

## Chapter 2

# Mental Health in Pakistan: Yesterday, Today and Tomorrow

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**Abstract** Muslim communities have a peculiar mental health scenario. The Muslim communities in the precolonial Indian subcontinent did have mental health conceptions, later termed Muslim psychology. The introduction of formal mental health institutions implanted the Western notions and practices of mental health in British India. The Partition did not disturb the largely autonomous evolution of the two traditions. Drawing its sustenance from the West, Western style psychiatry and psychotherapy became an integral part of Pakistan's officially maintained public health system, whereas the alternative practices have continued in the informal sector and benefitted from the increase in Islamization initiatives. The disruptions in the traditional way of social life in Pakistan, produced by factors such as the growing (disorderly) urban development, poverty, unemployment, cultural conflict and snowballing mistrust in state institutions, have significantly increased the incidence of mental health problems in Pakistan. In the case of Pakistan, the narratives about the nature and quality of the social environment have become a site of contestation between modernists and traditionalists in Pakistan, where the former would like the traditional cultural environment to make place for a modern social environment, putting individual freedom above the family and community. As the modernists dominate the cultural discourse in Pakistan, particularly in modern, urban settings, in their zeal to create strong sentiments in people against the traditional culture, the 'everything is wrong and rotten in Pakistani society', aided by the media, is creating an acquired helplessness, aggravating the mental health picture in Pakistan. Such a situation is unique to Muslim societies and sets these

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societies apart from the other societies in engaging with mental health problems. At the same time, the modern, affluent, urban sections of society are experiencing newer kinds of globalized life style linked to soft social pathologies, which become a fertile medium for serious mental ailments of epidemic proportions. The polarization on the questions of aetiologies and remedies has created a stalemate, which is helping nobody. The vacuum thus created should better be filled by research than the quackery of healers of different hues and shapes. Different traditions of mental health conceptions and practices in Pakistan need to develop a policy and practice consensus, with retooled techniques by the mental health professionals, to start addressing the pain and misery of growing mental health problems in Pakistan.

## Introduction

This chapter traces the history of mental health care in what is now the state of Pakistan, the sixth most populous country in the world. Pakistan won independence from Britain in 1947, when the Indian subcontinent was divided into the Muslim-dominated Pakistan and Hindu-dominated India. In many ways, the modern-day Pakistan is a successor state to the Mogul Empire which ruled almost the whole of the Indian subcontinent and parts of Afghanistan from 1526 to 1857. The chapter starts with a historical description of early influences on mental health traditions in the region that is now Pakistan. The remainder of the chapter is divided into a section on mental health establishments in the prepartition Indian subcontinent, followed by the development of mental health in Pakistan in its 67 years of independence. In the last three decades, the nation has faced major geopolitical, socio-economic and humanitarian challenges. The chapter explores the impact of these events on the current state of mental health of Pakistanis in the backdrop of the debates on causes and solutions of individual and collective psychological pathologies.

## Sources of Mental Health Traditions Amongst Muslims: Precolonial Era to 1947

### *Arrival of Graeco-Arab Medicine with Muslims in Precolonial India*

The Graeco-Arab approach has its own concept of aetiopathogenesis (Jamal et al. 2012). There are three major concepts in this approach; *Mizaj* (temperament) *Tarkeeb* (structure) and *Ittesal* (continuity of tissues). The aetiology of a disorder may be found in *altered temperament*, *altered structure* and *discontinuity in tissues*. The *Mizaj* in Graeco-Arab medicine is used to describe the state of neuroendocrine,

genatometabolic and somato-environmental balance in terms of individual's functioning level in the context of the given circumstances (Jamal et al. 2012).

Both Arab and Ayurvedic medicine are based on the Hippocratic theory of humours, which states that a healthy body should have a balance of four humours; *sodawi* (sanguine), *balghami* (phlegmatic), *safrawi* (choleric) and *saudawi* (melancholic). The imbalance of these humours can cause disorder or disease (Lone et al. 2011). The Greeks said that the melancholic humour was a trait of highly intelligent people. Subsequently, Ar-Razi said that melancholia and delusions are caused by excessive rational activities (Dols 1992). Galen described three different types of melancholia: cerebral, epigastric and bodily melancholia. In Galenic formulation, *melania chole* is a term for mental disorder, which involves sadness and fear and is caused by the excessive black bile in the body (Dols 1992). The earlier stages of melancholia, described later by *Ibn Sina* (Avicenna 980–1037), are similar to the features of anxiety, which include irrational thinking, phobia, irritability, avoidance of social interaction, palpitation, dizziness and tinnitus (Jamal et al. 2012), while severe forms of melancholia have been described by *Ali Ibn Al Abbas Al-Majusi* (died in 994) as inability to sleep, lovesickness, raving, reclusiveness and extreme restlessness (Dols 1992), which may resemble the current diagnosis of hypomania.

In Ar-Razi's opinion melancholia is caused either by the intensification or burning of black bile humour, which impacts and damages the brain. He advised two modes of treatment to address two levels of melancholic effect. For mild melancholia, he recommended keeping the body moistened by frequent baths and, for the severe form, he suggested evacuation of blood (Dols 1992). These treatments used to be given to inmates by frequent cold showers and through *blood-letting* and *leech therapy* (Weiss 1983; Patch 1939; Lone et al. 2011; Banerjee 2001).

The physicians who belonged to the Graeco-Arab tradition adopted the Hippocratic and Galenic approach and explicated and expanded it. Ishaq Ibn Imran's (died in 908) work 'On Melancholia' (*Miqala fi Malinhulya*) is an example. In Galen's view, the soul follows the body's influence, but Ibn Imran asserted that the opposite is equally possible (Dols 1992) and advocated for the possible role of non-pharmacological (psychological therapies) in the treatment of mental disorders.

## ***Sciences of Soul in Muslim Lands***

Parallel and intertwined with the psychiatry of the classical Muslim age, the philosophers and physicians continued with their efforts to define notions such as *normal* and *disorder* and to find effective remedies. For the Muslim psychologists, the theories of the soul underlining the dichotomy of the two natures of the things in the cosmos provide the clues to the remedies for problematic emotions. Muslim psychologists understood resentment in society as an aftermath of an imbalance of the equilibrium between soul and body. These forces can be disrupted when their

needs are not fulfilled either material or spiritual. The repercussions of such a disparity are protests, extremism, hue and cry, revenge, lethargy, apathy, lack of interest and lack of innovation and creativity.

The studies of an individual's psychology at a time when elsewhere the disorders were believed to be caused, more often than not, by external forces/spirits, remain a hallmark of Muslim psychological heritage. Muslim scholars studied the self and psyche (*al-Nafs*) to trace the source of disorder. In this regard, the Persian physician, Abu Zayd al-Balkhi (850–934) was amongst the pioneers who discussed disorders related to both the body and soul. According to Haque (2004), the Muslim scholar, Abu Zayd al-Balkhi was probably the first cognitive and medical psychologist to clearly differentiate between neurosis and psychosis. Al-Balkhi classified aggression and depression, in individuals and society at large, as endogenous depression, originating within the body, separately from reactive depression, originating outside the body. Such depressions contaminate the *self* leaving space for *Huzn* (sadness, sorrow or grief) and acute depression which, if not directed wisely, may lead to grievous reaction leading again back to heightened anger causing apathy and loss of hope. Such a dislocated equilibrium and the resultant social imbalance can lead to annihilation of a civilization. Al-Balkhi demonstrated in detail how rational and spiritual cognitive therapies can be used to treat each one of his classified disorders. He focused on the rational along with spiritual therapies because, according to him, a healthy individual always has healthy thoughts and feelings inside. For good personal health, balance between the mind and body is required while an imbalance between the two may cause sickness. Apart from his well-developed therapy for neurotics, Al-Balkhi also repeatedly refers to the emotional abnormalities of normal people, describing them as a diminished form of true emotional illness. He does not speak of the so-called neurotic as a patient, but rather as a person whose emotional overreactions have become a habit.

### ***Emergence of Indian Mental Health Tradition During the Muslim Period in India***

Muslim rulers and their armies were followed to India from the adjoining Muslim lands by a large number of traders, religious scholars, mystics and religious professionals. They brought with them the social, intellectual and spiritual baggage of Islam. Muslim rule in India is accompanied by a very rapid growth of cities, particularly in North India. These cities started having sizeable Muslim populations with their own network of mosques, *madrassas* (religious seminaries) and *khan-qahs* (centres for spiritual training).

Muslim physicians came to India from Arabia, Central Asia and Persia with a theory and practice strongly impacted by Graeco-Arab medicine. Najib Ud Din Abu Hamid Muhammad Ibn 'Ali Ibne Umar Al Samarqandi (1222) was the one who, according to some researchers, established the Graeco-Arab tradition in India (Syed

2002; Nizamie and Goyal 2010). Najab was inspired by the great Umar Al-Razi's concepts of human nature. In his book, *Kitab Al Nafs Wal Ruh* (The book of Psyche and Spirit), Al-Razi discussed not only different types of human souls but also different types of pleasures (Haque 2004). Al-Razi was of the opinion that as physical human needs and desires cannot be gratified, the mental pleasures are more important to focus upon. By going beyond the desires, like eating, drinking and sexual intercourse (which he calls sensual pleasures), one can achieve the knowledge and excellence in *Ikhlāq* (Morals). Najab described seven types of mental disorders. *Sauda-E-Tabee*, *Muree Sauda*, *Ishk*, *Nisyan*, *Hizyan*, *Malikholia-E-Maraki* and *Dual Kulb*. Najab suggested *Ilaj-E-Nafsani* (literally psychotherapy) to treat these disorders.

Muslim saints in the Indian subcontinent preached humane and compassionate attitudes towards the disadvantaged segments of society. Their Khanqahs and shrines still provide food and shelter to those in need regardless of religious affiliation. Different rulers made efforts to provide care to the mentally ill as well. Some researchers (Sharma and Varma 1984; Krishnamurthy et al. 2000) have traced the earliest institutional care of the mentally ill to the fifteenth century when facilities were established by Mohammad Khilji (1436–1469) with the help of a physician, Maulana Fazlullah Hakim Dhar, near Mandu in Madhya Pradesh.

## Mental Health Problems in Colonial India

It is widely accepted amongst historians that current services in mental health were set up initially by the British in colonial India (Nizamie and Goyal 2010; Ernst 1991), although there is evidence of a hospital for the mentally ill being established by the Portuguese in the seventeenth century in Goa (Sharma and Varma 1984; Somasundaram 1987; Jain 2003).

### *History of Modern Psychiatry in India*

Mills (2001) traced four broad phases in the history of modern psychiatry in the Indian subcontinent. The first phase was from 1795 to 1857, the second was from 1858 to 1914, the third lasted from 1914 until 1947 and the fourth started at the Independence of India and Pakistan in 1947. Mills dated his history from 1795, as the first facility for the mentally ill was sanctioned by the Governor General in that year. However, for some others, the earliest facility was started in Bombay in 1745 (Sharma and Varma 1984; Weiss 1983; Nizamie and Goyal 2010). Some other scholars (Kumar 2004; Sharma and Varma 1984) report the establishment of a lunatic asylum in Calcutta in 1787 by an English surgeon, Dr. George M. Kenderline. The assistant surgeon of Calcutta, W. Dick Even, established a mental hospital in Kalipauk (Madras) in 1794. These centres were developed because the

British were focused on the coastal cities, Calcutta, Madras and Bombay, on the way to establishing their stronghold in the Indian subcontinent. Later, many more asylums were established but only two in those regions which were to be included in Pakistan, one in Lahore and the other in Hyderabad.

As far as the quality of treatment administered in asylums is concerned, we should remember that, historically, the development of mental asylums coincided with political development in India. In the second half of the eighteenth century, the Mughal Empire was in a decline. The Marathas in Central India, the Sikhs in the North and the French and English in the South were struggling to gain control of ever greater areas. The British East India Company in the South founded the asylums like those in other parts of the British Empire (Weiss 1983), and they intended primarily to segregate those lunatics considered as dangerous to others. The mental health facilities in Madras, Calcutta and Bombay were privately run until 1800 (Ernst 1991), and it was considered a lucrative business.

After control of most of the subcontinent was secured in 1857, new asylums were established (Mills 2001) and a Lunacy Act introduced in 1858. The Act was modified first in 1888 and again in 1912 (Somasundaram 1987). The number of asylums rapidly increased until 1914, after which the focus shifted to expansion of existing facilities and quality of treatment. In 1920, the ongoing efforts of a British Army Psychiatrist, Lt. Colonel Owen Berkeley-Hill, were successful and the term 'asylum' was changed to 'hospital'.

Ranchi European lunatic asylum started receiving inmates in May 1918. In October 1919, Berkeley-Hill was appointed as the medical superintendent (Nizamie et al. 2008). He remained in his post for fifteen years. As it was a hospital exclusively for Europeans, many new services were introduced to India from here. Treatments included rest, morphine and organo-therapy and also exercise, excursions and amusements. The facility for male-female socialization, occupational therapy, hydrotherapy, use of psychoanalysis and the use of cardiazol and the ECT were the salient features of Ranchi asylum. Berkeley-Hill founded the Indian Association for Mental Hygiene in 1922. In 1929, cottages were built to house inmates with their families. The facilities available in Ranchi were not comparable with any other asylum in British India.

### *Development of Mental Hospitals in Punjab and Sind*

At the time of partition in 1947, there were about forty mental asylums in India. Northern India, which formed the current Pakistan, had only two; one in Lahore (established in 1840) and the other in Hyderabad (established in 1865).

Lahore remained outside of British control until ten years after the death of Maharaja Ranjit Singh in 1839. The psychiatric treatment of mentally ill had started in 1812, when a Hungarian physician, Dr. Johann Martin Honiberger, joined the Court of the Maharaja Ranjit Singh. This facility existed for few years but collapsed on Honiberger's return to Europe (Jain 2003). Dr. Honiberger passed on twelve

‘epileptics and idiots’, who were kept in a stable attached to Raja Suchet Singh’s palace, to Dr. C.M. Smith, the first ever appointed civil surgeon to Lahore (Patch 1939; Banerjee 2001; Punjab Institute of Mental Health). Dr. Smith introduced hydrotherapy to Lahore. Between 1849 and 1857, the number of inmates increased from 12 to 85, but the stable could only accommodate 40 inmates. It became difficult to keep proper hygienic standards. These inmates were then moved to another building known as Congee House. Within only six years, the inmate population increased threefold. Due to the increased number of mentally ill, some were being kept in another facility, near the Anarkali Bazar, a well-to-do locality of Lahore. But their presence disturbed the residents of the area so they had to be moved again in 1863 to a place that had been an inn and then into a prison. This facility was uncared for during the period, 1863–1900. In 1900, Lieutenant Colonel George Francis William Ewens was appointed as the superintendent of Lahore mental asylum. He is best known for his report on the microcephalics of Shah Daula (The Chuas of Shah Daula). He wrote an account on insanity in India, published in 1908 under the title, *Insanity in India. Its Symptoms and Diagnosis, with Reference to the Relation of Crime and Insanity*.

The quality of administration and treatment was very low. Lt. Col. C.J. Lodge Patch was appointed as the medical superintendent of Lahore Mental Hospital in 1922. He describes his first visit to the hospital as horrifying (Patch 1939). The patients were naked and handcuffed. They were restrained and being put into seclusion for minor or no reasons. They would crawl on their knees like cringing dogs to touch the feet of the superintendent to avoid punishment.

The mental asylum in Hyderabad did not attract as much attention from researchers as did Lahore. The asylum opened in 1865; however, its building was further extended in 1871. A donation of Rs. 50,000 by a Parsi philanthropist from Bombay, Cowasji Jehangir Readymoney, funded construction when the Government of India provided only Rs. 8000 (Talpur 2007). The asylum was named after him as Cowasji Jehangir Mental Hospital. There were eight wards for natives and a separate ward for Europeans. However, the condition and size of building was considered inadequate in an 1874 report by W. Thom, Surgeon General of the Indian Medical Department (Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency 1873–1877). The report confirmed that the inmates worked as labourers in the extension of building. The Muslims comprised 66% of its population. In Sind, the Hindus used to keep their insane at home. Dementia and mania were the common forms of insanity. The majority of inmates were *fukeers* (beggars), others rarely were admitted. The treatment was described as a combination of kindness and firmness, known in Europe as moral treatment. However, as the superintendent reported, the main mode of treatment was physical labour. The annual report (1875) described employment in the garden for males and grinding of corn for females as the chief work. In a 1904 report, the inmates were listed as coming from distant regions of India, Kurrachee (Karachi), Rohri, Sukkur, Larkhana, Thar and Parkar, Baluchistan, Kandhar, Punjab, Marwar, Lucknow, Muradabad, Bombay and Savantvadi. The numbers fluctuated; 65 inmates in 1874, and 52 in 1904. In the 1904 report, the

inmates were listed by occupation: cultivators, clerks and artisans. However, mendicants (10) were the largest group. It is clear that the inmates come from lower socio-economic class (Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency 1904).

The superintendent's reports confirm the salient aspects of Ernst's (1991) study. First, the development of these asylums coincided with the advances of the British across India. Second, the focus was more on the custodial service than on curative. Third, the large asylums, initially built in Calcutta, Madras and Bombay, were to serve Europeans; natives were admitted but at later stages. Fourth, the natives were kept separately from Europeans. The development of Ranchi asylum as exclusively for the non-natives was an example of racial discrimination. Fifth Europeans were divided into first-class and second-class categories. The first class was drawn from the European officers who would have diagnoses such as *temporary weakness, nervousness, fatigue or affected intellect*. They would stay in India for brief treatment. However, second-class patients belonging to the working class were described as '*perfect Idiots*' and '*maniacs*'. Their presence in India did not support the idea of white superiority over the natives; so they were compulsorily repatriated to asylums in Britain (Ernst 1991).

### ***Emergence of Modern Religion-Based Psychotherapy***

The war of 1857 ended Muslim control and ushered in Hindu domination. The revivalist movements of Aligarh and Deoband show the process of consolidation and retorting simultaneously. Since the response was on religious lines, it generated a sense of community within religious communities. The multifaceted revivalist movement created a wide array of intellectual and political response, ranging from efforts of Sir Syed Ahmed Khan, the Kilafat movement and other pan-Islamist movements. That can be read as an attempt to put the trauma of losing power behind. However, continued colonization botched the process expansively. It was in this environment that we see the *Ulema* (religious scholars) and *Mashaaeikh* (spiritual gurus) engaging themselves with the Muslim community on mental health issues. While with the abolition of 'waqf/trust endowments' by the British, the endowments of Islamic institutions of learning and outreach suffered a great blow. The resurgence of Muslim community feeling and the somewhat improved economic condition of Muslims in some areas witnessed the emergence of Muslim philanthropy aimed at helping the destitute and needy, including the mentally ill.

Muslim religious scholars recognized the misery suffered by those with mental health problems and established the necessary facilities. One of the best examples is the *Khanqah Imdadia* established by a leading religious scholar of India, Ashraf Ali Thanvi (1863–1943). His methods of teaching spiritual enhancement are explained in his two books: *Tarbiat-Us-Salik* and *Bawadir un Nawadar*. Dr. Azhar Rizvi (1936–2008) translated the salient notions of Thanvi into modern therapeutic terms (Umar and Tufail 1999; Rizvi and Tufail 2012).



In Thanvi's normative view, abnormality is caused by deviation from *Quranic* standards of good human beings. Deviation from them creates a distance between the Creator (God) and the creation, which is the root cause of all the sufferings. The foundation of mental health problems is laid down with irrational thinking and unreasonable behaviour (Rizvi 1999). A healthy person is one who is well able to differentiate the rational mode of conduct from the impulsive one. People suffering from some form of confusion or a mental disorder used to contact Thanvi for help in two ways; either by writing to him or by meeting with him.

A questionnaire was developed to collect basic information about the sufferer. Before talking to the individual, he would inform the person that his services neither guarantee any rescue for the day of judgement nor any benefit in this worldly life. The *Murshid* (spiritual guide) will neither pray for the cure nor do anything for the individual except referring him to the right instructions and resources. The cure would lie in individual's will and effort. He would recommend books to people, some of his own and some written by others, such as Abu Hamid Al-Ghazali (1058–1111), particularly *Kimiya As-Saadah* (Alchemy of Felicity). According to Rizvi (1999), Thanvi himself wrote around eight hundred small- and medium-sized books. Rizvi (1999) called this approach as *Khwanai Tareeqa-e-Ilaj* (Reading Therapy), which is very similar to contemporary 'bibliotherapy'. He emphasized the importance of the individual's own narrative, an account of his problems, desires, observation, thoughts and concerns, written daily, at a set time of his choosing. The individual would be asked to pay attention to suppressed expression.

Thanvi's approach to therapy for mental disorders provides the cognitive structure and emotional strength through faith in God. His advice to participate in all life's activities was meant to bring the individual out of disorderly inertia.

## Mental Health in Pakistan: Post 1947

### *Institutions*

Gadit (2007), charting the history of public psychiatric facilities, describes the state of affairs in 1947, when there was a total of 2000 beds for a population of more than 100 million. The asylums were in a neglected condition, there were few qualified psychiatrists, and patients were managed by minimally trained doctors. These hospitals were called 'Mad Houses' in the local languages and patients could be admitted in chains. There was very little change for the first 20 years of Pakistan's existence. Much of mental health care continued to be provided by unregulated practices based on concoctions of traditional influences described in previous sections. This continues to be the case for a large proportion of Pakistan's rural population today, as most modern facilities are concentrated in urban centres. Karim et al. (2004) divide such practices into religious and traditional. They

describe religious healers as usually the first healthcare contact, particularly for the mentally ill. The system has its own popular aetiologies, such as 'evil eye', bad wishes from others, and machinations of sorcery. Usually, the solution would involve religious talismans and reciting holy verses.

There are many types of traditional healers. Karim et al. (2004) describe the spiritual healing and healers. *Khalifas* and *gadinashins*—'the person who sits on the master's or teacher's seat' and commonly applied to people who have inherited the craft of healing. Magic and sorcery, as well as spiritual power associated with the saints, is used to 'heal' patients. *Hakims*, adherents of Ayurvedic or Greek medicine, are formally registered with the Pakistani Medical and Dental Council as practitioners of alternative medicine. Other 'alternative' healers include homeopaths, practitioners of Chinese herbal medicine and acupuncturists. The anecdotal evidence suggests that the number of these traditional healers has significantly increased, mainly due to the soaring costs of allopathic medicine and modern health services. There is a large increase in the demand for formal psychiatric services as well as traditional healers.

Concerning modern facilities, Gadit (2007) dates the beginning from the establishment of the psychiatric units at the Jinnah Postgraduate Medical Centre, Karachi, in 1965 and the Government Mayo Hospital, Lahore, in 1967. Although the shortage of mental health specialists was a problem, such units were set up all over Pakistan in large teaching hospitals. Currently, there are over 20 such 'teaching' departments (Gilani et al. 2005), with 4100 beds in the public and private sector, and about 342 practising psychiatrists, mostly located in major cities.

Many small psychiatric hospitals have been opened throughout the country, privately run in most cases by psychiatrists and allied mental health professionals. Though still very small, the private sector has started playing a major role. Lately there has been a significant increase in self-help techniques described through television and the emergence of 'soft psychotherapy' services in the form of courses like sleep management or 'yoga' as well as inspirational speakers.

Mental health care is therefore a patchwork of care. However, in the last three decades, influenced by the World Health Organization (WHO) and other developments in the field, primary care and community-based models have been tested. Karim et al. (2004) give two examples. The first is the community-based model established at the Institute of Psychiatry, Rawalpindi, in collaboration with the WHO (Mubbashar et al. 1986). The model grew out of dissatisfaction with centralized, urban, hospital-based models. Specialist professionals are in short supply, numbering less than one per million. The community or primary care model attempts to bring care within the reach of the mass of the population by integrating mental health care into the primary care network with support from specialized personnel. This approach has required changes in roles and training, and a focus of health workers on preventive aspects of care and community involvement. The second model is that of collaborative care in partnership with religious and traditional healers (Saeed et al. 2000). This was demonstrated in Rawalpindi where faith healers were given brief training in recognition of the more severe mental disorders (severe depression, psychosis and epilepsy) and referral to the specialist centre,

while continuing to help patients with common mental disorders. In one district, faith healers referred 25% of their clients to the specialist centre (Saeed et al. 2000). Unfortunately, these models have not yet been scaled up beyond the demonstration stage.

However, a lot of research has been carried out in Pakistan, which shows great potential for primary care and community-based services, demonstrating that it is possible to deliver effective interventions through non-specialist health professionals and community-based agents. The main challenge is the scaling up of these promising interventions.

## ***Resources***

Since independence, the number of trained mental health professionals has increased gradually, but has seen a much larger rise in recent years due to the introduction of postgraduate training programmes. Following the development of structured training programmes in teaching hospitals, the College of Physicians and Surgeons of Pakistan began to confer postgraduate psychiatry degrees in the 1980s. Similarly, many universities in Pakistan deliver training and professional qualification in clinical psychology. While this has led to a large increase in the number of mental health specialists, further improvements are needed, for example in uniformity of service delivery structures across the country.

## ***Developments in Mental Health Policy and Legislation***

A National Mental Health Policy (NMHP) was devised in 1986 but not fully implemented until 2001 (Karim et al. 2004). A National Mental Health Programme was also devised and implemented in 2001. Its strategic goals included the improvement of mental health and the reduction of related disability, mortality, suicide and substance abuse. It also aimed to prevent illness, promote mental health and care for the already ill. The programme emphasized community and primary care services, and it was envisaged that the departments of psychiatry would train and supervise primary care staff (physicians and community health workers) (Gilani et al. 2005). The importance of including spiritual healers in the mainstream health care and referral system has also been recognized in the programme as they are frequently the points of first contact. The programme also covered the links between the health sector and other organizations such as the police, prisons and social welfare organizations. In 2011, the Federal Ministry of Health, under whose authority the NMHP was to be administered, was abolished and all health matters were transferred to the four provincial ministries of health.

The evolution of mental health legislation demonstrates the low priority given to mental health. According to Gilani et al. (2005), until 2001 the relevant law was the

Lunacy Act of 1912. After the partition, Pakistani mental health law continued to be based on this relic, with sporadic changes made in the light of drastically changed conditions. The 1912 Lunacy Act, however, remained in effect, despite occasional protests by the medical profession and citizens. On 20 February 2001, the Pakistan Mental Health Ordinance came into effect, replacing the 1912 Act. The ordinance has brought about significant changes in the law ‘relating to mentally disordered persons with respect to their care and treatment and management of their property and other related matters’ (Gilani et al. 2005). For example, it is mandatory to have ‘informed consent’ for treatment; there are limits to the period of involuntary detention to a maximum of 72 h during which time examination by a qualified mental health practitioner is mandatory; and it is a criminal offence to make false statements about someone’s mental state with the purpose of exploitation, punishable with up to 5 years imprisonment (Gilani et al. 2005).

## **Mental Health Challenges in Today’s Pakistan**

### ***A Glimpse of the Contemporary Mental Health Picture***

During recent years, many epidemiological studies have been carried out. A systematic review of prevalence and risk factors for anxiety and depressive disorders (Mirza and Jenkins 2004) found an overall mean prevalence in the general population of 34% (range 29–66% for women and 10–33% for men). Factors positively associated with these disorders were female gender, low level of education, financial difficulty and relationship problems, suggesting that social factors play an important part in the aetiology of anxiety and depression. There is a strong feeling in the research community that the exposure of Pakistanis to serious bouts of sociopolitical instability, economic uncertainty, violence, regional conflict and dislocation during the last three decades has contributed to these high rates. In Pakistan, an unusually high percentage of the population has been exposed to violence, related to wars in Afghanistan and to huge disasters such as the 2005 earthquake in which more than 78,000 people died and the massive floods of 2010 and 2011. All these events caused population displacement, producing post-traumatic stress disorder (PTSD). Pakistan now houses about five million refugees, the highest number in the world. The violence has also increased due to increased weaponization creating high levels of insecurity, particularly for high-risk communities. A cross-sectional survey of Afghan women in a refugee camp in North West Pakistan showed that 36% screened positive for a common mental disorder and over 90% of those screening positive had suicidal thoughts (Rahman and Hafeez 2003). In the tribal areas where the Pakistani army is engaged in the war against the Taliban, 65% of women and 45% of men suffered from severe mental distress (Husain et al. 2007). Karachi, the largest city of Pakistan, has been experiencing violence sporadically for the last three decades, with serious implications

for the mental health and morale of citizens, including medical professionals. A survey of medical students in Karachi found 70% to be suffering from anxiety or depression (Khan et al. 2006), compared to 13–25% in US and Canadian medical students (Dyrbye et al. 2006). A similar survey of Karachi's family practitioners found 39% suffering from these conditions (Khuwaja et al. 2004).

In the current context of conflict, natural disaster and fragile health systems, the most vulnerable groups are women and children. The rates of perinatal depression in Pakistani women are amongst the highest in the world (Klainin and Arthur 2009), ranging from 18 to 30% in urban areas and 28 to 36% in rural areas (Karmaliani et al. 2009; Husain et al. 2006). About 11% women in one urban sample of 1369 had contemplated suicide during pregnancy (Asad et al. 2010). Perinatal depression has been found to be strongly and independently associated with infant undernutrition in Pakistan, making it a public health priority (Patel et al. 2004). Half of Pakistan's population is below the age of 18. Estimations of the prevalence of emotional and behavioural problems in school children in the last two decades suggest an almost threefold difference from 9.4% (Javed et al. 1992) to over 30% (Syed et al. 2009). There are no reliable estimates for prevalence rates in children not attending school. The rate of severe intellectual disability (ID) in children is 1.9% and mild–moderate ID about 6.5% (Yaqoob et al. 2004; Gustavson 2005), both associated with very high levels of parental mental distress (Mirza et al. 2009). In the absence of child mental health professionals, general practitioners and paediatricians manage these disorders. But in one study in Karachi, over 80% of such professionals surveyed were found lacking the knowledge to diagnose attention-deficit disorder and learning disorders in children (Jawaid et al. 2008).

### ***Socio-economic Backdrop of Mental Health Problems***

Pakistan has witnessed the twin phenomena of rapid overall population growth and urban growth during the last four decades, which has increased urban poverty. In addition to the two high-risk groups identified above, urban youth could also become a high-risk group. The mental health of youth is crucially important for the future of the country since economic progress, national cohesion and social peace depend in substantial measure on the success of providing opportunities for them to enter into national life. It is a commonplace observation that the young people play an active part in political violence. The presence of a youth bulge in fact historically has been associated with the periods of political crisis. With a median age of 21 years, Pakistan's population is one of the youngest in Asia. About 65% of Pakistan's population is below 30 years, and those between 15 and 29 constitute about 30% of the population.

This surge of adolescents virtually guarantees that the number of educated youth will outpace employment growth, leaving even educated young men underemployed and resentful of those who enjoy the opportunities they lack. While not the

prime cause of armed conflict, these demographic factors can facilitate recruitment into insurgent organizations and extremist networks or into militias and political gangs. They can also promote the positive public action that is needed for a robust democratic system. Recently, a survey of youth and young adults aged 20–34 was conducted in Karachi (April 2011) seeking information on their demographic, economic, social backgrounds, religious practices, perception of the current conditions, future prospects for the country and for themselves, their opinions about the key players in the country (such as politicians, and the media figures) and attitudes about entrepreneurship and its potentials. The survey found the youth tended to be more tuned towards religious practices. The majority of them used and had access to the Internet and mobile phones. Most of those surveyed were single and living with their parents and let the latter make decisions for them and 31% of the males were unemployed. Most of the unemployed were uneducated, most wanted government jobs. An intention to start a business was not strong. Most respondents were very concerned about overpopulation. Almost 36% males and 36% females said that the situation in Pakistan is going to grow worse and that is the cause of anger amongst youth. With poverty and conflict deeply impacting the social fabric, such a bleak psychological picture presents a daunting public health challenge to the government and the health services.

### ***Future Mental Health Policy Challenges for the Government***

In spite of being a low priority for governments in Pakistan, mental health has seen positive developments in service delivery, policy, legislation and research. However, developments have been patchy and only a small proportion of Pakistan's population is able to access care. Researchers and policymakers will need to consider key issues, such as scaling up care services in areas affected by conflict and disaster; supporting and strengthening health systems; ensuring equity and quality of health interventions; and developing means of financing such programmes in a sustainable fashion. The needs of vulnerable groups, notably women, children and displaced populations, need to be given priority. Researchers should also explore alternatives to health systems for the delivery of mental health care, utilizing existing community and family support. The capacity of traditional healers to provide therapy for anxiety and depression (Saeed et al. 2000) and of the family to support the pharmacological treatment of schizophrenic patients has been researched and found to be effective (Farooq et al. 2011). However, much more needs to be done by researchers, policy experts and the international community before tangible relief can be provided to the millions suffering from mental health problems.

## Contemporary Debates and New Research Challenges

### *Role of Colonialism and External Environment in Creating Mental Health Pathologies*

Contrary to the traditional preoccupation of the psychiatric establishment in Pakistan with biological causes of mental health problems, for the past three decades more and more analysts seek to relate an increasingly dire mental health situation in Pakistan to the external environment of sociopolitical upheavals the people have gone through. There are several social scientists who go even further back in the history and propose that the state of mental health in Pakistan was an outcome of the perpetuation of colonial setting in today's Pakistan (Syed 2012b). The contributions of writers such as Mannoni, Fanon, Bhabha and Ashish Nandy are very popular with this group of Pakistani psychologists. At a more popular, one would say journalistic, level colonialism is considered responsible for the production of a shifty character which reduces the possibility of a consensus at the group level, eventually creating a split personality, with alienation embedded deep in the personality. Colonial oppression makes the individual an eternal disbeliever, a cynical manipulator, whose habit of using hypocritical coping mechanisms, learnt during the colonial experience, makes trust disappear from the community. As the successor to the British colonial empire in Pakistan retained most of the features of colonial governance, especially its civil service and natural leadership, the hypocritical coping mechanisms continued having a central place in the personality of many Pakistanis. Establishment of socially emancipating democracy could have supplanted this mindset, but it did not happen.

The issue of the nature of continuity between the structures of control from the colonial to the post-colonial periods has been tackled less in research than in disputational discourses. As a result, the debate has become more of a philosophical debate, unable to impact upon public health policy and practice in any significant way. One 'popular' view in this regard is that Pakistan qualifies as a neocolonial state, where former colonizers with the new emerging empires (particularly the US) would keep playing the key role in deciding economic systems and political and cultural structures. The new structures of control would exercise their control through non-governmental organizations and multinational corporations. These interactions and entanglements between the local, national, regional and international have produced a muddled, ambivalent, multilayered interdependence as suggested by Ashish Nandy in his book, *The Intimate Enemy*. The success of these neocolonial masters, armies and militias, as this narrative continues on, depends on their ability to maintain if not war, then this war-like situation, which they are doing in the streets of Pakistani towns and villages. Many consider this situation as the principle cause of post-traumatic stress (Syed 2012b).

Another popular view talks less about the international imperatives in Pakistan's affairs and puts the blame instead on a 'security oriented' state, which capitalizes on the tensions with India to justify its salience and the attendant anti-democratic

environment, inherently oppressive in nature. Both these narratives, however, agree that the local elites, who cooperated with the neocolonial masters and/or the security state, were allowed to continue with their own oppressive, feudal tradition and mindset. In the name of saving the country or Islam, the religious were found, more often than not, standing with the state and its elites than with the proponents of social emancipation. All these debates, however have not produced any significant call for collectively jettisoning these historical burdens. The Pakistani mental health establishment so far has been largely immune to these theoretical debates. However, as the now an extensive literature appears, particularly in the USA and Europe, relating the political environment to the incidence of mental health problems, Pakistani mental health professionals may rethink the situation and retool their techniques.

### ***Cultural Conflict Causing Mental Health Pathologies***

In the Pakistani context, traditionally, the oppressive family/community environment is identified by Western trained psychiatrists as an important cause of mental health problems in Muslim societies. The opponents of this view underscore the positive therapeutic role of the family and community in resolving conflicts and stresses which could otherwise grow into severe mental health problems. The narratives about the nature and quality of the social environment have become a site of conflict between the modernists and traditionalists in Pakistan, where the former would like the traditional cultural environment to make way for a modern social environment, putting individual freedom above family and community. As the feeling of living under an oppressive social environment can create politically inclined reactive sentiments such as anger, frustration, helplessness and apathy, these conflicts have become the means for winning the soul of Pakistanis. As the modernists dominate the cultural discourse in Pakistan, particularly in urban settings, and in their zeal to create strong sentiments against the traditional culture, the view that 'everything is wrong and rotten in Pakistani society' has possibly created an acquired helplessness, aggravating the mental health picture in Pakistan.

As the 'informal psychotherapy' market in the West flourishes with religion, religious and motivational authors/speakers and spiritual healers, Islamic psychotherapy is gaining respectability in Pakistan in rich urban settings too, complicating the relationship between tradition and modernity and instrumentalizing the faith in the process.

In case of the traditional, religiously embedded spiritual psychotherapy, individual agency and suffering are embedded in a paradigm in which most of the socio-psychic stresses are approached from a faith-based perspective, putting a premium on the family and predestination. As faith and family both exist in Pakistan in a fairly robust way, these may be preventing the individual's psychological problems from becoming severe, which in turn could lead to suicide or



rampant deviance and a heavy public health burden. One often hears, however, the lament that both the faith and family are becoming weak.

It is, however, an open question whether the incidence of mental health problems is greater in Muslim developing countries compared to non-Muslim ones, with whom they share more than they share with the West. Doing a different kind of typology may yield better insights into the management of mental health problems. In any case, emergence of modern technology-based fields of shared meaning in developing countries may result in the emergence of stronger social/mass pathologies, assuming oppressive characteristics; this requires much more cross-national research and learning.

### ***Finding Common Ground for Better Mental Health Tomorrow***

Despite the divergence in the general approaches towards mental health of the Western and Islamic traditions, they share many features. Thanvi's approach outlined above, for example, is close to the now widely practiced cognitive behavioural therapy (CBT). Both work to cure as well as to prevent. However, as the ethos of CBT could be vastly different as between a predominantly Muslim and a non-Muslim context, serious efforts have been made, particularly in the USA, to modify CBT and to embed it in the Muslim faith and social environment; many researchers have reported positive results (Hodge and Nadir 2008).

There is a popular adage in Muslim psychology literature that emotions should be subservient to reason and that reason should be governed by the revelation. This is also the reason that Muslim psychologists, believing that the emotions and moods are influenced by patterns of thinking, focus much less on past events in a patient's life, such as childhood experiences. They tend to put a premium on the here and now, helping the patient realize the spiritual relationship with God by explaining to him/her the limitations his/her agency as an individual. In the West also, there is a growing debate on the moral dilemmas caused by an unbridled freedom of the individual, a thing considered sacrosanct in the West.

Akhter Ahsen, an eminent American psychologist of Pakistani origin and the founder of eidetic psychotherapy, is an excellent example of someone who combines Eastern philosophy and Western methodologies in psychotherapy (Ahsen 1977, 1986, 1987, 2005, 2010; Hochman 1995). In his theory and therapy, he attempts to bridge the theoretical gaps that not only show the cross-cultural efficacy of his model but also to develop a holistic approach (Dolan 1997). His model has been adopted for a wide range of problems and populations, for example, people with intellectual disability both in the West and in Pakistan (Bent 1995; Syed 2012a).

The job of Western and developing country psychotherapists has, however, been made more difficult by the emergence of newer kinds of globalized lifestyle, linked

to social pathologies like negative thinking, which become a fertile medium for serious mental ailments in developed and developing countries. The political implications of cynicism in a society are quite well studied, but there is much less research on the linkage between cynicism and deviance on the one hand and depression on the other hand. Cynicism towards national institutions and desire to emigrate from Pakistan might represent a symptom of widespread anxiety; and acquired helplessness could be the deep cause of the anxiety.

The media and mass culture are producing a personality type which is given to satire, cynicism and hyperbolic language in which the words of killing and dying are used so easily. This language pervades magic realism, particularly in the lives of young inhabitants of the virtual world. The psychological impact of these new realities is also another common challenge for soft, socio-psychic pathologies. The linkage between the social environment and individual pathologies, where the former is so radically changing due to social media, remains an area which calls for much more research so that the epistemic frameworks used in training and practice can be better adjusted to the lived realities of the population.

In short, the political anthropology of mental health is a very controversial subject in Muslim countries due to a continuing conflict between tradition and modernity, and this needs much more research. In a globalized age, Muslim countries like other countries are subject to a plethora of influences for change. The polarization on the questions of aetiologies and remedies has created a stalemate, which is helping nobody. Indeed, it has produced policy paralysis. Further, legislation takes decades to change. The resources allocated to mental health establishments are meagre and very few doctors opt to become psychiatrists. The vacuum thus created would be better filled with scientific research than the quackery of healers of assorted types.

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