

The Use of Culturally Appropriate Representations of Distress in the Treatment of Mental Illness

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Abstract

This qualitative study compares the experiences of men who conceptualized their distress in cultural or religious terms (Al-Krenawi & Graham, 1999; Dein, Alexander, & Napier, 2008) and sought relevant treatments with the experiences of men who were treated for mental illness by psychiatrists. Using grounded theory methodology (Fassinger, 2005), results indicate that men who represented their distress in cultural or religious terms were not stigmatized and were instead treated with sympathy. They were therefore able to express their distress and seek help rather than resort to avoidant and self-destructive behaviors typical of men suffering from mental illness (Brownhill, Wilhelm, Barclay & Schmied, 2005; Chuick et. al., 2009). Moreover, shifting the cause of dysfunctional behavior to external entities enabled them to transcend typical gender role socialization that emphasizes stoicism and autonomy (Sheppard, 2002) and allowed the expression of weakness and vulnerability.

Introduction

According to models of emotional processing in psychotherapy (Kennedy-Moore & Watson, 1999; Greenberg & Watson, 2006) this reduced stigma enabled the articulation and sharing of emotions, which was critical in the experience of relief. Thus it is argued that the conceptualization of mental illness in culturally appropriate terms itself plays a role in the healing process. In this study implications for improving mental health accessibility and treatment in Pakistan are discussed.

The prevalence of mental illness in Pakistan and the stigma associated with seeking psychological help has been documented extensively by Ayub et. al. (2009), Kausar (2005), Karim, Saeed, Rana, Mubbshar and Jenkins (2004) and Zafar et. al. (2009). While these studies describe how this stigma can exacerbate an individual's distress and deny potential support from family and community, other studies suggest that this stigma is also manifested in delays between the onset of mental illness and contact with mental health professionals (Sadruddin, 2007), self-medication for anxiety and depression, especially the common use of benzodiazepines which are freely and cheaply available without prescriptions (Khan & Reza, 1998), and the expression of mental illness in terms of physical pain and somatic symptoms (Zaman, 1997). Khan and Raza (1997) also point out that Pakistan is unique in the higher incidence of married individuals seeking psychological help as compared to those who are single, possibly because merely the suggestion of mental illness could have severe consequences for a family's reputation and consequently the individual's marriage prospects.

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Gender Difference in the Stigmatization of Mental Illness

While the stigma attached to mental illness is likely to affect both men and women, findings by Ali, Israr, Ali and Janjua (2009), and Mumford, Minhas, Akhtar, Akhter, and Mubbashar (2000) indicate that women in Pakistan are more likely than men to suffer and seek help for psychological distress, which is consistent with research on other populations (Piccinelli, & Wilkinson, 2000; Kessler et. al., 2003). Kilmartin (2005), however, suggests that diagnostic criteria, especially for depression, are biased towards symptoms and manifestations characteristic of women rather than men, while studies by Angst and Dobler-Mikola (1984) and Murphy, Olivier, Monson, Sobol and Leighton (1988) examining the gender bias in the diagnosis of mental illness indicate that the prevalence is greater for men.

A possible explanation for this discrepancy is that the lack of social acceptability and stigma associated with mental illness is greater for men, who are likely to believe that their distress should be concealed and managed by themselves without seeking help. Addis and Cohane (2005), Levant (1995),

Robertson, Lin, Woodford, Damos and Hurst (2001), and Tepper (1999) describe how men are socialized to adhere to rigid gender role identities and expectations of behavior that emphasize, stoicism, autonomy, aggression and success. O'Neil, Good and Holmes (1995) describe how men who do not conform to these identities and expectations are likely to perceive themselves as inadequate, devalue themselves and find themselves stigmatized by society. In addition, the internalization of these identities and expectations can lead to additional psychological distress due to the perceived need to hide feelings of weakness or vulnerability, manage problems on their own, to suppress uncomfortable emotions or express them as anger or aggression (Good & Wood, 1995; Mahalik & Cournoyer, 2000; Moller-Leimkuhler, 2002; Tepper, 1999). Greig (2000) points out that due to political and cultural reasons many Muslim men are likely to have been exposed to violence, thereby normalizing it, validating emotional expression through anger and aggression and reinforcing the value of stoicism and dominance and the need to conceal weakness and vulnerability.

Brownhill, Wilhelm, Barclay and Schmied (2005) and Chuick et. al. (2009) describe how rigid gender role socialization and the fear of stigmatization results in mental illness amongst men being characterized by a reluctance to acknowledge, express or seek help for their distress and instead resort to maladaptive coping strategies such as immersion in work, self-medication through alcohol or drugs and increased sexual activity to suppress their symptoms of depression. While these coping strategies may provide temporary relief, they eventually become ineffective and exacerbate their distress, often due to interpersonal conflict and withdrawal of support systems, leading to further avoidant, numbing, escapist and frequently risky and self-destructive behaviors. This study therefore examines ways that the stigma associated with mental illness might be reduced for men, thereby enabling them to seek help and begin the process of healing.

Treatment of Mental Illness by Psychiatrists in Pakistan

Consistent with the findings of Zaman (1997) that mental illness in Pakistan is expressed as physical pain and somatic symptoms, Kausar (2005) reports that most individuals suffering from mental illness initially consult general physicians to alleviate these symptoms. Due to lack of awareness, limited availability of psychiatrists as well as the fear of stigmatization, only individuals who are experiencing severe mental illness such as schizophrenia, those who have attempted suicide, overdosed on opiates or psychotropic medication or been hospitalized for substance abuse are likely to be treated by psychiatrists (Khan & Reza, 1998). In such instances, Zaman (1991) points out that individuals expect or even demand that medicines be prescribed, while Khan, Islam and Kundi (1996) describe infrequent follow-up visits or premature termination accompanied by either abrupt discontinuation or extended self-administration of prescribed medication.

Conceptualization and Treatment of Mental Illness in Islamic Contexts

Notwithstanding the stigma associated with mental illness in Pakistan, which is a predominantly Muslim society, the Quran, which is believed by Muslims to be the unchanged words of God revealed to the Prophet Muhammad instructs Muslims to "feed and clothe the insane... and tell splendid words to him" (4:5). For Muslims the omnipotent and personal nature of God implies that nothing happens to individuals apart from what God wills and causes. Thus, "both health and illness are caused by Allah, through the natural and supernatural powers created by Him" (Al-Krenawi & Graham, 1999, p. 55). Mental illness or distress is therefore perceived as the result of a distant or defective relationship with God, punishment for not adhering to what has been decreed, or a test. Bhui, King, Dein and O'Connor (2008) report incidents of Muslims attributing symptoms of distress to irreligious feelings such as greed, jealousy and envy, or sinful behaviors such as not praying enough or being remiss regarding religious duties.

In Islamic contexts, mental illness is often conceptualized as possession by evil spirits (Al-Krenawi & Graham, 1999; Dein, Alexander, & Napier, 2008; Gadit & Khalid, 2002). These spirits, known as jinn, are believed to follow Iblis, the Islamic counterpart of the Biblical Devil. Jinns can possess individuals due to their desire for an individual, sorcery, black magic and the evil eye (Dein & Sembhi, 2000; Gadit & Khalid, 2002; Qidwai, 2003), but mainly they "seduce mankind in punishment for their sins against Allah" (Al-Juhri, 1991, cited by Al-Krenawi & Graham, 1999, p. 55). Symptoms of possession, described by Dein et. al. (2008), include depression, social withdrawal and isolation, disorientation and incoherence, as well as deviant or erratic behavior such as aggression, infidelity and dishonesty. There is considerable literature documenting the prevalence of attributing misfortune, illness and dysfunctional behavior to jinn in Islamic cultures (Al-Krenawi & Graham, 1999; Dein & Sembhi, 2000, Dein et. al., 2008).

Individuals in distress often turn to pirs who typically claim to be descended from generations of healers and may even trace their lineage to Sufi saints and miracle workers (Dein et. al., 2008). Pirani, Papadopoulos, Foster and Leavey (2008) describe their treatment as being based on "ritualistic communication with the spiritual world... based on dialogue with the spirits" (Pirani, 2008, p. 382). Interventions can include

prayer, singing, dancing, playing music, blowing over the patient, making the patient drink water that has been poured over the Quran and the use of charms or amulets for protection (Dein et. al., 2008; Inayat, 2005).

If the illness or distress is specifically attributed to possession by jinn, then individuals or their families may seek an exorcism to drive out the evil spirits. This process may include ritual cleansing, interpreting the individual's dreams to gain information about the jinn, reading specific verses of the Quran to agitate the jinn, and even addressing the jinn directly to initiate a dialogue, which, according to Al-Jzari (1987) as cited by Al-Krenawi and Graham (1999), could include attempts to convert the jinn to Islam. Al-Krenawi and Graham (1997; 1999) and Bilu and Witztum (1994) point out that the exorcism of jinn relies on the individual's confidence and belief in the healer's expertise which can instill hope and raise expectations of success.

A consistent theme throughout the treatment of illness in Islamic contexts is that illness is due to the will of God and caused by Him (Al-Krenawi & Graham, 1999; Dein et. al., 2008; Hodge, 2005; Inayat, 2005; Hamadan, 2007). However, as Dein et. al. (2008) point out, Islamic traditions do not require individuals who are suffering to take a fatalistic attitude and passively accept their condition, but to seek social, behavioral, medicinal and spiritual cures.

Method

This study employed grounded theory methodology as described by Fassinger (2005), which incorporates the techniques developed by Charmaz (2000), Glaser (1992), Rennie (2000) and Strauss and Corbin (1998) and requires detailed descriptions of the research team and the process for collecting and analyzing participant interviews.

Research Team

The primary researcher was a 37-year-old male doctoral student in counselling psychology of Pakistani origin currently residing in Canada. He was accompanied by a 45-year-old female epidemiologist and 24-year-old male research associate. All three members of the team had received post-secondary education in Europe and North America, came from middle- and upper-middle socioeconomic class backgrounds and identified themselves as Muslims holding moderate beliefs. While all the researchers had experience of conducting research on mental health in Pakistan, only the primary researcher had specifically conducted research on the conceptualization and treatment of mental illness in Islamic contexts. The other researchers did, however, possess generalized knowledge about commonly practiced traditions of Islamic healing. Before beginning the study and during the data collection process the team members met to examine and reflect on their understanding, assumptions and preconceived notions regarding these topics in order to reduce the risk of the data collection and analysis being affected by potential biases.

Procedures

Participants who had sought faith-based healing were recruited from visitors to a pir based at a shrine, which implies an association with sufi and mystic traditions, and a religious scholar and healer belonging to the mainstream Sunni sect known to provide advice on a variety of topics. Attempts were made to cover a range of religious beliefs and traditions to avoid participant homogeneity. After securing the approval of both the pir and the scholar, prospective participants were recruited by approaching their clients, asking them if they were seeking help for feelings of sadness, hopelessness or despair, social withdrawal, heightened irritability or aggression, drug abuse, loss of energy, the inability to concentrate or work or other symptoms consistent with the criteria for depression in the DSM-IV-TR (American Psychiatric Association, 2000) or the atypical manifestations of male depression described by Brownhill, Wilhelm, Barclay and Schmied (2005) and Chuick et. al. (2009). If they admitted to symptoms that could be attributed to depression, they were then invited to participate in a study on the efficacy of Islamic healing. The words "depression" or "mental illness" were not used during the recruitment process.

Participants seeking psychiatric treatment for depression were recruited from a teaching hospital run by a charitable trust. After receiving permission from the hospital administration, handouts in both English and Urdu were distributed by hospital staff to male patients who had appointments with either of the two consultant psychiatrists practicing at the hospital. The handouts explicitly asked whether they were being treated for depression and would be willing to participate in a study on the treatment of depression.

Eligible participants included men between the ages of 18 and 75 who were being treated for depression (for those seeking psychiatric treatment) or symptoms that could be attributed to depression (for those seeking faith-based healing). Prospective participants were asked whether they had sought help from faith healers, psychiatrists or both, and inquiries were made regarding attempts at healing through rituals, behaviors and medication. Since the goal was to obtain a broad and heterogeneous sample of men who self-identified as being treated for depression or symptoms that could be attributed to depression neither any particular diagnostic criteria nor details regarding specific beliefs or membership of particular religious sects were considered.

Participation entailed an initial screening interview which consisted of confirming that they were being treated by a psychiatrist for depression or a faith healer for symptoms consistent with depression, a brief interview to collect demographic information followed by a longer semi-structured interview regarding their treatment that lasted up to 60 minutes, and a final follow-up interview 10 to 12 weeks after the initial interviews.

The interviews were conducted in person by the primary researcher accompanied by the research associate who audio taped and subsequently transcribed them. The duration of the initial interviews was between 30 and 60 minutes and that of the follow-up interviews between 15 and 30 minutes. The main interviews consisted of eight open-ended questions accompanied by predetermined probing questions. (See Appendix 1 for questions). As required by Fassinger (2005), the interview questions and predetermined probing questions were pilot-tested by the research team before proceeding with the

study. All interviews followed the same semi-structured format and the only difference between the questions for participants undergoing psychiatric treatment and those undergoing faith based healing was that the former explicitly asked about depression while the latter referred to the ailment for which they were visiting the pir or religious scholar. The follow-up interviews were scheduled approximately 10 to 12 weeks after the initial interviews and served to gain a more thorough understanding of the participants' experience of their treatment as well as to verify the accuracy of the emerging models of seeking help from psychiatrists or faith-healers. No monetary compensation was paid to the participants and raw data was not shared with them.

Participants

The recruitment process yielded 41 eligible participants. Out of these 14 did not appear for the initial interview due to scheduling difficulties, the inability to establish contact with them or subsequent reservations regarding the study, and three participants did not appear for the follow-up interview due to similar reasons. Participants' ages ranged from 18 to 42 years with an average age of 27 years and 4 months.

In the group seeking faith-based healing, only one of the participants possessed a post-secondary degree although three had completed up to two years of college, eight had at least 12 years of schooling and two were functionally literate after completing basic primary education. In this group, four participants lived alone, eight lived with their families, nine were employed, three were unemployed, six were married and six were single. While all the participants identified themselves as Muslims, there was considerable variation regarding observance of religious obligations such as prayer and fasting.

In the group seeking psychiatric treatment, four of the participants had post-secondary degrees, three had attended college for at least two years and five had received up to 12 years of schooling. All of the participants in this group lived with their families, five were employed, seven were unemployed, eight were married and four were single. All the participants identified themselves as Muslims and the observance of religious obligations such as prayer and fasting was similar to that of the group seeking faith-based healing. The entire sample of 24 men was homogenous regarding ethnicity with all the participants identifying themselves as Pakistani and no inquiries were made regarding income or sexual orientation due to cultural sensibilities.

Data Analysis

Transcripts were coded using a grounded theory approach described by Fassinger (2005). The first phase, open coding, consisted of a detailed review of each transcript by the research team and resulted in the identification and definition of themes. During the second phase, axial coding, overarching categories were identified that described the relationships between the themes created during the open coding process. These categories aimed to represent the actual narratives of the clients and allow the emergence of a theory through the selective coding process. The third phase, selective coding, consisted of classifying central categories from those defined during axial coding and then using them to develop and elaborate a theory. Finally, in the follow-up interviews

these central categories were shared with the participants who were asked whether the descriptions were applicable to them. The follow-up interview therefore evaluated the accuracy of the categories as well as ensured that the emergent theory was actually grounded in participants' narratives.

Results

Results indicated a number of differences between the experiences and attitudes of participants seeking psychiatric treatment for depression from those participants seeking faith-based healing for symptoms consistent with depression. The coding process identified four main themes, experience of the treatment or healing process, family support, external judgments and social consequences, as well as attitudes towards depression or symptoms consistent with depression.

Experience of Treatment or Healing Process

Despite nine out of 12 participants seeking psychiatric treatment acknowledging that the prescribed medication had been effective in reducing their depression, only two described being treated by the psychiatrist as a positive experience. In addition, only two participants expressed satisfaction with the time the psychiatrist spent with them, with the remaining 10 complaining that he was too quick to prescribe medication and six complaining about a lack of advice and guidance regarding not just medication and managing their depression, but also relationships, career, financial and religious concerns. All of the participants appeared to resent the psychiatrist's fees and the cost of the medication, with two clients describing his motive to treat them as primarily financial and four speculating about collusion with pharmaceutical companies to prescribe their medication in return for monetary compensation or other benefits. All of the participants expressed a desire for the treatment to end as soon as possible, with seven being frustrated by the slow progress and one participant stating that he continued seeing the psychiatrist only because he was forced to by his parents.

The symptoms of six of the participants who sought faith-based healing were blamed on possession by evil spirits or jinn, and while no specific cause was given for symptoms of the remaining six participants, a distant relationship with God was implied. For all 12 participants, the healing process included prayer, giving money to charity and sacrificing goats and distributing the meat amongst the poor. In addition, those who visited the pir underwent ritual cleansing, dialogue with the jinn and were told to carry talismans or perform specific tasks such as cleaning the shrine. All 12 participants followed the instructions they were given and while five reported they had resulted in an improvement in their condition, seven said that they had made no difference. Only three participants, however, expressed skepticism about the treatment with two considering discontinuing their visits. Eight participants were grateful for the opportunity to discuss and explore their experience, even though two described the process as uncomfortable and two others said it was frightening.

Family Support

All the participants seeking faith-based healing reported that their immediate families knew that they were visiting a pir or religious scholar and encouraged and supported their decision to seek help. For 10 out of the 12 participants, family members had identified the healer and nine of the participants reported being accompanied by spouses, parents or siblings when they visited the healer. Nine of the participants had shared information of their visits with their extended families (for example, cousins, aunts, uncles and grandparents) and also received support and encouragement. While six of the participants described social withdrawal, none of them sought to actively hide their symptoms or the fact that they were visiting a pir or religious scholar for help. All of the participants seeking faith-based healing described talking with their families about their symptoms, the healer's explanations and treatments for them as a positive experience.

In contrast, only five out of the 12 participants seeking psychiatric treatment reported that their families were aware that they were visiting psychiatrists. Out of these five participants, three reported that their families initially questioned or disapproved of their decision to visit a psychiatrist while all five reported feeling that their families were impatient for their treatment to end, particularly for their medication to be discontinued. None of the 12 participants who were visiting psychiatrists had shared this information with their extended families, 10 of them reported actively hiding their symptoms and nine had established stories, such as suffering from diabetes or hypertension, to explain their doctor's visits and medication. From the five participants whose families knew they were visiting psychiatrists only two reported their families being involved in their treatment – in both cases the involvement was limited to scheduling, keeping or paying for appointments and the purchase and proper usage of prescribed medication.

External Judgments and Social Consequences

Amongst the participants seeking faith-based healing, only two attempted to conceal their symptoms or visits to the pir or scholar from their friends while the remaining 10 shared this information willingly with friends and acquaintances. All the participants received support, sympathy and consideration and none reported any significant interpersonal conflict or changes in relationships. Apart from one participant who perceived mild fear or uneasiness in others, the remaining participants reported being able to talk about their experiences, the treatment process, their fear and distress as well as possible underlying reasons or causes without worrying about being ridiculed, criticized or stigmatized. All the participants were grateful for the opportunity to talk about what they were going through, with five of them explicitly stating that they felt better after talking about being possessed.

None of the participants visiting psychiatrists shared information about their depression or its treatment with their friends or acquaintances. Only three were willing to admit that they were seeking help for depression if the information were to somehow be revealed. The remaining nine maintained that they would either deny their visits altogether or pretend that they were suffering from another ailment such as diabetes or hypertension. Despite their efforts and apparent success at concealing their depression and their

treatment for it, 11 of the participants being treated by psychiatrists reported social withdrawal and isolation as well as feeling judged and evaluated by others.

Attitude towards Depression or Symptoms Consistent with Depression

Eight of the participants seeking faith-based healing believed that they were either being punished for a transgression or for not being sufficiently religious and not fulfilling obligations such as prayer or fasting, while the remaining four did not think that there was a specific reason for their symptoms. All 12 of them wanted rapid relief from their symptoms, but their attitude was one of acceptance, patience and having faith in God.

The participants being treated for depression by psychiatrists displayed markedly diverse attitudes with nine of them describing feelings of frustration and eight saying that they felt helpless and trapped. Seven participants blamed parents or family members for their depression and 10 of them were critical of themselves for suffering from depression and not being able to overcome it on their own.

Discussion

The findings of this study indicate that conceptualizing depression or symptoms consistent with depression in religious terms is beneficial for men in Muslim societies. Such conceptualizations reduce or remove the stigmatization associated with mental illness due to gender role socialization and cultural notions and enable them to acknowledge, express and seek help for their distress in several ways that are discussed in this section.

Externalizing the Cause of Distress

By shifting the cause of distress and dysfunctional behavior to an external force such as God or jinn, which was explicitly or implicitly an integral part of the religious conceptualization of their distress, the participants did not feel personally accountable for it. Externalization set the stage for healing by removing or significantly reducing the internalized blame and criticism that would typically have been directed at the participants themselves, along with judgments of defectiveness, weakness and worthlessness that are characteristic of depression and likely to exacerbate it (Segal, Williams & Teasdale, 2002; Persons, Davidson, & Tompkins, 2000). The process ultimately allowed the men to distance themselves from their distress and engage with it in a detached and productive manner. As such, it is comparable to the strategy of externalization described by White and Epston (1990).

Ascribing symptoms to an external cause also meant that the men were not deemed morally accountable or judged for having transgressed or failed to live up to cultural and gender role expectations. They were therefore not stigmatized or ostracized, but considered deserving of care, sympathy and encouragement by family and friends. The social support they received further reduced or eliminated the social withdrawal and isolation that is characteristic of depression and can be an impediment to healing (Leahy & Holland, 2000; Persons, Davidson, & Tompkins, 2000) as well as reinforced the notion that there was no reason to feel weak or defective or ascribe personal blame (Segal, Williams & Teasdale, 2002).

Seeking Help

In addition to engendering attitudes conducive to healing, conceptualizing distress in religious terms also made it possible for men to seek help. Not afraid of being judged, criticized or stigmatized, as well as unconstrained by masculine notions of stoicism, autonomy and the need to conceal weakness, the men were able to seek outside help without perceiving themselves as inadequate and devaluing themselves. As a result, they visited healers of their own volition and relatively soon after experiencing distress, which is in contrast to the findings of Chuick et. al. (2009), who report that most men suffering from mental illness need to be persuaded by a family member to seek help, and Sadruddin (2007), who reports an almost five-year treatment delay for depression in Pakistan. It is, however, consistent with research conducted by Pirani et. al., (2008) regarding individuals with similar conceptualizations of distress seeking healing at shrines.

Relationship with Healers

Since the men who conceptualized their distress in religious terms and sought faith-based healing received extended social support, they could visit the pir or religious scholar without any need for concealment or fear of social consequences. Consequently, they were not resentful of the process or impatient for it to end. In contrast, the men who visited the psychiatrist were not only likely to judge themselves as defective or inadequate, but the fear of exposure, humiliation and stigmatization also meant that the process was stressful and taxing for them. Thus, even if the psychiatrist was able to provide a safe, accepting and non-judgmental environment, the participants were unable to take advantage of it, wanted the process to end as quickly as possible, and felt frustrated when it did not. Despite the participants seeking psychiatric treatment reporting greater and faster relief from their symptoms compared to those seeking faith-based healing, their internalized judgments and fears of stigmatization meant that faith-based healing was generally a more positive experience than psychiatric treatment, thereby reducing the likelihood of premature termination.

Further, these judgments and fears not only tainted the experience for those men seeking psychiatric treatment, but also made it less likely for them to develop a good rapport or therapeutic relationship with their psychiatrists. The seemingly unwarranted suspicions regarding the psychiatrists' motives and integrity can probably be understood in this context. In contrast, the absence of such fears and judgments meant that the faith-based healers enjoyed better relationships with the men who sought help from them.

There is extensive research documenting the importance of therapeutic relationship towards positive outcomes in psychotherapy (for example, Clarkson, 2003; Wiener, 2009), and the findings of this study indicate that real or perceived stigmatization, as well as the fear of being stigmatized, compromise the therapeutic relationship and ultimately the healing process. By reducing the likelihood of being stigmatized for seeking help, conceptualizing distress in religious terms allowed the men in this study to develop relationships with their healers that could in turn facilitate the healing process.

Expression and Exploration of Emotions

The overarching theme that emerged from this study was that of emotional expression. By conceptualizing their distress in religious terms, thereby avoiding or reducing stigmatization due to cultural or gender role expectations, participants were able to express and ultimately regulate their distress.

In the five-step model proposed Kennedy-Moore and Watson (1999) the process of expressing emotion in response to a stimulus begins with individuals perceiving the stimulus, processing it at a preconscious level and responding physiologically. Next they become aware of their affective reaction. In the third step, individuals use internal and external information to cognitively process the reaction. They become aware of its emotional nature, label and interpret it, and begin to ascribe meaning to the experience. The fourth step involves evaluating the emotional experience in the context of personal priorities and notions of propriety and desirability. At this stage individuals also consider the validity and acceptability of their emotional experience. Finally, individuals take into account social contexts and the consequences of expressing their emotions in the current environment. It is by going through these steps that individuals decide whether to express the emotion as well as how to express it.

Due to cultural and gender role expectations, accompanied by the prospect of stigmatization, men, especially in Pakistani contexts, are likely to experience disruptions at a number of stages of this process. At the stage of conscious perception of the reaction they may deny or block feelings of vulnerability and inferiority. Kennedy-Moore and Watson (1999) term this form of non-expression as a "motivated lack of awareness" (p. 13) and describe it as being maladaptive and resulting in the inability to use emotional responses to guide behavior in a productive manner. At the stage of labeling and interpreting the emotional response, disruptions are likely to take the form of an inability to adequately interpret, understand or symbolize the emotional experience. Thus feelings of vulnerability, inferiority and insecurity along with fears of being exposed and stigmatized may be understood and experienced as anger, especially since men are likely to suppress uncomfortable emotions or express them as anger or aggression, which are generally considered acceptable emotions in men (Good & Wood, 1995; Mahalik & Cournoyer, 2000; Moller-Leimkuhler, 2002; Tepper, 1999). Referred to by Kennedy-Moore and Watson (1999) as "skill deficits in emotional processing," (p. 15) disruptions at this stage of emotional processing are likely to preclude adaptive and effective coping strategies.

At the fourth stage of this process, men are likely to judge their emotional reactions as neither acceptable nor justified since they imply weakness or the inability to manage their distress on their own, and are therefore contrary to masculine expectations of stoicism and autonomy. Finally at the last stage, when the social context and environment for emotional expression is evaluated, men suffering from depression invariably suppress their emotional expression due to fears of exposure and the expectation of being humiliated, stigmatized and ostracized if they reveal their true selves and feelings.

In this model, depression, especially amongst men, can therefore be understood in terms of non-expression of emotion due to individuals denying, suppressing, and not being able to express their emotions. The fear of stigmatization due to cultural and gender role expectations is likely to contribute significantly to this non-expression, and even if it is not one of the underlying causes of depression, it is likely to exacerbate it.

By conceptualizing their distress in religious terms such as possession or a distant relationship with God, thereby removing or reducing the fears of stigmatization, participants in this study seeking faith-based healing were able to label and interpret their experience as well as consider it valid and acceptable. In addition to this process being consistent with the model of healthy emotional processing described by Kennedy-Moore and Watson (1999), the therapeutic value of not resisting or suppressing emotions and instead accepting them in a non-judgmental manner without shame, guilt or anger has been documented by Segal, Williams and Teasdale (2002).

Religious conceptualizations of distress also allowed the participants to receive support from family, friends and healers thereby providing an opportunity to express and articulate their emotions. This expression then allowed the men to deconstruct their emotions and eventually ascribe meaning to them. The findings that faith-based healing was considered a more positive experience compared to psychiatric treatment despite the greater and rapid relief provided by medication can therefore be explained by accepting and validating environment, along with the vocabulary and epistemological framework to express, explore and deconstruct the emotions, provided by the pir or religious scholar.

For those participants seeking psychiatric treatment for depression, however, the fear of being exposed, stigmatized and ostracized remained largely intact, with the result that they continued suppressing their emotions and processing them in a distorted manner. Notwithstanding the relief provided by medication prescribed by psychiatrists, it was the inability and lack of opportunity to interpret, deconstruct and accept their emotions which compromised the healing process for them. It can therefore be argued that the conceptualization of distress in religious terms, the associated reduction or elimination of the risk of stigmatization and the benefits derived from this reduced or eliminated risk, rather than rituals and strategies employed by the faith-based healers, play a critical role in healing process.

Limitations

There are three major limitations to this study. First, the demographic make-up of the participants was restricted to men who identified themselves as heterosexual, Muslim and Pakistani and was therefore potentially biased by a specific or narrow worldview. Similarly, the influence of income levels and barriers to healthcare, especially mental health, may have forced some of the participants to seek faith-based healing without having had the option to consider psychiatric treatment. The conclusions may therefore not be representative of men with different worldviews or financial resources. Finally, and perhaps most importantly, the participants were not selected on the basis of any specific criteria for depression and the research team relied on their self-selection based

on reported symptoms, particularly for the participants seeking faith-based healing. It is therefore possible that some of the participants were not suffering from depression, but from conditions such as bipolar disorder or other co-morbid conditions such as substance abuse or personality disorders that may have distorted cognitive and emotional processing.

Implications for Counseling and Psychotherapy

The importance of understanding illness within the context of representations and meanings of illness in the client's culture, which can shape ideas about causes, duration, cures, consequences, and coping strategies, has been highlighted by Moodley (2006). In this light, counselors or therapists who encounter clients who believe that their distress may be explained in religious terms such as a distant relationship with God or possession by jinn would be well advised to refer them to reliable faith-based healers or work in collaboration with them, assuming a supportive role in which they help their clients reframe the experience and process it in a productive manner. Based on the findings of this paper, disabusing such clients of the belief that they are not sufficiently religious or possessed by jinn and attempting to manage depression through Western psychotherapy is likely to be unproductive and hinder healing. Alternatively, while it would probably not be helpful to try to force Muslim men suffering from depression to conceptualize their distress in religious terms, the framework and vocabulary provided by such conceptualizations can be employed to reduce stigma and facilitate emotional expression. Used in this manner, the conceptualization can also provide opportunities to culturally adapt therapy and to segue into an eclectic therapeutic process that incorporates elements of Narrative Therapy (White & Epsom, 1990), Process-Experiential Therapy (Greenberg & Watson, 2006) and Mindfulness Based Cognitive Therapy (Segal, Williams & Teasdale, 2002).

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Appendix 1: Interview Questions

1. What did you do to deal with your distress/ depression? (for example, ignored it, prayed, worked harder, resorted to alcohol or drugs).
2. What prompted you to get help for your distress/ depression?
3. Did you discuss your distress/ depression with anyone (for example, family, friends, religious figures, doctors) and if yes, what advice did they give you? What was it like to talk about your suffering? (P)
4. How did your family and friends respond to your distress/ depression? What was your relationship with your friends and family like at the time? How did it change? (P)
5. How do you feel about yourself for being distressed/ depressed?
6. Do you think there was a specific reason why you were so distressed/ depressed? If so, what?

(P) indicates predetermined probing question.