as well; they create their own problems. This is funny, but some people are like that where they are constantly worrying now what is going to happen, how is it going to happen. (Waqar, Engineer)

Here, it is apparent that Waqar is constructing mental health issues as stress although here his construction of stress is embedded in the individualisation discourse. His comments imply underlying moral judgments. To him, mental health issues or stress is inflicted upon oneself,

which he suggests in this quote is a part of one's personality. Mental health issues as an individual's problem or a disease of the mind devoid of sociocultural context reflect the biomedical understanding of mental health issues. Such an individually oriented construction places the burden and responsibility of mental health issues on the individual. As suggested by Waqar, they "create their own problems", an idea reflected in the well-being discourse as well. This reflects similar views found in an India-based study exploring perceptions of mental health issues. This study demonstrated that the general public had a lack of sympathy towards people with mental health issues because of the belief that it was the person's responsibility to "pull himself or herself up" and the person who is dealing with mental health issues "is just not making an effort" (Kishore et al., 2011, p. 4).

Constructing mental health as a hierarchy of needs

Some participants emphasised the socioeconomic issues faced by Pakistani people in Pakistan as an explanation for disregarding mental health issues in general. For these participants, mental health issues are not especially important in light of other socioeconomic issues faced by Pakistani people. This is evident in how Sahil articulated, "there are multiple bigger issues in Pakistan than mental health issues". Sahil's position is echoed by Ali, who also points to the different emphasis placed on mental health by Pakistani people and Aotearoa people:

> It's more like we are still behind these [Aotearoa] people. They have sorted all their personal issues or all basic life issues. They [people in Aotearoa] have controlled the main issues and now they are on the next level to see that why is the person upset. They have researched, they have gone to the extent, they have gone one step further to foresee mental health. We are one step behind; we are still fighting without basic life. I mean people [in Pakistan] are still having hepatitis and lot of heart condition, T.B. and polio, all things are still there. They [Pakistanis] are still trapped in those sorts of things, can't fix those issues properly yet...They are still [stuck in] how should we earn money, how should we earn our livelihood, how should we deal with basic things like we are having basic medical diseases. They are still trapped in that sort of cycle. They can't think that there can be something. If those things are sorted, they will go one step further and think about mental health (Ali, general practitioner)

Ali believes that the systems in Pakistan are lagging in progress, and people are still battling fundamental survival issues. In contrast, in Aotearoa, fundamental issues such as absolute

poverty are largely eradicated, and people generally lead a better quality of life. Therefore, the attention of the health system in Aotearoa has moved towards mental health issues which he describes as a state of being "upset". The framing of mental health issues as simply being "upset" is interesting in that it trivialises mental health issues, a stance of many Pakistanis (Suhail, 2005). But it also reiterates the subjection position that emphasises mental health is secondary to survival issues.

Furthermore, Ali's perception about fulfilling basic needs before paying attention to mental health issues is insightful; if a health care system cannot carry the burden of diseases such as hepatitis or tuberculosis, it is not equipped to deal with mental health issues. Moreover, it has been widely commented upon that Pakistan significantly lacks resources to deal with an ever-growing epidemic of mental health issues (Nisar et al., 2019).

The construction of mental health as being about basic needs of food and shelter has a lot of merit, but it does not relieve the enormous burden of mental health issues that Pakistan faces (Amir-Ud-Din R., 2020). Furthermore, thinking about mental health issues only when other problems are resolved is short-sighted because these very problems, such as poverty, unemployment, and political instability, are some of the causes of mental health issues (Miller & Rasmussen, 2010) in Pakistan (Khalily, 2011; PBS, 2015).

While Sahil and Ali's comparative discourse around mental health as prioritisation of hierarchies such as the socioeconomic conditions in Pakistan rather than the focus on mental health as in Aotearoa, Waqar provides a somewhat contrasting perspective. Waqar recognises that the material conditions in Pakistan are not met, but he makes sense of it differently:

> The biggest issue we face in Pakistan is money. We have money issues. These are the biggest issues in our country. Pakistan does not have mental issues because we enjoy little things there. If you haven't had electricity for some time and then you have electricity, you are very happy. Here people think and worry about that during holidays we have to go for a tour to Europe, it is not the case for us. We don't get holidays. I have worked in Pakistan for four years and have never taken annual leave. For us enjoyment has different parameters. We have set it very low. For us though, there is a big gap in society between rich and poor. For us, basic level needs are not met…even though our society has a lot of problems, but we are still satisfied because of the spiritual well-being, our connection with the God.

In Waqar's comments above, a discourse of denial emerges. He explains that because people in Pakistan have set the criteria for enjoyment or happiness as very low, for example, finding pleasure in restored electricity, people are generally happy. The reference to electricity in the house is quite poignant because houses in Pakistan generally struggle with electricity due to load shedding for extended periods during winter or summer. Despite these social issues, he thinks that people are generally happy and therefore do not have mental health issues.

The discourse of denial of mental health issues is one way people distance themselves from mental health issues. A Pakistan-based study to understand the perceptions of mental health among a minority group found denial to be a key theme in how participants constructed mental health (Choudhry & Bokharey, 2013). The authors showed that despite evidence of mental health issues in the community, the denial was quite strong. They claim that denying mental health issues is cultural, and mental health issues are considered "a source of embarrassment" due to the high levels of stigma in the community (Choudhry & Bokharey, 2013, p. 5). The stigma attached to mental health issues may be one of the reasons the participant denies the presence of mental health issues in Pakistan. However, it is also possible that some participants felt a cultural responsibility to show Pakistan positively, which meant that they spoke about mental health issues in Pakistan in a specific positive way.

Furthermore, it would appear that the participants move between arguing that the value imposed on mental health is secondary to basic needs and, on the other hand, saying that mental health issues are trivial or do not exist in Pakistani society. Thus, presenting two distinct but interrelated discourses: mental health issues as a hierarchy of needs and denial of mental health issues. Scholars argue that discourse variation is due to how people are positioned, how they are positioned through the influence of others in social interactions and by the wider discourses they are embedded in, in a particular time (Davies & Harre, 1990). In this instance, the participants are speaking to mental health issues as a comparison between Pakistan and Aotearoa, highlighting the material issues in Pakistan as a reason for the lack of development in the health sector and in doing so, rejecting the notion of mental health in general.

While the participants' own position is revealed in the above discussion through constructing mental health issues as trivial or denying that they exist, in the next section, they discuss mental health through the way they situate others.

Construction of mental health through the positioning of others

Another way participants discussed mental health issues was through framing how other Pakistanis construct mental health issues. For example, Ali's reference to other people's positions works to distance himself from those who might have narrow constructions of mental health issues. It allows him to adopt a liberal subject in which he can freely speak about mental health issues without judgement from me as a researcher.

> Because people can't understand it…They think that this person is just spoilt. He is trying to show this type of behaviour (Ali, general practitioner)

Ali suggests that Pakistani people refuse to accept when presented with mental health issues. The denial discourse is evident again, but instead of his own denial, he positions others within a discourse of denial. This denial or refusal is manifested through the idea that the person is choosing to show symptoms of mental health issues because they are spoilt. Spoilt in this context does not mean the spoiled identity, as articulated by Goffman (1963), but a reference to someone who is privileged. To describe someone as spoilt implies someone who has or is given everything and is often used to describe children's and young people's behaviours. Thus, in this context, the participant infantilises those who present with mental health issues and describes this as a lack of understanding of mental health issues.

Mental health literacy is largely embedded within the biomedical discourse by its emphasis on recognising the aetiology and symptoms of mental health issues. Mental health literacy is described as "knowledge and beliefs about mental disorders", which are argued to help recognise and manage mental health issues (Jorm et al., 1997, p. 182). The general belief is that the more educated a person is, the more aware of mental health issues. A survey of 3101 people in Canada reported that as the level of education increases, people tend to consult health care professionals for mental health issues more (Steele et al., 2007), implying a direct correlation between education and help-seeking.

Similarly, within literature from Pakistan, mental health literacy has been given a lot of attention (Suhail, 2005; Kausar & Sarwar, 1999). By repeatedly constructing mental health issues from an awareness perspective reflects wider discourses of mental health, such as individualisation discourse that place the responsibility on the individual to change their behaviour. In this instance, change behaviour through mental health literacy. At the same time,

some have even gone so far as to suggest that mental health literacy causes mental health issues. For example, in a Pakistan-based study, Nisar et al. (2019) attribute "low mental health literacy" as "one of the main causes of high rates of mental illness in a population" (p. 2). The authors further claim that social capital in the form of higher education is correlated with a greater understanding of mental health literacy and awareness, as reflected in Ali's statement.

> It's more like I said certain people understand, certain group of people who are more educated like in Rawalpindi, Islamabad or Lahore, people are more educated and take it seriously, they understand, and they empathise with the patient (Ali, general practitioner).

Ali's subject position remains that of an expert here when he refers to people with mental health issues as "empathising with the patient". Even though the scholarship maintains that level of education is correlated with mental health awareness, more education does not necessarily mean a change in perceptions. Fatima's experience in Aotearoa with a Pakistani acquaintance to whom she disclosed her interest in mental health is evidence of this:

> This guy who told me that the people who work around mental health are mental themselves is a PhD and a medical doctor himself, so can you say that it is a lack of awareness? I think more than the awareness, it is the cultural, societal mindset (Fatima, social worker)

Despite being highly qualified, Fatima points out that the ideas about mental health issues are still considered stigmatising resulting from cultural and societal mindsets. The cultural mindset in Pakistan around mental health issues is generally negative, with a considerable amount of stigma and taboo attached to it. This contradiction also suggests caution when taking the approach that mental health literacy depends on the level of education. In the same study, in which Nisar et al. (2019) argued that mental health literacy is linked to awareness, graduate students were found to have more knowledge of mental health issues than postgraduate students. The authors did not comment on this discrepancy but maintained their assertion that literacy determines awareness. The emphasis placed on the qualifications by the participant in this instance implies her challenging the discourse that awareness is correlated with education and instead highlighting the cultural and social roles.

Similarly, people from rural areas are generally constructed as people who lack awareness of mental health issues in Pakistan (Suhail, 2005). Several participants highlighted that the lack

of awareness about mental health issues was prevalent in rural areas compared to urban areas in Pakistan:

> As we go in our rural areas, they don't take it [mental health issues] very seriously, they think that this person is either just acting, or he is under influence or they don't take very seriously I would say (Ali, general practitioner).

> As I mentioned, it is quite confusing for them [Pakistani people in Rural areas]. They don't recognise it as mental health issue…They talk about superstitious things, sometimes the things that there is other power that is driving them, they don't realise that it is mental health issue rather they think in a different way (Sahil, PhD student)

Ali and Sahil's perspective highlights that people who generally belong to rural areas in Pakistan ignore mental health issues or have alternative beliefs and explanations for signals of mental ill-health. When Ali refers to "being under the influence", he means the influence of the spiritual realm. Here, Ali's subject position as an expert in the health sector is apparent. He believes that non-medical explanations, such as possession, are a reason for ignoring biomedical explanations of mental health issues. The non-medical beliefs about mental health issues in rural areas have been widely reported as a predictor of awareness in Pakistani scholarship. For example, Kausar and Sarwar (1999) studied the 'misconceptions' of mental health issues and reported that participants in rural areas held these misconceptions more than participants in urban areas. These misconceptions were described as beliefs in possession, magic, and evil eye (Kausar & Sarwar, 1999). However, it is essential to note that understanding of mental health and mental health issues, including cultural explanations, is nuanced. Some authors have explicitly argued against "stereotypical generalisations… that [assert] certain groups have no real understanding of 'mental illness'" (Fenton & Karlsen, 2002, p. 17). For example, despite the framing of religious and spiritual explanations of mental health issues as a construct that perpetuates a lack of awareness, several participants discussed religious and spiritual healing as coping mechanisms to deal with mental health issues. I will discuss this further in the religion/spirituality section.

The idea of development is apparent in the comments from the participants. Rural areas are constructed as places that do not take mental health issues seriously because they are not developed, not progressive enough and have more traditional beliefs. Similarly, reference to education implies a lack of development because formally uneducated people are framed as

holding onto traditional or superstitious beliefs. Encompassed in these constructions of mental health lies the idea that western biomedical understanding of mental health issues is better in some way, and indigenous belief systems, "customs and practices, and forms of healing" are considered to be "primitive and backward" (Cohen, 2020, p. 39) and without value.

Alongside this construction of rural and/or uneducated Pakistani people and therefore ignorant of the realities and impact of mental health, participants also constructed a distancing discourse. Implicit in their distancing discourse was their awareness of the ideological representation of Pakistani people as lacking understanding of mental health issues. As a response to these widely held negative beliefs, the participants distanced themselves by implying that negative ideas about mental health issues exist in Pakistani society but away from urban, educated people. In this way, positioning themselves as the other, the educated, the residing abroad in urban city ones.

Construction of mental health through relationship conflicts

Social relationships and conflict within relationships have been shown as one of the ways mental health issues are understood and responded to among Asian collectivist communities (Naeem et al., 2012). The collectivist cultural value that emphasises the role of social relationships (family, friends and community) was apparent in participants' conceptualisation of mental health. Mental health as a relationship conflict discourse showed that mental health is dependent on how others treat you, how others behave with you and how others judge you.

> What kind of behaviour people are doing with other people? (Raza, engineer).
>
> How can I say what mental health is to me? It is not easy to say. I can say that it is a feeling maybe…when people are rude to you, you become upset, and you are under dimagi tanao (mental pressure) (Eliza, housewife).
>
> In my thinking, mental health is related to emotions, how you deal with family and friends. All these things make up our mental health. How we are brought up, how family and friends treat us and react to us. How do the family and friends judge you? (Waqar, engineer)

The construction of mental health through an emphasis on conflict in relationships was discussed in several ways. First, as highlighted by Raza and Eliza, mental health was

constructed through other people's "behaviours" in social relationships. Eliza provides an example of what this behaviour looks like. For her, mental health means mental pressure caused by "rude" exchanges in social relationships. Second, how an individual responds to the pressures of social relationships determines mental health, as highlighted by Waqar. In all these accounts, the cause of mental health issues would initially be explained externally through western paradigms that privilege individuality. However, connections to family and friends are fundamental to South Asians' well-being, and therefore these interpersonal connections must be considered when understanding individual mental health.

Furthermore, Raza, Eliza and Waqar have strikingly different ways of describing mental health than the participants who are well-versed in the medical and health industry. They have positioned their understanding of mental health through relationships with others, while the participants embedded in the health industry reflected the well-being or biomedical approach. Even though initially only Raza, Eliza and Waqar discussed the influence of social relationships on mental health, further conversations with all the participants revealed that relationships were essential in informing and conceptualising mental health among the Pakistani people.

Diasporic communities are influenced by the belief systems and cultural and social values of their home countries (Sheikh & Furnham, 2000). These mental health influences, therefore, might be explained as part of the individual's immediate milieu where interpersonal relationships are a key dimension of one's personal identity and mental health, as discussed above.

While this is certainly the case, it was evident among participants that their conceptualisation of mental health was also shaped by predominant narratives in Aotearoa, for example, the well-being discourse.

That said, the collectivist values of Pakistan were ever-present in participants' talk, and as alluded to above, at times, this materialised as moral discourses that attributed blame and responsibility at the feet of those who suffered from mental health issues. The following section examines this tension more closely by focusing in particular on the way that collectivist values, particularly judgment from other people resulting in the construction of shame and fear of disclosure, inform the construction of mental health issues among the Pakistani diaspora.

Construction of mental health as stigma and shame

Pakistan is a collectivist and family-orientated society (Yusuf, 2020) which means that people are interdependent, and a tremendous amount of importance is placed on societal standing. Maintaining the societal standing in such tightly intertwined societies has implications on how mental health issues are collectively constructed. Most of the participants discussed that they were taught to consider mental health issues as private affair that should not be discussed with other people. Eliza's account suggests the social expectations of keeping the issues private:

> We are told that our problem is our own problem and sharing with anyone else is shameful the same way if you have depression, it is your own thing you cannot share with anyone. I have also learnt this thing now. I never share my issues of depression or anxiety with anyone (Eliza, housewife).

Mental health issues are constructed as shameful, which materialises as dealing with them privately. The feeling of shame associated with mental health issues has been widely reported in non-western communities (Gilbert et al., 2004; Gilbert et al., 2007). For example, a study on the Chinese diaspora in Australia found that the prevalence of shame around mental health issues in the Chinese community acted as a barrier to seeking help for mental health issues (Wynaden et al., 2005). Similarly, Amri and Bemak (2013) argue that many Muslim migrants in the United States who are dealing with mental health issues are reluctant to seek help from mental health services because of the accompanying "fear of being stigmatised and outcast in their communities" (p. 50). The authors suggest that the stigma is not reserved for the individual with mental health issues but also attaches itself to the family. This further alienates the individual "for fear that they will shame their family or that they are revealed as being weak" (p.50). Within the Pakistani diaspora communities as well, shame has been found to be one of the reasons people do not seek support for mental health issues because of the fear of tarnishing personal and family reputations (Rehman, 2007). In this way, shame is not constructed as a feeling or emotion that rises from inadequacy (Scheff, 2013) but is relational. These ideas are reflected in Fatima's comment below:

> If we share a house problem, it will be spread. He will talk to someone, and my family reputation will be tarnished. We cannot talk about our problems (Fatima, social worker).

Fatima shows how the process of talking about issues spreads in the community through gossip, which deters people to not talk about their issues because of the fear of family reputation. I will discuss gossip in detail in chapter five.

An important distinction in how shame is constructed in collectivist cultures as relational can be put in context by a very popular saying in the Urdu language: *log kya kahein gay?* (Translation: what would the people say?). This saying is a household term used to protect societal standing, maintain family honour, exert control, regulate behaviour and deter unpopular decisions.

The socialisation to keep family matters private to protect societal standing materialises as a fear of disclosure. The emphasis placed on confidentiality was described by Alia when reflecting on her experience of working in a call centre/helpline for those with mental health issues in Pakistan. The need for discretion and concerns for secrecy was made very clear at the beginning of the calls, even before callers had a chance to disclose anything:

> They used to discreetly call us. Out of them, about 90 per cent had not told their families or their families did not know. The new caller would always ask if it was confidential and ask if their number was showing on the CLI [the called I.D.]. They said, you can't see my number right, and you will not call me back right? We used to tell them that we have not got their number and that we will not call them. They can call us and also on your bill it will not show and then they will feel relieved and they will say 'now we can talk about our issues' (Alia, counsellor).

The heightened fear of disclosure has consequences and implications for help-seeking. Furthermore, the role of medical professionals in disclosing mental health issues to the community or family is a concern among South Asians because there is a real fear that their health histories might be shared with family members without their consent (see Gilbert et al., 2004, for evidence of this occurring in U.K.-based South Asian families).

While Alia's counselling experience was in Pakistan, Amanda discussed her counselling experience in Aotearoa. She provided an example of a Pakistani client whose confidentiality was breached:

> She knew her life was getting ruined, and she did not want to just sit and let her life get ruined. I got told that she had seen a Pakistani counsellor and that Pakistani counsellor

> had breached her privacy. The Pakistani counsellor leaked it to the community, and everyone found out that she had issues (Amanda, counsellor)

Amanda's account suggests the dilemma of disclosing mental health issues. On the one hand, there is recognition of the negative consequences of not seeking help, and on the other hand, if disclosed, the negative consequences of disclosure. Several studies have highlighted that the cost of concealing and managing information about one's mental health issues impacts social relationships and causes a high level of stress (Claire et al., 2005; Beatty & Kirby, 2006).

The cultural construction of mental health as a private affair is embedded in the wider discourse of the negative impact of being labelled as mentally ill. Historically, the institutionalisation of people with mental health issues in asylums and contemporarily through shackling posits that people with mental health issues are not deemed fit to be part of society. By keeping the issues private, individuals and their families avoid ostracism from the community and wider society. Interestingly, mental health as a private affair discourse also illuminates the role of the community in monitoring deviance to uphold the status quo. The fear associated with disclosure is not unfounded; the next section discusses some cultural and social ways in which stigma manifests and its implications for mental health.

The use of derogatory language to belittle and mock people who have mental health issues is found to be very common in South Asian communities. A survey of 191 people dealing with mental health issues in North India showed that many reported that their family members and friends used derogatory language to mock and tease them about their mental health issues. Words like *aalsi* (lazy), *sust* (lethargic) and *pagal* (mad/crazy) were regularly used by family members. This resulted in some participants reporting that they felt the need to stop seeking help or had stopped seeking help (Grover et al., 2020). Similarly, the participants in this study discussed prevalent stereotypes around mental health issues among their families and the wider community, reinforcing their belief in the importance of concealing mental health issues, as the following quotes highlight:

> And, when people reach out, they get worried that what will happen if someone finds out that I am taking counselling, am I *pagal* (crazy)? … In a family, they will think that this person is pagal and will treat him as a *pagal*. Like they won't take him seriously and if he will do something, they will tell him not to do it because you are pagal. They will keep on reminding him that *tum toh pagal ho, tum toh pagal ho* [you

> are crazy, you are crazy]. And, make him more mental. And anything he says will not be taken seriously (Alia, counsellor).
>
> People make a lot of fun of mental people within our community. These people are not taken seriously (Raza, engineer).
>
> In a family, mocking factor is big. These people are laughed at. They make fun of them as well. If someone is suicidal and says they are suicidal, people will take it in a joke and say that, should I tell you ways to die? I will tell you how to die. Don't create drama. They put this person in extra pressure (Fatima, social worker)
>
> …they [Pakistani people] wait until the person commits suicide before doing anything about it. One uncle was sick with some psychological problem, and we all saw it; no one interfered until he jumped in front of a train. Afterwards, everyone was cursing the fate but not realising that it was their fault, not the fate (H, undergraduate student)

People with mental health issues are mocked within the family and community and are not taken seriously. Alia shows that people regulate their own behaviours, "I am taking counselling, am I *pagal*". Their position in the family is damaged because no one would take them seriously while playing a role in exacerbating the impact of mental health issues, "make[ing] him more mental". Sometimes the response to mental health issues can be extreme, as highlighted by Fatima and H's reference to suicide. H believed that the suicide was due to a mental health issue, and the silence from the family and the community perpetuated it. Such instances paint a dark, grim picture of the consequences of concealing and ignoring mental health issues. This cultural construction of mental health highlights how families and individuals actively take part in disciplining deviance through labelling or derogatory language.

Besides being mocked, there are other familial consequences of being found to have mental health issues; for example, marriage prospects are negatively impacted. A study among the Pakistani diaspora in the U.K. found that all participants reported they would not consider marriage with someone dealing with mental health issues (Tabassum et al., 2000). One of the participants, Eliza, discussed the implications on marriage for one of her friends should she disclose her diagnosis:

> It's because of her [the friend's] in-laws. If they know that she is taking medicine for mental issues ghir sir per uthalenge (an idiom which translates to: storm in rage, throw a tantrum) and tell her that they can't marry their son to someone who is mental… She stopped taking her medication. [She] was forced to stop taking them…I mean she is married now but very sick. Some days it is diabetes, some days blood pressure. She lives in hospitals, it feels (Eliza, housewife).

Given the importance of societal standing and the high level of stigma in the community, marrying someone with mental health issues would tarnish their reputation in the family. This speaks further to the collectivist dimension of culture. It is not just about risking one's personal reputation within a family, but it is also that the family marrying off a bride with mental health issues would be shamed. Likewise, the family bringing a new wife in with mental health concerns would be shamed. It would be similar if the man were alleged to have mental health concerns, although it would play out differently because of the gender dynamics in Pakistan.

As Eliza described, to avoid such significant consequences, people choose not to disclose their mental health concerns or maintain a level of dishonesty to ensure that their health condition does not become a hindrance in their lives. There is also the suggestion that a huge cost ensues because of the concealment in the form of heightened presentation of somatic symptoms.

In Pakistan, one of the extreme ways of constraining the behaviour of those with mental health issues is by hiding them and, in some instances, shackling them. Marrow and Luhrmann (2012), in a study comparing U.S. and India, described how beliefs in the Indian community around family honour and shame propelled the family members to hide those with mental health issues. Ali narrated an account that he witnessed in Pakistan where a girl was chained because of her mental health issues:

> When I was in Hafizabad like a small town or city close to Lahore. We used to see one girl, I am not sure what condition she had but there was some mental issue or something like that and she used to run away and she was living in our street, next door, we used to see her chained because she used to run away and people were living their own life and they did not want her to run away so they used to literally put chains on her (Ali, general practitioner).

Ali reiterates his position that practices such as shackling are limited to rural areas. Here the shackling is not constructed as an inhumane practice but as a response to the circumstances –

the inability to care for people with mental health issues. Similarly, in the Human Rights report, some of the reasons families shackled those with mental health issues were a lack of health infrastructure and the prevalence of stigma (Human Rights Watch, 2020).

The participants showed the ongoing struggles that people in Pakistani communities have to live up to, which means engaging in practices such as concealing mental health issues or hiding and shackling people with mental health issues to pass for "normal" (Goffman, 1963) to protect the societal standing and the family reputation.

Besides the struggles faced by the Pakistani communities through social relationships (families and communities) and the perceived stigma (fear of being found out), some other ways in which stigma is enacted is through discrimination in various areas of an individual's life. One participant discussed how she chose to not disclose her mental health issues to a potential employer because of the perceived stigma and the consequences, which were shaped by her experience working in a call-centre/helpline in Pakistan:

> The first time I came to New Zealand, and I had an interview with the [one of the helplines] counselling. The first question they asked me was have you gone through mental health issues? I said no. It was the first reaction that came to my mind. If I said that yes, I thought that they will think that I cannot be a good counsellor. I have heard from other people about their experiences with mental health and how they are treated later in life and that had scared me to be open or honest about anything (Alia, counsellor).

Alia's concern about disclosing her mental health issues was not displaced. Fatima, for example, explained that she faced discrimination from potential organisations when seeking employment because she had previously utilised mental health services. After she recovered, she wanted to help the community but was struggling to find any placements because of her history at the time of the interview.

> She [supervisor] said that 'where should I place you [Fatima]?' You have been a client everywhere. Mental health services also connected me to a lot of NGOs, I did not know but now I realised that this means I cannot get a job anywhere…If you have been recovered, the stigma still does not leave you. If you try to become something and if you have gone through mental health, you have a lot more hurdles to clear because of

> the stigma…I feel like I have been convicted like I have committed a crime which will always be on my record (Fatima, social worker).

The Human Rights Amendment Act 2001 outlines that workplaces in Aotearoa cannot discriminate based on mental health issues. Despite this legal protection for people with mental health issues, a survey conducted in Aotearoa to understand the nature of mental health discrimination found that people reported being discriminated against when searching for employment (Peterson, 2007). Fatima's construction of stigma illuminates the reality of discrimination through the judgement of her placement supervisor and in the employment sector in Aotearoa.

Stigma through labelling and stereotypes is present in every society (Kabir et al., 2004). Within a cultural context, derogatory language, and hiding people with mental health issues are some tools employed to regulate behaviour. The consequences of mental health issues impact social opportunities such as marriage proposals and disrupt the honour and reputation system. By concealing mental health issues, the Pakistani community ensures that family reputation is maintained and protected which has significant challenges for health services.

While participants discussed the negative impact of mental health issues, showing frustrations towards Pakistani communities in Aotearoa and Pakistan and their response to mental health issues and the need for awareness in the community to eradicate the stigmatic attitudes towards mental health issues, some of them held conflicting prejudicial views. An illustration is provided by Fatima, who critiqued Pākehā women in Aotearoa for the way they amplify what she considers to be the smallest of mental health issues:

> Mothers tend to exaggerate a lot, they make little, little things into big things and say that it is anxiety. From my experience, mothers are playing a very negative role in this. So, with teenagers there are their own growth and hormonal issues. But they keep on saying that my child has anxiety and use this term over and over again and then the child also feels that they have anxiety because this is how our brain works. (Fatima, social worker)

Fatima's account downplays mental health issues and places responsibility for producing issues in young people on mothers. Indeed, for Fatima, the only real example of mental health issues is suicide.

> When someone suicides then it is mental health, otherwise other than that, there is nothing mental health. I have seen kids who have attempted suicide because their friend has committed suicide. But, what about your [the person who has suicided] parents and family? How can you suicide for a distant friend? (Fatima, social worker).

The above quote by Fatima contradicts her earlier position where she relayed her own experiences of being discriminated against because of a diagnosis of mental health issues. Her comments imply that nothing can be done to help someone with mental health issues because it can only be recognised or acknowledged retrospectively after they have suicided. Implicit in Fatima's discussion is the concept of moral judgement that promotes the idea that individuals who are facing mental health issues should manage better and think about others in their lives. The contradictions were also apparent in how Alia framed self-harm as attention-seeking, while earlier, she emphasised that mental illness is just like any other illness:

> Depression also has many phases. I have seen cut marks on people who have gone through depression. These people don't hide it as well, especially teenagers. It is an attention-seeking activity (Alia, counsellor).

Such comments might appear as a lack of empathy towards those who are struggling. However, there is a cultural context for such statements. Suicide and self-harm are illegal in Pakistan and "are socially and religiously condemned" (Kiran et al., 2021, p. 1). Alia's comments are culturally contextual and reflect the dominant religious discourse of suicide and self-harm in Pakistan. Self-harm is viewed in Pakistan in a similar way, and it is common among the general public in Pakistan to consider it an attention-seeking activity (Kiran et al., 2021).

> Because people can't understand it…They think that this person is just spoilt. He is trying to show this type of behaviour (Ali, general practitioner)

> I think that might be changed a little bit, but sometimes that might be totally negative look how much they are spoilt they are talking about these little trivial things which don't have any proper purpose in life (Ali, general practitioner).

I have mentioned Ali's first comment above in the section on the construction of mental health through the positioning of others. Placing these comments side by side reveals that the construction of mental health is contextual. In the first instance, Ali was positioning others, arguing that a lack of awareness among the Pakistani community is the cause of stigmatising

attitudes. In contrast, in the second comment, he subscribes to the dominant discourse of stigma.

Furthermore, Kusow (2004), in his research on Somali Canadians, revealed how stigma was reversed and imposed on the dominant society. Referring to mental health issues as "spoilt" allows Ali to subvert and impose stigma on the dominant group, i.e., Pākehā.

Construction of mental health through religion/spirituality

Islam plays an essential role in the day-to-day lives of Muslims. Multiple studies understanding Pakistani communities' perceptions of mental health have highlighted the importance of religion (Choudhry & Bokharey, 2013; Mirza et al., 2006). While several studies have shown the importance of religious and cultural beliefs as protective factors for mental health issues, there is a plethora of research that originates from a western biomedical discourse producing an ethnocentric view of mental health issues where religious explanations are shown as a hindrance to seeking help. For example, Kishore et al. (2011), in an India-based, claimed that religious belief is "a denial of reality" (p. 2) and prayers and other religious methods are one of the reasons people are prevented from seeking psychiatric help (Rehman, 2007; Ali et al., 2005; Inman et al., 2007; Sheikh & Furnham, 2000). Despite the apparent tension within these two positions, where one is concerned with objective scientific truth, and the other pathway leads to spirituality and religious understanding, both of these perspectives can coexist and shape and influence understanding and managing mental health issues, as shown by the participants in this study. Pakistan's health care is influenced by Western biomedical science and religion, predominantly Islam. Pakistan is, therefore, an example where the legacies of colonialism and Islamisation "interact in complex ways that pose difficulties…but their interaction also suggest directions for coping and healing" (Yusuf, 2020, p. 442).

Most of the participants who I described above as defining mental health from a western biomedical perspective turned to prayers and utilising services from healers when managing mental health issues.

> Pakistani woman who supported me who is support worker, she helped the most because she understood my religious beliefs but she did not tell me that depression is nothing but she freed me religiously from the guilt that I am not doing this or that and

> I am accumulating sins. She freed me and said that you are a human being and God loves you. So, I believe that the person who understands your religion and culture, that help is the best. (Fatima)

> We know how to deal with the problem. We have religious interlinks, so we can say that we pray or make dua [prayer]… Here the problem is that the religious life has been separated from practical life, and I think that creates issues, so who do you rely on when you have nothing else left. Among us, we are given the inner satisfaction because of our religion. (Waqar)

One of the ways participants negotiate mental health is by adopting religious or spiritual discourse. It is obvious in Fatima's experience that she found support in a social worker who could reconcile her faith with her experience of mental health issues by drawing on Quranic scriptures. Throughout her experience with depression, Fatima was regularly advised by her family and other Pakistanis that her experience is not real and that depression does not exist. For her to find support from someone who was culturally and religiously aware was beneficial. Similarly, Waqar speaking broadly about the Pakistani community, argued that Pakistani people have the religious knowledge to deal with mental health issues by turning to prayers. Waqar draws on a comparison between Aotearoa and Pakistan, suggesting that the separation of religion from personal life impacts how mental health issues are dealt with. Faith, he argues, is what people go to when there are no options left to deal with issues. Whereas Fatima is reconciling the western discourse of mental health with the traditional religious discourse, Waqar has maintained that religion is a protective factor for Pakistani people and, in some instances, has rejected that mental health issues exist because of the strong connection to religion. While some participants maintained the positive role of religion, others continued to frame the spiritual or religious explanations as a lack of awareness in the Pakistani community.

The belief in supernatural causes attributed to mental health issues is quite prevalent in Pakistan (Shafiq, 2020; Nisar et al., 2019). The causes of mental health issues are sometimes attributed to supernatural entities that are perceived only to be cured by faith healers. Several studies (Shafiq, 2020; Choudhery et al., 2016) on mental health issues among Pakistani communities, including the Pakistani diaspora, have found a firm belief in supernatural entities as an explanation for mental health issues. In a U.K.- based study of the Pakistani diaspora, it was shown that one-quarter of the respondents believed that mental health issues

could have a supernatural cause, and the method of treatment was variable with some people seeking help from faith healers (Tabassum et al., 2000). These studies have helped demonstrate that the Pakistani diaspora also shares a particular construction of mental health issues rooted in the spiritual context. Similarly, the participants revealed that supernatural beliefs attributed to mental health issues are held by the Pakistani community in Aotearoa and Pakistan.

> People still, in our culture, people still think that it's more like, he is under influence of ghost or something like that…I mean I know one case [in Pakistan], only one case in our village, …and he just spent his life seeking [spiritual] treatment. Only when he was acutely sick, he used to be hospitalised for a while. (Ali)

> I used to talk to an old man in my neighbourhood [in Aotearoa]. He is Pakistani, and his daughter-in-law looked after him. No one had seen him in many days, and I went to his house to see if anything happened to him. The daughter-in-law told me that he is very sick. I asked what is the problem but she did not tell me and did not let me see him to say he was resting. Later the other neighbours which are related to him said that he was seeing his ammi [mother] who was dead long time ago. He got bad and hospital gave him medication. The people who were telling us said that he is pagal now or someone had done kala jadu [black magic] on their house. (Eliza)

Implicit in Ali and Eliza's comments is the idea that communities exhaust spiritual healing methods before seeking out medical support both in Pakistan and in Aotearoa. One way to deal with supernatural beliefs (black magic, *jinn* possession) is through seeking help from religious leaders or faith healers. Faith healers practice in Aotearoa as well and many Pakistanis seek their support for mental health issues as Eliza explains, "Anyone who has religious knowledge [is a spiritual healer]. Mostly it is the imams [religious leaders] in mosques. I know some Pakistanis going to Hindu *babas* [healers] in Papatoetoe who remove ghosts and black magic." This is evident in the literature in Aotearoa. For example, in a study on supporting Muslims in Aotearoa, the authors found that *Imams* (Religious leaders) are the first point of contact for issues and in some instances the only point of contact (Shah & McGuinness, 2011). This shows that support in the Muslim communities looks different to the way support is traditionally considered in Aotearoa i.e. health services.

While religion is considered a source of support, participants also shifted in their ideas:

> I know this person [in Aotearoa] who is normal in most circumstances but sometimes he eats a lot of onions. A lot of onions. So, his family takes him to spiritual healers saying iss k uper *Jinn* hogaya hai [he is possessed by *Jinn* or ghost]. I don't think it is the *Jinn*, I think it is a mental illness, but no one listens to me. (Fatima)

> Someone messaged me last week and said that I see the *jinns*. I told her to recite the Ayatulukursi [Quranic scripture]. She said that I see the *jinns*, doctors say that I have schizophrenia but how can that be possible? I really see the *jinns*. This is her reality but other people say that she is mental (pagal)… I think to myself, how can she see the *Jinns*? I don't think she can see the *jinns*, I think she has the *jinns* on her. (Fatima)

Fatima rejects the notion of *Jinn* [ghost] in one instance and argues that it is a mental health issue. In another context, Fatima contradicts herself. Here, Fatima explains that she has advised someone to read the Quran to deal with seeing *jinns*. Fatima also explains that *jinns* cannot be seen; instead, one is possessed by *jinns*. In one case, where the person's family believes that eating many onions results from possession by *Jinn*, therefore, requiring spiritual intervention, Fatima disagrees with it. In the other case, where people believe and label the woman as "mental" because of a scientific diagnosis, Fatima believes otherwise. These contradictions reemphasise that the participants hold competing ideas, medicalised and religious discourse of mental health simultaneously.

On the surface, a religious/spiritual discourse may appear to be contradictory because the spiritual or religious methods of dealing with mental health issues have been portrayed as a counter-discourse to the biomedical approach, however, a third space becomes apparent where negotiation takes place. Turning to God for mental health issues while simultaneously describing mental health from a biomedical and well-being discourse suggest how the participants navigate the shifting knowledges and offer new subject positions. It also highlights a negotiation of cultural construction of mental health as they are manifested in different places.

Conclusion

All societies have different explanations of mental health and mental health issues, and culture influences the manifestation, presentation and management of mental health issues (Shafiq, 2020; Burr & Chapman, 1998). Several studies on mental health issues among the Pakistani population have shown that conceptualisations of mental health issues are indeed culturally

specific. For example, Tabassum et al. (2000) and Naeem et al. (2012) showcased how somatisation, interpreting and presenting mental health issues as physical illnesses (Karasz et al., 2019) was part of how Pakistani people experience and explain mental health issues. Presenting with somatic symptoms such as headache, backache, and lack of appetite instead of reporting mental health concerns is argued to be less stigmatising in South Asian communities therefore, it is "one of the few ways some individuals can express their [mental health] problems" (Kinzie & Leung, 1993, p. 287). Similarly, how people respond to others with mental health issues has also been found to be culturally specific (Shafiq, 2020). For example, Ikram et al. (2011) demonstrated that Pakistani people show high emotions, such as hostility, towards relatives with schizophrenia but are also overly involved in their lives. My research reflects the scholarship but also shows a more nuanced understanding of mental health with multiple meanings of mental health and mental health issues held by the participants.

This chapter shows how mental health is socially constructed among the Pakistani diaspora in Aotearoa through articulating cultural explanations of mental health that cut across fixed binary notions of western and eastern paradigms. Certain discourses of mental health have travelled with the participants from Pakistan to Aotearoa, some ideas of mental health are adopted while others are rejected. What emerges is a complex interaction of fusion of some ideas and navigation of others. When articulating what mental health means to them, they reflect on the dominant ideas of medicalisation of mental health while introducing new discourses such as the hierarchy of needs; when they discuss how they navigate mental health, they rearticulate culturally and religiously specific ideas through religion and stigma.

The argument that Pakistani people are collectivist in their family units, help each other out and are the primary source of support for mental health issues was challenged by the participants as they discussed the ill-treatment of family members who have mental health issues, pointing out a culture of deep-ingrained stigmatic attitudes. Despite close-knit, highly networked communities, when it comes to dealing with mental health issues, an individualist approach is taken where mental health issues are constructed as a private matter and are encouraged to be kept hidden because of the culturally specific ideas of shame, tarnishing of family reputation, stigma and taboo.

An apt way of summarising how I see these results is poignantly penned by Arundhati Roy,

> Every human is really a walking sheaf of identities – A Russian doll that contains identities within identities, each of which can be shuffled around, each of which may, in entirely inconsistent ways (Roy, 2020, p. 168).

This sheaf of identities was apparent throughout my participants' discussions about mental health issues. Mental health was seen as holistic but also trivial, as an illness but also attention-seeking, as stigmatising but also as someone who is spoilt, as exaggerating but also discriminatory. These multifaceted, at times contradictory discourses of mental health emphasise the complexity of social constructs examined.

This chapter has examined the social and cultural construction of mental health, the following chapter builds on this work by better accounting for the gendered construction of mental health.

Chapter 5: Gendered construction of mental health

Introduction

In the previous chapter, I explored various ways the Pakistani diaspora in Aotearoa constructs an understanding of mental health. Woven throughout these various social constructions, participants drew on ideas related to individual/collective, biomedical and religious discourses. Rather than seeing the different ways of understanding mental health as contradictory or competing, they fuse them in different ways both in terms of meaning and practice. In this chapter, I show how expected gendered norms and roles within Pakistani culture are more fixed when it comes to constructing ideas and practices of mental health. In particular, I explore how mental health conceptualisations and practices are gendered and the implications of these gendered constructions on practices related to mental health among the Pakistani diaspora in Aotearoa.

The first section discusses how men and women construct gendered ideas of mental health and its implications for support. In the second part, I discuss the social construction of *izzat*, a cultural value system that disproportionately disadvantages women and their experience of mental health. I also discuss the role of community and family in maintaining *izzat*. I argue that *izzat* has remained part of the Pakistani diaspora's norms, values, and practices in Aotearoa, which produces marginalised positions for women. In the third section, I discuss gendered power dynamics within the family, especially in relationships with in-laws and intimate partners and its implications on mental health for women.

Gendered construction and responses to mental health

Dominant ideas of masculinity and femininity are culturally informed. Men are considered to be the authority figures in the family, the breadwinners, and the gatekeepers of women's behaviours. While women are considered to be docile, conform to societal and cultural norms and are considered homemakers. These narrow constructions of the gender ideologies and roles influence health-related behaviours, such as men are considered to have a "lack of concern about physical and psychological health, and not seeking help for health issues" (de Visser, 2020, p. 2). These ideas also play out in the Pakistani community. Participants in this study (specifically women) commonly believed that men would be less masculine if they had

health issues because men uphold hegemonic masculine ideals, which "conceive help-seeking as a weakness" (Morrow et al., 2020, p. 1313). In the cultural context of Pakistan, where a man is considered the provider and gatekeeper of family honour, female participants understood that men choose not to seek help or acknowledge they have mental health issues:

> The men also have a lot of ego; they never accept they have an issue because if they do, they will be less mardana (masculine). Even if they are physically sick, they will not say to anyone (Eliza, housewife)

> They have been taught that there are no such things as emotions. For them, there are two or three basic emotions, and that's all. Happy, sad or angry…There is no such thing as anxiety, greed, feeling down. For ladies, there are so many. It is again about awareness. Of course, they [men] must experience these emotions as well I think but what do they name it? They ignore it (Alia, counsellor).

The gendered expectation of Asian men is to display emotional invulnerability and strength (Morrow et al., 2020). Through upholding these ideologies, Alia first reproduces the dominant discourse, which posits women as emotional and complex and therefore not to be taken seriously. She then suggests that men have complex emotions too. And in doing so seems to be challenging the dominant discourse, albeit hesitantly.

Male participants constructed mental health from a resilience discourse – without differentiating between men and women. They believe that Pakistani people, in general, are resilient and strong; therefore, they deal with their own mental health issues rather than seeking help. They emphasised that first internal resources for dealing with mental health issues need to be exhausted before help is sought.

> In fact, talking about myself as I mention in campus, we do have this facility, I do feel stress, I do feel problematic situation sometime, but I never ever go to that consultation [counselling]. Reason is that I feel..something I can address, do by myself it is not that much problematic…If Pakistani people find a very problematic situation which is harming impacting at a very large scale then they move to the consultation [counselling] otherwise they don't feel that. They feel they can address these issues by themselves. So, its strength of this person, resilience of the person (Sahil, PhD student)

> Our threshold of getting depressed it bit higher. Because we go through a lot of trouble right from the beginning. We would say comparatively, we don't have another, it's like the survival of the instinct, like we don't have another option, we don't know much about that we can seek help from health professionals, the only thing we know is that fight with these conditions by yourself. It's sort of more resilience. (Waqar, engineer)

Sahil emphasised that he has access to counselling at his workplace but does not utilise it because he prefers to deal with his issues on his own. He further claims that if a person is strong and resilient, they do not require help from outside. This is reflected in the literature, where a large number of Pakistanis believe susceptibility to mental health issues is linked with morally weak character (Suhail, 2005, p.178). The reference to being resilient stems from a number of factors. First, it upholds the masculine ideals of strength and does not require support. Second, the Pakistani people experience a lot of social, economic and political instability in Pakistan, making them more resilient to developing mental health issues. The literature does not support this perception. In fact, research highlights that being constantly subjugated to instability negatively impact mental health (Gadit, 2001). Thus, male participants recognise the debilitating economic, health and political conditions in Pakistan and frame Pakistanis as resilient as a result of these. However, not seeking help and dealing with it on their own in some ways also suggests men trying to uphold the reputation of the Pakistani diaspora as a collective rather than just within the family/Pakistani community. It is also important to highlight that men in general, irrespective of ethnicity or migrant status, tend not to admit to having concerns with mental health (Emslie et al., 2006). However, for Pakistani men (or South Asian men more broadly), these masculine issues are exacerbated by culture, migration, and racism.

One of the ways in which people are expected to deal with mental health issues is through accessing support from friends and family (Fellmeth, 2015). However, the level of support for Pakistani men and women differs significantly in Pakistan, and the difference has also remained among the Pakistani diaspora in Aotearoa. Men are more visible in public spaces, have more prominent positions and have more freedom to access community support for issues. In contrast, women are not as visible in public spaces, tend to have household and childcare responsibilities, and generally occupy private spaces. Furthermore, the Pakistani community is a very close-knit community. Women fear gossip in the community, which

consequentially leads to tarnishing family honour and reputation that a woman needs to protect at all costs (elaborated in the following section). Thus, even if well-connected, a Pakistani woman does not perceive the community as supportive. The gendered distinction and knowledge that men occupy a more public space is reflected in comments made by one of the participants who describes the difference in support between men and women:

> For men, they have a lot of social interactions; they are very connected in the community, we are isolated mothers (Fatima, social worker).

> I think from my experience, the amount of time I have spent with the Pakistani community in New Zealand that they have awareness [about mental health issues]. Not a lot but the people who live here they help each other, especially the new people coming over here, they help them so that they can live easily because they don't find a job or anything and get mentally disturbed. So, people are very active and help a lot in these matters. Not a lot of help but 50% to 60% help so that the person does not get mentally disturbed (Raza, engineer)

Fatima suggests a lack of support for women in the form of social relationships in the community. She feels that men have more access to support in the community because they do not have to worry about private matters of the home that most often fall on women. While men have greater access to support (as discussed by Waqar) and the financial resources required to secure them. On the other hand, Women must be available for children and running the household and often have limited financial resources. This means women do not have the same level of access to social relationships in the community. Furthermore, if men go out and socialise with their male peers for support, they will not be stigmatised or subjected to community gossip the same as women would be. However, if women go into the public realm, even to socialise with other women, they risk being surveilled and possibly accused of socialising too much.

Social construction of *Izzat* and mental health implications for women

As I discussed in chapter two, *izzat* is a socially constructed gendered concept. It is closely tied to the idea of reflected shame, which is described by Gilbert (2002, as cited in Gilbert et al., 2007) as "related to the shame one can bring to others (or others can bring to the self)". However, *izzat* is also considered as family honour, a term that dictates the "norms of the society" which guide how individuals are expected to perform in society (Takhar, 2016, p.

129). The word *izzat* is more than honour, argues Gill and Brah (2014), it synthesises a "wide spectrum of socio-cultural relationships and ties that bind family and community groups together" (p. 73).

In South Asian cultures, the term *izzat* represents family standing, and in particular men's standing. In contrast, family honour can be tarnished through women's actions, but those actions ultimately end up shaming the men, who are seen as not being able to control "their" women. Thus, *izzat* is a cultural construct that "perpetuates the patriarchal order" in a collective, patriarchal society (Sangar & Howe, 2021, p. 344).

While these explanations of *izzat* provide a good starting point to encompass a term so value-laden, Kamal (2018) aptly captures the depth and essence of the term:

> In Pakistan, izzat is a way of life. It's as insidious as self-respect and as mighty as reputation. It's an easy justification for acts of violence and a get-out-of-jail-free card. It's an agent of socio-cultural (and at times, legal) immunity, and above all, it is a silent weapon of patriarchy (Kamal, 2018)

The maintenance of *izzat* through family

One of the ways in which South Asian communities, including Pakistan, regulate the behaviour of individuals or "establish cultural order" (Kushal & Manickam, 2014, p. 227) is by defining what is acceptable, unacceptable, shameful and honourable (Sangar & Howe, 2021). Conforming to cultural norms is perceived as valuable, while deviancy tarnishes honour.

Izzat is gendered, and as such, there are different rules and implications for upholding and maintaining it for men and women. Women's behaviours have a particular impact on the family. Women uphold or maintain *izzat* by ensuring that their behaviour does not bring shame to the family and by policing "the conduct of other women to ensure that they do the same" (Gill & Brah, 2014, p. 74). While men uphold *izzat* through monitoring women's behaviour and ensuring that the "women avoid shame" (Gill & Brah, 2014, p. 74).

The dominant biomedical discourse of mental health reinforces that "mental ill health is a pathological condition that can be understood and effectively dealt with through the use of demarcated diagnostic categories" (Thomas et al., 2018, p. 2). Such a discourse is prevalent

in Pakistan and has huge implications on the response to mental health issues. Sangar and Howe (2021) argue that the "pathologising nature" of mental health issues "has the potential to bring shame to individuals and their family" (p. 355). Furthermore, such a construction of mental health issues reflects shame on the family and is "heightened for females as their behaviour is deemed reflective of collective family honour" (Sangar & Howe, 2021, p. 355). If a woman is labelled with mental health issues, it implies that she is inadequate. Thus, the protection of honour plays an essential role in informing and influencing family and community expectations of men and women and their responses to mental health.

Given the emphasis on how *izzat* is socially constructed as a woman's disproportionate responsibility, it is not surprising that only female participants explicitly discussed the concepts of shame and honour when conceptualising mental health. Eliza describes how the process of adherence to *izzat* is lifelong for a woman:

> Eliza: We are always worried about how people will see us. Any issues that I am having in personal life, I keep it to myself because *humari izzat humarey haath mein hai* (our honour is in our hands).
>
> Interviewer: Can you tell me more about this?
>
> Eliza: What should I say. You are Pakistani too and you know in our society, we girls are told about this from young age. Anything we do, we have to first think, will it hurt my family's *izzat*. Then you get married and think about husband and in-laws *izzat*.

Pakistani women are socialised to believe that they are the keepers of *izzat*. The socialisation process of understanding the codes of *izzat* is developed and learnt in early childhood through family, community and friends (Gunasinghe et al., 2019). In the above quotes, Eliza highlights how women uphold *izzat* through fear of what other people think of them and how it will impact their family reputation. Eliza maintains that a Pakistani woman is supposed to protect the family's *izzat* before marriage. After the marriage, the responsibility of guarding *izzat* also extends to her husband and his family. Here, Eliza situates herself in the *izzat* discourse through self-surveillance. However, it is also important to note that the freedom to situate oneself in a subject position is dependent on how much power an individual or group has (Parker, 2014). In this case, Eliza as a woman, a marginalised identity in Pakistani culture, is not situating herself; instead, she is situated by restrictive ways of being in a patriarchal society.

The implication of *izzat* results in women being silenced. This means they cannot discuss any problems without being reminded that they are tarnishing the *izzat* of the family.

> First of all, no one will believe if you have mental health issues… just like my husband kept on telling me about my depression or anxiety that *humari izzat humarey haath mein hai* (our honour is in our hands) so I should not take help or tell anyone… (Eliza, housewife)

> [If] I say I don't like my husband or family and it is upsetting me then the whole mountain will fall on me and they [family] will just say you have taken our *izzat* away… I will shut up about it and do this on my own [deal with the distress] so better not to say anything (Alia, counsellor).

Any action that brings shame to the family is avoided by silencing women. If a woman is labelled with mental health issues, the family's reputation is considered to be tarnished. The silencing of women occurs in two ways, according to participants. First, there is a dominant discourse of denial, where mental health issues are not believed or ignored and second, through actively discouraging seeking help for mental health issues by reminding them of the rules of *izzat*. Women's behaviour is being regulated and controlled in both denying and discouraging discussion of mental health issues.

Seeking and acquiring help when experiencing mental health issues is challenging in the Pakistani community. Even when people believe their claims of mental health issues and/or accept them, as is the case with Eliza's husband, the belief does not translate into providing help. In the quote above, Eliza's husband positions himself as the upholder of the *izzat* by reminding Eliza that she should not seek help or disclose it to other people. Eliza revealed that her husband was worried about the disclosure because of the judgement he expected from the community and family. Because he is a reputable member of the Pakistani community, he did not want his social position/honour to be tarnished as a consequence of his wife suffering from depression and anxiety. Women, therefore, keep their opinions to themselves at the cost of bearing the distress silently and dealing with it on their own. This is reflected in literature. Chantler and Burman (2002, cited in Gilbert et al., 2007), for example, highlighted that "*izzat* could be used to reinforce a woman's subordinate role in the family and to coerce them into staying silent about their issues" (p. 128).

Some participants subverted gendered expectations and sought help regardless of the implications for *izzat*. Eliza, for example, did not argue with her husband about his insistence that she remains silent about her mental health issues. However, without her husband's knowledge, she continued to get support from her Pākehā GP. That said, Eliza chose to speak to a Pākehā doctor rather than a doctor from within her community. The emphasis Eliza placed on the ethnicity of the GP implied the trust of a Pākehā GP because, as discussed in the previous chapter, there is a general perception among the South Asian communities about their potential to breach confidentiality when seeking help from a professional who is from within the culture. This subversive act also highlights that women find ways to resist cultural and societal norms and exercise agency which in this case helped Eliza to combat the gendered expectations and seek the help she needed.

Izzat is tied to the social construction of women's character and behaviour. Women's behaviours and actions are regulated through cultural and familial expectations. If women fail to align with the expectations, their character is judged. Alia explains how women are controlled through a judgement of their behaviour and attributing it as good or bad:

> Alia: Now, at this age [28] if I say I don't like that person and if I don't like my family or I don't like my husband, I will be reminded that I am not supposed to say that. This is not a good lady. *Izzat* is all about it. So, I am not a good lady or I have a good character
>
> Interviewer: What is the consequence of let's say if you tell someone that you are having problems?
>
> Alia: They will label me that I am not a good lady because a good lady is supposed to behave well and cannot have problems. Everyone will look at me with judgement and talk behind my back that oh Alia is not a good lady she has so many issues

Implicit in Alia's comments is a moral discourse that constructs particular ideas about women and mental health. A 'good woman' is constructed as someone who knows what is permissible to talk about and what is not, who is not supposed to have problems with other people, and who puts the *izzat* of the family above their own needs (Gunasinghe et al., 2019). Indeed, behaving like a good woman has been found to add prestige and status to the family (Chew-Graham et al., 2002). Deviating from this narrow construction of a 'good woman'

results in being labelled as deviant and "not a good lady". In this way, *izzat* regulates the conduct of women.

Izzat is also a feature of everyday life for women, as Fatima explains:

> *izzat…rozmarah ki kahani hai* (it's a story of every day). Think like this do like this…Pakistani ladies, I will say don't like to take help because if the in-laws find out they will call the family and say, your daughter is mental you cheated us…this is the mindset. No one can change it for you. They [must] take responsibility (Fatima, social worker)

In addition to being labelled as a 'bad woman', there are other tangible consequences of disclosing mental health issues. If the marital family finds out about a woman's mental health issues, pressure is placed on the birth family, blaming them for cheating their son into marrying a woman who has mental health issues, in some cases, resulting in divorce. In addition, it becomes exceedingly problematic for the woman because she has to typically live with her husband and her in-laws. Thus, due to these patriarchal cultural customs, she gets trapped in an oppressive family situation. I will expand on these relationships later in this chapter.

While Fatima captures the consequences of seeking help and explains its impact on *izzat,* in the same instance, she transfers the responsibility to the women. She argues that women should change their mindsets and take responsibility for their mental health issues. In this way, she internalises the cultural codes of *izzat.* She absolves the responsibility of families in their role in forcing women to deal with mental health issues silently and places the responsibility on the individual. Women are caught in this tension between being regulated and surveilled and self-regulating and self-surveillance.

Maintaining *izzat* through community gossip

Gossip in the community is another way of monitoring women's behaviour, ensuring they uphold the family's honour and do not disclose personal issues, including mental health issues. All four female participants discussed that gossip was the reason they do not disclose their issues to anyone. Fatima highlights the implications of gossip:

> Because our community does not know how to respect information of other people. Today, you tell them my husband is having issues with job and stays angry. On your face, they will sympathise but, as soon as you are gone, they will call other women and say, did you hear Fatima's husband doesn't have job. And, all this flying information [gossip] will come back to my husband and then he will get more angry with me (Fatima, social worker)

While Fatima socialises with other Pakistani women in Aotearoa, when it comes to sharing problems, she chooses not to do so because she believes that the information would be shared, negatively impacting her married life. Here the gossip is related to her husband, which implies that *izzat* is also related to how men's well-being can affect a family's reputation. Despite the gossip's recipient being the husband, Fatima is the one who has to take responsibility for ensuring responsibility for familial harmony is retained. It demonstrates that women are the repository for honour regardless of whether the gossip is about them or not.

Fear of gossip is also found to be a significant factor in not utilising mental health services among South Asian communities (Bradby et al., 2007; Cinnirella & Loewenthal, 1999). In a study on psychological distress among South Asian women in the U.K., it was reported that "an efficient community grapevine had developed" to ensure that women were monitored to behave appropriately (Chew-Graham et al., 2002, p. 342). Similarly, the participants strongly focused on how gossip plays out in the Pakistani community in Aotearoa and is used to regulate women's behaviour:

> …if someone sees [a Pakistani woman] going to the clinic [mental health services], they will talk about so and so's wife is mental. They will spread it like fire. If someone tells me that you have to go and get counselling, I will say leave it, I will get better on my own. (Alia)

> They don't talk about it because of the fear that the information will be leaked out. We are very close-knitted community, but we don't share personal information. Gossip within the ladies group. And it is exaggerated, something that is not even true…they will not go to a counsellor or a psychotherapist even if they are on the verge of killing [suiciding]... [gossip is a] very ugly nature of our communities. (Amanda)

Women's positions as the primary agents for upholding and maintaining *izzat* of the family means that they come under heavy policing from the community and family through gossip and being silenced. The implication for such a construction means that a risky subject position is created for women, where she has to weigh up the consequences of seeking help for mental health issues before she can reach out, even if it means neglecting her needs.

The role of shame and gossip on *izzat* was strongly gendered. While female participants talked about *izzat* and how to manage it, the male participants did not. It is not to say that family honour does not apply to men, but their role is to be the gatekeepers for ensuring that women conform to the rules of honour (Virdi, 2013). Through the conversations with the women, I learned how the men, families and communities ensured that the women upheld *izzat* at a cost to women.

Gendered power dynamics within the family (partners and in-laws)

As discussed in the previous chapter, social relationships inform and influence mental health conceptualisation and performance in the Pakistani diaspora. This section will highlight how the female participants construct mental health through two key relationships: in-laws and intimate partners. These relationships had implications for the mental health of the female participants.

Patrilocal residence, i.e., women living with their husband's families in the same house or nearby after marriage, is a manifestation of the stronghold of patriarchy in Pakistan and other South Asian communities. While it has been argued that living in close-knitted joint or extended family units alleviates financial burdens, provides support for individuals, and greater well-being of children (Hackett & Hackett, 1993), some have also suggested that there are negative impacts on women (Chandran et al., 2002; Gausia et al., 2009).

In diaspora communities, extended family structures do not exist physically as they would in the country of origin. Despite this, one of the features of a diaspora community is "a continuing part of the transnational family, characterised by frequent reciprocal visits and daily or weekly telephone calls" (Singh, 2016, p. 195). My participants discussed the role of these relationships, specifically with their mothers-in-law, as a significant factor influencing how they construct mental health issues.

The relationship between women and their in-laws has been given much attention in South Asian literature. In Pakistani society, a common expectation for a married man is to provide financial support to their family. This support is not exclusive to their partners and children but extended to parents and siblings. When a man marries, there is a fear of losing such financial support because the daughter-in-law will be prioritised (Ali et al., 2021). This fear of transfer of support perpetuates conflicts between a woman and her in-laws and has been found to impact mental health (Kumar et al., 2005). Despite most mothers-in-law living in the country of origin, they continue to have a stronghold over how their daughters-in-law live their day-to-day lives. This was a significant source of conflict for some participants.

> Because they [other women] have gone through so much, they are burnt out. They have gone through so much. They have suffered so much, especially in families. I am glad my in-laws are good but there are so many problems with the in-laws that the woman has no more *bardasht* [endurance]. [She] is burnt out. So, anything you tell her [the woman], she will say that she has more issues than you. More stressed out than you. You are nothing [compared to the issues that she has] (Fatima, social worker)

> My in-laws were sometimes very good like *gur* [sweet/sugar], [but], some days my father-in-law would lie to my husband that I have ignored him when he would call me for something. My husband would always take their side and tell me to not be upset because parents are old and they just want the best for us… I prayed two *rakat nafal* [as a thanks to God] when I came to New Zealand. They did not stop interfering in our lives [in New Zealand as well]. My mother-in-law calls my husband every day and meddles in our business for little things. What has she [I] cooked, tell her to cook this, why has she not cooked this. I am tired and sick of this. When she calls, I go sit in the bathroom so that I don't have to hear how she is poisoning my husband towards me. My husband gets upset with me for no reason and sometimes does not talk to me for couple of days because of all this drama. I just pray and pray [that I am] still in better position (Eliza, housewife)

In the previous chapter, some participants discussed that mental health issues are not taken seriously in Pakistan because Pakistani people are still grappling with basic survival issues. The quote from Fatima highlights a similar idea but through a subject position of an emotionally burnt-out woman. On the surface, the focus seems to be explicitly on endurance

and implies that the woman has faced much adversity, therefore, other people's concerns about mental health issues are inferior to hers. However, it illuminates the realities of a woman in a patriarchal society where constant demands are placed on her through various relationships while she is expected to remain resilient. Simultaneously through the discourse of demands placed on a woman, Fatima implies a rejection of mental health issues because she reconstructs mental health issues within the framework of these demands.

Female participants constructed the in-laws' role as highly intrusive despite living away from them. For Fatima, her experience with her in-laws was good, but Eliza had a negative perception of her in-laws. Even though her in-laws live in Pakistan, her husband has maintained strong connections with his family. When reflecting on the news of her migration to Aotearoa, Eliza was extremely happy, but this happiness was short-lived because the daily phone calls from her in-laws and a high level of control over all aspects of her life became a source of distress. As described by Alia earlier, normative ideas about what constitutes a 'good woman' include maintaining the position of an observant woman who tolerates mistreatment by in-laws (Ali et al., 2011). Eliza's frustration was quite apparent and has shaped her understanding of mental health issues. She conceptualises mental health issues as something caused by in-laws meddling in her life. Mistry and Sonuga-Barke's (2000) study explored the relationship between family structures (extended and nuclear) and mental health issues in three generations of Asian British people. The authors concluded that young mothers were at the most risk of mental health issues in extended family structures because of "intergenerational tensions" (p. 138) and performing the "tripartite role of mother, wife and daughter-in-law" (p. 138). Eliza was very informed about her mental health issues and located these in the context of her relationships with her husband and her in-laws.

Besides relationships with in-laws, some participants discussed how their intimate partners respond and influence their response to mental health issues. Fatima's partner did not believe she had mental health problems:

> My husband still does not think that I had depression. But he always said that I had an issue of anger not depression…I had a lot of anxiety talking or meeting with people. My husband used to tell me that it is easy, why don't you go and meet people, it is easy you just go and meet people. It was easy for him because with men they have high strength level and they have strong interactions with other people that is why

> they cannot understand these issues and they get irritated because for them they think it is easy (Fatima, social worker).

Fatima discussed that despite her diagnosis of depression, her partner attributed her mental health issues to anger. Fatima believes that her partner's suggestions were not helpful in her situation because she did not have strong social support outside her immediate family. Furthermore, she draws a comparison to her husband's support network and that men have better support networks. These suggestions, when not acted upon, also meant that her partner felt "irritated". Kushal and Manickam (2014) problematise the role of women in diasporic communities as the "custodians…of ethnic identity" (p. 228). They argue that women are responsible for ensuring that no transgressions that would bring shame to the family occur. Thus, women continue to be controlled without having the space to "express or exercise any difference from the norm" (Kushal & Manickam, 2014, p. 228). Similarly, Fatima's comments showed that women are still embedded in a patriarchal structure, upholding *izzat*, maintaining subservience and dealing with mental health issues through silence. Here, mental health issues are a transgression, and it is dealt with by ignoring or minimising the experiences.

Furthermore, acknowledging mental health issues legitimises them. Given the role of a man as a gatekeeper to protect the family's honour and reputation and the presence of stigma and taboo in the Pakistani community around mental health issues are primary reasons why men minimise or ignore the mental health issues of others, even those in their family. In Pakistani society, a woman is very dependent on her partner for financial and emotional support, which adds to the pressure of not being believed or her issues being minimised.

The gendered dynamics of Pakistani families mean that a woman has to seek permission from her husband to access services. This points towards the dependent role that women occupy in intimate relationships and, conversely, the more dominant role that men occupy.

> So, among us the Pakistani ladies, they are not outgoing and if we have to go out, we have to tell our husbands and they will ask why do you have to go every week, every other day, what's the need? Are you just going for counselling or shoqia [for pleasure, for enjoyment]? Within our culture, they should look into it that it is not easy for women to access such services. Not easy to go and get counselling in our culture (Alia, counsellor).

Research suggests that women in South Asian cultures may find it challenging to make autonomous health decisions (Jafree et al., 2020). Similarly, gender mobility contributes to the low return rate for women when accessing support services in Pakistan, where women "often need to seek permission from their family before leaving the house" (Nisar et al., 2019, p. 10). Similarly, in Alia's case, she had to seek permission from her husband while being interrogated about her need for support. If they do manage to find the support, they often use that support to gain legitimacy, an idea I turn to next.

Seeking legitimacy through the authority of others

Women seek legitimacy for their mental health issues by drawing on the authority of medical professionals. This authority is used to appeal to family members. It has been argued that due to the collective nature of Pakistani society, people tend to look up to elders as authority figures; similarly, they also "tend to relate to mental health professionals as authority figures or elders who are expected to provide concrete solutions to their problems" (Yusuf, 2020, p. 440). For example, Amanda describes the experience of a Pakistani client of her who was receiving support for mental health issues, but the family did not believe she had mental health issues until a letter of diagnosis was provided:

> My client had bipolar, and the family did not believe. The only way for the family to understand and believe was when the health professional wrote a letter of diagnosis. That was a shock for me. That the parents did not believe her (Amanda, counsellor).

While medical professionals are constructed as authority figures who are able to provide legitimacy for mental health issues, a diagnosis by a medical professional (a psychiatrist) supersedes a counsellor's. Furthermore, it also demonstrates women's lack of autonomy over their own bodies by depriving them of their agency and shifting it to health professionals. Another participant highlighted her own experience with post-natal depression. She stated that there is a high prevalence of post-natal depression and referred to it as the least understood form of mental health issue recognised in Pakistani communities. She was impressed with the service provided in Aotearoa, where she was asked, after giving birth, if she had any symptoms of post-natal depression. Alia wanted the health professional to ask her husband and in-laws the same questions. When asked why, Alia responded:

> Giving birth is so stressful. If you try to explain to in-laws and husband that you have post-natal depression, they will say it is nothing, [but] they respect the hospital

> doctors so it helps the woman when someone else from high positions say that she is going through a lot and this [post-natal depression] is real. They understand and leave you alone because the doctor said…If the men are asked if the wife has post-natal depression, they will say no. They should be asked in a way such as: "Does your wife get angry randomly and start screaming?" they would say, "yes, she does" but I don't think she has a problem. Then doctors explain that it is a problem. (Alia, Counsellor)

Appealing to the authority of doctors was a way for Alia to find her voice and legitimise her condition. Family members would hear, believe and understand her condition if the explanation came from the health professional. Leveraging this expertise results in the provision of support that would not otherwise have been provided. This idea is reflected in the scholarship. Suhail (2005) argues that symptoms of mental health issues are often "interpreted as a way of avoiding duties, especially in the case of married women" (p. 178). The health professionals legitimising the condition would also suggest to her family that the woman is not neglecting her duties on purpose and therefore is less likely to face backlash or be expected to continue doing all the housework.

Even though some women might seek medical professionals to legitimise their mental health issues, such as post-natal depression, managing family responsibilities is not always possible and can compromise the support a woman seeks. For example, Eliza had childcare responsibilities that she found hard to manage with mental health issues:

> I was told by my GP that I need counselling. My GP helped me in booking appointments…I attended only one session because in the middle of the session, my neighbour called and told me to come back home because my son is crying so much. I never returned for counselling and just took medicines (Eliza, housewife).

Eliza's husband was at work when she went to the counselling session and asked a neighbour to watch over her child. She further explained that she had access to money to organise childcare but, it would also mean that in doing so, her husband would find out about her counselling. For her, it was more than the childcare duties; it was also ensuring that her husband did not find out she was attending counselling services since he had already deterred her from seeking professional help for her mental health issues. In this case, initially, Eliza does not perform a subservient role instead she subverts her husband's authority by not disclosing that she has been seeking counselling. However, by not returning to counselling

suggests that ultimately, she was subservient to her family obligations over her own mental well-being.

Pakistani women have less physical mobility than Pakistani men. Many Pakistani women do not know how to drive because women are not encouraged to drive in Pakistan. This is evident in research that transportation is one of the barriers faced by South Asian women in accessing support for mental health issues (Ahmad et al., 2004). Women in my study discussed the inability to drive as one of the barriers to accessing support:

> Another thing is driving for women. There has to be pickup service available as well because most of the Pakistani ladies don't drive. (Alia)

Eliza also recounted her experience with accessing counselling, saying that she had to walk 30 minutes to get to her counselling appointment because she was not aware of the bus services around her area and had never taken a bus before. The comments from the participants illustrate that the women are conscious of their inability to traverse spaces because of not knowing how to drive or utilise public transport to seek support for mental health issues. Despite, this restriction, they found ways to manage it. This also demonstrates that women navigate the space of mental health and reconstruct their own ways of resolving the gendered tension that is inherent in their roles as women.

Conclusion

Gendered ideologies significantly shape the way participants make sense of mental health issues. These gendered ideologies are embedded in a patriarchal structure that positions women as subordinate to men. This influences how men and women construct mental health in quite different ways. For male participants, mental health is constructed as resilience and self-reliance, while women construct mental health through the challenges they face in their submissive social positions. Specifically, women are situated in these narrow subject positions through family and community in the name of upholding *izzat* (honour) through the construction of good women.

These gendered subject positions have different implications for men and women. Women cannot disclose anything that would bring shame or harm to the family's reputation, including mental health issues. And men, as the guardians of *izzat*, as those who have to maintain a stoic front, would not seek support. Both women and men were concerned with women not

sharing mental health issues with the community or family. The intersection of *izzat* with gender norms produced significant concerns about the family reputation and community reputation, which both men and women upheld. Some women navigated the highly patriarchal structures and sought help demonstrating a complex and subtle process of negotiation to seek support while balancing the cultural norms.

These raise important questions about the mobility of gendered norms and practices that have traversed spaces from Pakistan to Aotearoa. While resistance takes place in individual cases, for example, seeking support in secrecy, the gendered ideas are fixed and remain unchanged.

Chapter 6 – Conclusion: Pakistani diaspora's negotiation of socially constructed ideas and practices of mental health

At the time of writing this conclusion, a news headline by Radio New Zealand read: "National [party] calls for better mental health for Asians amid worrying stats" (RNZ, 2022). Informed by a report by Asian Family Services, this media report discussed a lack of mental health strategy aimed specifically at the Asian population in Aotearoa. The Asian Family Services report surveyed 580 people from Asian populations and, in doing so, highlighted the rising incidences of mental health issues and concerns around mental health among diaspora communities. As a member of the Asian diaspora in Aotearoa and one who has experienced mental health challenges, I was not surprised by the report's findings. It did, however, highlight and reinforce the importance and timeliness of research that seeks to understand diasporic communities' relationship/s to mental health in Aotearoa.

This study sought to better understand the social construction of mental health among the Pakistani diaspora by exploring how they navigate and negotiate the conceptualisations and practices of mental health, in light of the dominant discourses of biomedical, religion/spirituality, within the context of mental health.

In the opening chapter of this thesis, I discuss the dominant social constructions of mental health in both Aotearoa and Pakistan to establish that there are multiple constructions of mental health already present.

In chapter two, I reviewed the literature on the multiple ways in which mental health is socially constructed. This chapter shows that constructions of mental health in Pakistan are influenced by the biomedical model, Islam, the prevalence of stigma and taboo and the collective values such as a strong emphasis on social relationships, the notion of shame and *izzat*. In comparison, the perceptions and practices of mental health in Aotearoa are influenced by individualism, stigma, discrimination, and the biomedical model.

My social constructionist qualitative methodological approach and research design were explained and described in chapter three. A social constructionism paradigm allowed me to articulate the multiple understandings of mental health within a culturally and socially specific community. Shafiq (2020), in a systematic literature review conducted on Pakistani

communities in Pakistan and diasporic communities, revealed that "there is no such scientific work carried out so far that uses these methodologies [Social constructionism] in Pakistan" (Shafiq, 2020, p. 45). The chapter also discussed the ethical considerations of this study and the implications of my positionality on the ethical considerations.

In chapter four, I discuss and explore the empirical findings from interviews and examine the dominant discursive constructions of mental health. In this chapter, I illustrate that conceptualisations of mental health take a variety of shapes: mental health as an illness, mental health as holistic, mental health as secondary to basic survival needs, mental health as influenced by relationships, influenced by the stigma of mental and religion.

In chapter five, I turn to gender and mental health. I discuss the gendered constructions of mental health through the focus point of *izzat*. I show that gendered expectations and practices of mental health remain unchanged in the Pakistani diaspora in Aotearoa.

In this concluding chapter, I pull the threads of these discussions together to explain how the Pakistani diaspora in Aotearoa negotiates and navigates different social constructions and practices of mental health. I argue that some constructions of mental health are fluid while others are static. The first section discusses the fusion of constructions underpinned by biomedical and religious discourses of mental health. The second section discusses the navigation and negotiation that takes place through cultural constructions of mental health and the last section shows the rigidity and resistance of the gendered context of mental health.

Fusing biomedical and religious discourses and practices of mental health

Fusion is defined as "the process or result of joining two or more things together to form a single entity" (Lexico Dictionaries, n.d.). In the context of this research, fusion is the coming together of two discourses which have been traditionally positioned as contradictory, conflicting and oppositional. These two discourses are the biomedical or scientific discourse and the religious/spirituality discourse of mental health. They do not fuse to become one distinct entity rather they create a third space with elements from both the discourses co-existing. I argue that the participants drew on and attempted to negotiate these two competing dominant discourses in order to construct their own positions on mental health.

As discussed in the introduction and literature review chapters, the biomedical discourse of mental health is one of the dominant discourses in Pakistan and Aotearoa. While a shift in language from a biomedical discourse to a well-being discourse (which encompasses all aspects of life) is apparent in Aotearoa as represented in mental health services and official Government reports, mental health issues remain primarily dealt with as a health issue. The social determinants such as poverty, homelessness, and unemployment are neglected in practice. The cause of mental health issues is almost always located in the individual and framed as an individual's responsibility requiring medical intervention. Furthermore, the focus on the biomedical approach also fails to consider indigenous healing methods that are central to various cultures (Kopua et al., 2020)

Similarly, biomedical explanations triumph over other mental health discourses in Pakistan, especially in the health literature. The literature is specifically concerned with mental health literacy (attitudes and help-seeking behaviours) but with a focus on awareness, especially recognition of the aetiology of mental health issues and relinquishing other mental health beliefs among the general population. This construction of mental health has deep roots in the western psychiatric colonial history of Pakistan.

Despite, framing Pakistani people in biomedical literature as lacking awareness, and as needing an intervention to recognise medical mental diagnoses, Islam remains the other dominant discourse of mental health in Pakistan. Embedded in the religious discourse is the idea that mental health is caused by the evil eye, magic, *jinn* and other supernatural possession (Mitha, 2020). Consequently, management of mental health issues reflects the belief and connection to God. For example, reciting Quranic scriptures, prayers, seeking support from faith healers and *Imams* or religious leaders.

Participants' construction of mental health was influenced by the dominant discourses in both Pakistan and Aotearoa. For example, reproducing notions of mental health as well-being was prominent among the participants' discussion of mental health, a distinctive framework utilised in Aotearoa but absent from Pakistan. As mentioned earlier, the shift (of language from biomedical to well-being framework) and the tension (language versus practice) present in the Aotearoa mental health narratives was reflected in the participants' construction of mental health within both these frameworks. Philosophically, participants conceptualised

mental health as holistic capturing the social determinants of mental health or within a biomedical framework "like any other illness, it [mental health issues] is an illness" (Alia). This would, on the surface, be enough to explain that the Pakistani diaspora conceptualises mental health within wellbeing and a biomedical discourse. What emerged was the management of mental health issues within a religious discourse.

Despite drawing upon both discourses, tension was always apparent between the biomedical and religious discourses. A religious discourse of mental health is perceived as a counter-discourse to a positivist, objective biomedical discourse, in which some participants positioned themselves. They did this by framing people who believe in spiritual or religious explanations as those lacking awareness. However, they somewhat paradoxically distanced themselves from such a 'regressive' construction of mental health. The participants constructed people who are unaware of mental health issues as uneducated and from rural geographical areas. The participants themselves were educated, and most were from urban areas in Pakistan living in Aotearoa. The distancing discourse of many participants was underpinned by their status as health professionals who are embedded in a western system. This subject position of a health professional also means that they were aware of the negative association of religion with mental health and therefore, distanced themselves from it. The Islamic perspective of mental health has been highlighted in the literature as non-compatible with the western biomedical worldview (Carter & Rashidi, 2003). To this end, the participants positioned themselves in the biomedical framework arguing that those who do not believe are "unaware".

However, the participants also showed that the space between the biomedical discourse and religious conceptualisation of mental health could be navigated. The participants talked about turning to the Quranic scriptures and prayers to deal with mental health issues. Hence, a complex picture emerges where religious or spiritual explanations of mental health are constructed as regressive or as fixable through education and awareness while simultaneously being embedded in religious practices when dealing with mental health issues. The implications for such constructions of mental health point toward one, that awareness of mental health does not automatically translate to seeking support from mental health services and two, that people manage mental health in various ways, including religious practices.

While the practices and conceptualisations of mental health showed a fused space between the religious and biomedical discourses, other discourses of mental health, such as collectivist cultural values, demonstrated constant negotiation.

Navigating individualist/collectivist discourses and practices of mental health

Collectivist values are a critical determining factor in how members of collectivist communities construct ideas of mental health. Scholarship on collectivist communities takes note of the relationships between families rather than dismissing or judging these relationships as too entangled or dependent (Dagirmanjian, 2005). Similarly, within the Pakistani diaspora, relationships with family, friends and the community often determine how they interact with ideas about mental health. For example, some women in my research discussed their relationships with their in-laws who remained living in Pakistan, relationships that continued to negatively impact their mental health. This demonstrates that despite the transition to a new homeland, the diaspora community does not suspend old relationships as though in a place of stasis, but actively negotiate and renegotiate day-to-day struggles with their distant homeland within the framework of their families. For example, Eliza's expected daily phone calls with her in-laws were described by Eliza as impacting her mental health negatively. This constant communication with the homeland meant that she was oscillating between Aotearoa and Pakistan, and mental health for her was an extension of her continued negative relationship with her in-laws. Eliza negotiates the influence of her in-laws on her relationships and mental health by seeking mental health support in Aotearoa – a practice highly discouraged.

Despite constructing mental health as influenced by social relationships, participants also constructed mental health as an individual problem, including something that is imposed on oneself through excessive worrying. This reflects the prevalent individualising biomedical discourse, that constructs the individual as defective, and locates the onus of responsibility on the individual. The individual as responsible for their mental health was also embedded in the highly cultural value of social standing in the community, an important aspect of Pakistani communities. While the interconnectedness of social relationships (with family, friends and community) is found to be an integral part of support for mental health issues in Asian communities in general, mental health issues could also reflect and pose a threat to the family

standing. This is at least in part due to the stigma and taboo associated with mental health issues that reflect a discourse of abnormality within a biomedical framework that positions people with mental health issues as faulty (O'Rielly & Lester, 2016).

The stigma associated with mental health issues receives significant attention in the literature, including among government agencies and health professionals (Weiss et al., 2006). Stigma negatively impacts individuals with mental health issues and is a significant barrier to seeking support in Aotearoa (Peterson et al., 2008). Mental health studies that focus on understanding diasporic communities also highlight the role of stigma as a barrier to seeking support and a need for culturally inclusive mental health services (Knifton, 2012; Moller et al., 2016; Ali et al., 2017). Similarly, mental health research in Pakistan suggests the general public is also likely to stigmatise those with mental health issues (Husain et al., 2020).

Even though stigma is constructed as a barrier and a problem to combat, in Pakistan, in Aotearoa and the diasporic communities in general, the construction of stigma differs significantly. In Aotearoa, stigma studies discuss an individualised form of stigma. Referred to as discrimination in the form of self-stigma (negative feelings about self) resulting from discrimination experienced through various institutions including the health system, family and the workplace (Peterson et al., 2008). In contrast, studies of stigma in Pakistan almost always construct stigma within an 'attitudes and behaviours' framework, demonstrating negative attitudes of family, health professionals, and the general public towards mental health issues. The emphasis on attitudes and behaviours of individuals absolves the responsibility of institutions. It also essentialises Asian cultures as stereotypically stigmatic. Studies have shown that Asians have "more stigmatising attitudes" towards mental health issues (Kvalsvig, 2018, p. 20). While stigma is prevalent in all communities, however, the way stigma has become connotated with Asian communities is problematic.

Within the Pakistani cultural context (while emphasising a discourse of abnormality), a person who is labelled as "mentally ill" would not be taken seriously by anyone in the family or community while simultaneously being referred to using derogatory labels and perceived as a risk to the community and family. There are also severe implications of being "found" with mental health issues, such as negatively impacting marriage proposals. With such consequences, mental health issues are constructed as shameful, a private affair not to be disclosed to anyone. To avoid bringing shame to the family reputation, individuals have to

navigate whether they disclose or seek help for their mental health issues. These ideas are reflected in the present study. Participants revealed several positions when navigating the cultural values of social standing and high levels of stigma and taboo.

The space that the diasporic communities occupy imposes a challenge where participants often resolve the tensions between the individualistically aligned Aotearoa and collective values of Pakistan through negotiation and navigation. Self-reliance provides participants with a way of negotiating mental health issues. The participants discussed how the Pakistani community exhausts internal resources, including religious healing methods before seeking medical support. They framed Pakistani communities as generally resilient who do not need support. Yet, they also highlighted that community support is crucial in dealing with mental health issues, for example when new Pakistani migrants arrive, the community provides support to find employment, and deal with visa issues. In this way, by supporting individuals, mental health is supported through the community. Some navigate these collectivist values by still seeking support from mental health services without disclosing it to immediate family.

Another way of resolving the tension is through contestation, for example, by comparing Aotearoa and Pakistan. Some participants praised the health systems in Aotearoa and criticised Pakistan's lack of focus on mental health concerns. In contrast, others argued that the excessive focus on mental health in western countries demonstrated a lack of understanding of basic pleasures, implying that people in Pakistan do not have to be concerned with mental health issues because they are easily satisfied. Furthermore, some participants were quite critical of how people in Aotearoa deal with mental health issues, referring to them as spoilt or exaggerating their experiences. Such a construction of mental health appears to be shaped and influenced by the challenges of migrating from a place that was perceived as struggling with fundamental survival issues.

The collectivist values that impose expectations of dealing with mental health issues are navigated rather than fused but the gendered mental health practices are predominantly retained with no space for negotiation.

Rigidity and resistance to gendered discourses of mental health

Gender was not a focus of this study but it organically developed through the analysis of the findings. It retrospectively posed an important question concerning the understanding of mental health within the context of migrant communities. In the last section, I looked at the findings from a cultural lens. In this section, I introduce the intersection of culture and gender. The gendered context suggested a fixed and static understanding of mental health. Traditional gendered expectations shaped and influenced how the participants constructed mental health. These gendered expectations were quite rigid and fixed and had no space for negotiation in the context of mental health. For example, female participants felt they were not allowed to acknowledge or seek help for their mental health issues because of the imposition of the social construction of *izzat.*

Both men and women are responsible for maintaining *izzat* because deviant actions (including a diagnosis of mental health issues or speaking about mental health issues) that do not conform to the prescribed societal expectations tarnish the family's reputation. However, the responsibility of maintaining family honour or *izzat* is gendered and has different codes, values and implications for men and women. Family shame can and often does happen through women's and girls' actions, but those actions are ultimately thought to end up shaming the men who are seen as not being able to control "their" women.

Furthermore, the patrilocal residence structure in Pakistani communities, where women often live with their husbands and in-laws, has implications for mental health. For example, if the women's in-laws find out or believe that the woman has mental health issues, it becomes exceedingly problematic for the woman. Thus, a woman gets trapped in an oppressive family situation due to these patriarchal cultural customs. The implications are also not reserved for the woman but also extend to her birth family, who gets pressured and shamed. There is a physical disruption of patrilocal residences in Aotearoa because the in-laws of the women still reside in Pakistan but the influence they have over the individuals has not changed instead morphed into a new form. For example, control over the women through regular phone calls.

Social relationships are central to Asian communities and are found to be a positive influence on mental health. While male participants discussed the supportive nature of communities

when dealing with any issues signalling their hypervisibility in the community and social networks, the reality for female participants was quite different. They did not find the community and social support as helpful because of their gender roles as wives and mothers with childcare and household responsibilities. They also highlighted an insidious form of control, including gossip in the communities (almost always directed at women) which served as monitoring deviant behaviours in the community.

Gossiping in the community and denying mental health issues were some of the ways the participants discussed that ensured the women adhered to the rules of *izzat* and did not seek support for mental health issues. These gendered constructions of mental health have challenges, especially for women when seeking support and highlight a need for inclusive services which take into consideration the gendered context of mental health in the Pakistani diaspora.

It is important to highlight that the participants were not passive subjects in this construction of mental health but actively demonstrated resistance to these gendered discourses. The subversion of *izzat* occurred in many ways: by seeking Pākehā GPs, to avoid leaking information about their mental health status in the community, attending counselling sessions without the knowledge of their husbands or families, and utilising telecounselling so they could deal with an inability to drive.

The participants in this study showed that people draw from a range of discourses on mental health available to them and cannot be generalised or categorised in either/or narratives. While some discourses reflected cultural expectations valued in Pakistan, others showed a reflection of discourses available in Aotearoa. Participants demonstrated an active fusion, negotiation and navigation within multiple worldviews and value systems. Some aspects of the culture were non-negotiable such as gendered notions of mental health.

This study shows that efforts to increase the mental well-being of diasporic communities in Aotearoa cannot be reduced to a discussion of culture or gender or stigma. A prevalent discourse concerning Asian communities in Aotearoa is that these communities underutilise mental health services because of stigma. Indeed, stigma has almost become synonymous with Asian mental health. Furthermore, the prominence of the biomedical discourse in practice has implications for constructing migrant communities with a high prevalence of

mental health issues but groups that are hard to reach. This works to marginalise and pathologise migrant communities without considering the contextual and social determinants of mental health. The discussion needs to be intersectional, and it incorporates and acknowledges the nuances and complexities within the diasporic communities when dealing with mental health issues and allows a space for negotiating discourses.

Overall, the research shows that one approach to mental health and well-being cannot fit all. The taken-for-granted assumptions about mental health among Asian communities need to be questioned. It is important to understand that conceptions of mental health are contextual, cultural, social, religious and influenced by dominant western discourses. There are multiple ways of constructing mental health, for example, whether it is the woman who resists patriarchal norms, subverts honour and seeks mental health support, whether is the person who finds support in their community or the person who believes in self-reliance or the person that finds comfort in Quranic scriptures and medication both. The analysis of this study shows that all these subject positions exist and the 'solution' to mental health is honouring and including these constructions.

Final reflections

I started this thesis believing that mental health issues can only be "fixed" if we seek biomedical help, and I wanted to raise 'awareness' of mental health in my community. My own understanding of mental health was a reflection of accepting and participating in the knowledges, opinions and beliefs of the dominant biomedical discourse. For me, mental health issues meant diagnosed medical categories that could be fixed by medication. I did not have access to any other way of thinking.

I started this thesis believing that Pakistanis don't seek biomedical help because of the stigma and taboo associated with mental health issues, because they do not understand mental illnesses, because they are not aware of the issues and that we have to raise awareness among the Pakistani community so they can seek medical help. My understanding was driven from a place of grief, my understanding was driven by my experiences which were always explained within a biomedical framework.

I leave the thesis with a different understanding: that mental health is a social construction, and the psychiatric or biomedical discourse, albeit the dominant discourse, is just one way in which mental health can be situated and talked about. I leave the thesis with a renewed appreciation for the plethora of ways in which mental health can be described and practised.

I started the thesis with a logical mindset, if A happens, then B occurs. The literature I was reading confirmed my prejudices against my own community. The literature confirmed that Pakistani people don't seek help because they have stigmatising attitudes. fullstop.
As I progressed, I learned that A doesn't always follow B, and such a line of thinking reproduces problematic discourses. I learned that my thinking was regurgitating a very decontextualised way of framing mental health. This learning significantly transformed me. Transformation also occurred while interviewing participants, sharing time and space with them in a place away from home, attempting to understand their sense-making while simultaneously attempting to understand how I made sense of it. I learnt that diaspora communities occupy a unique space where complex negotiations of sociocultural meanings of mental health take place. I learnt that it is essential to acknowledge and integrate the multiple knowledges and avoid the one size fits all model of mental health.

Through this research process, I found a way of understanding mental health that has given me answers to my own journey of seeking to understand my past challenges with mental health issues. Through this research process, I am able to put to bed the labels that have defined and haunted me for so long because I understand that mental health issues are socially constructed.

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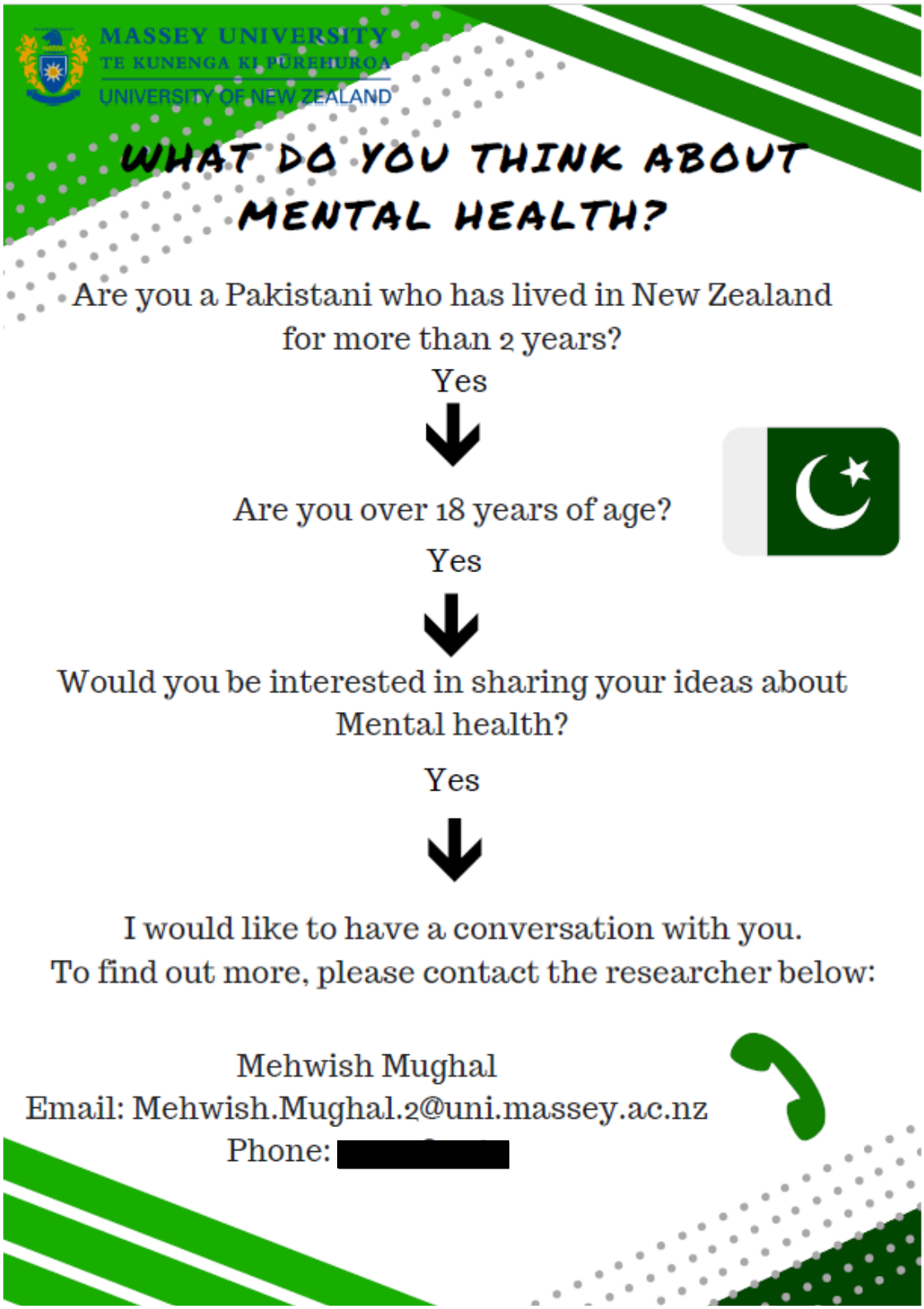
Appendices

Appendix A: Advertisement Poster



Appendix B: Participant Information Sheet

Understanding Mental Health perceptions and attitudes among Pakistani Diaspora in New Zealand

INFORMATION SHEET

My name is Mehwish Mughal. I am a postgraduate student in Sociology at Massey University enrolled in a Masters of Arts Degree.

I am carrying out research that looks at the perceptions and attitudes of Pakistani people living in New Zealand towards mental health. I would like to invite you to take part in this research.

What will you have to do?
If you agree to take part in the research, you will have an interview with me. The interview will take no longer than 2 hours. The interview will be like a conversation, I will ask you questions about your thoughts and insights about the topic.

Where will the interview be held?
We can meet at your home or if there is any other place you prefer.

Will the interview be recorded?
You will be given an option for voice recording; you can opt out if you are not comfortable in your voice being recorded.

How will the interview be used?
The data will only be used for the purpose of the research. No identifying information will be included in the research. Your identity will be kept confidential. Before we start the interview, you can choose a pseudonym, which will be used for the entirety of the research.

What happens if you feel discomfort?
If you feel emotional discomfort during the interview, we will end the interview. If you want to talk to someone confidentially, please contact: **Lifeline (0800 543 354), Healthline (0800 611 116), Youthline (0800 376 633)**

Please note that the researcher is not a professional licensed mental health practitioner and cannot provide counseling service.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study (up to two weeks after the interview);*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used;*
- *be given access to a summary of the project findings when it is concluded;*
- *If you have allowed for voice recording, you* can *ask for the recorder to be turned off at any time during the interview.*

If you agree to take part, you will be required to sign a consent form.

Thank you very much for your time in considering participating.

Kind Regards,
Mehwish Mughal

Project Contacts

My contact details:

Mehwish Mughal
[redacted]
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My supervisors are:

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 18/64. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz .

Appendix C: Participant Consent Form

MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Understanding Mental Health perceptions and attitudes among Pakistani Diaspora in New Zealand

PARTICIPANT CONSENT FORM

I have read and understood the Information Sheet attached. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction.

- I agree/do not agree to the interview being sound recorded.
- I wish/do not wish to receive a short project summary sent to me.
- I agree to participate in this study under the conditions set out in the Information Sheet.
- I would like to be known as _____ in any written work resulting from this research.

I_____ [Full name - printed] hereby consent to take part in this study.

Signature: _____ Date: _____

Appendix D: Interview schedule

Interview Questions:

1. What does the term mental health mean to you?
2. What do you think causes mental health/illness issues?
3. How do people experience mental health issues?
4. What areas of life are impacted for someone who is experiencing mental health issues?
5. Would these people looked upon differently in a:
    a. Family setting?
    b. In a community setting?
    c. Yes: Why do you think? No: Why do you think?
6. Do people in Pakistan talk about mental health issues?
    a. Yes: How is it talked about? Can you give me an example?
    b. No: Why do you think it is not talked about?
7. Do people within the New Zealand Pakistani community talk about mental health issues?
    a. Yes: How is it talked about? Can you give me an example?
    b. No: Why do you think it is not talked about?
8. How do you think non Pakistani people in New Zealand talk about mental health?
    a. What about different ethnic groups?
    b. What do you think about this?
9. Have you seen any of the New Zealand government's initiatives around depression?
    a. Yes: What do you think about these messages?
10. What do you think about mental health services in New Zealand?
11. Has your understanding around mental health changed since the time you have moved to New Zealand?
12. If a Pakistani person has mental health issues in New Zealand, where do they go for support, if at all?
13. What do you think can be done, if anything, to support Pakistani people living in New Zealand who experience mental health issues?