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# Indigenous Conceptualization Of Depression And Anxiety: Fgds With Pakistani Youth And Health Practitioners

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**Abstract**
Mental health issues are alarmingly prevalent in Pakistan and there is a need for attention to cultural nuances of mental disorders like depression and anxiety. This study explored the conceptualization, perception understanding, causes, solutions and consequences of youth, and medical and mental health practitioners regarding depression and anxiety in local Pakistani context. Data was collected through four focus group discussions (N=26). Results were grouped into five major themes: (1) conceptualization, (2) signs and symptoms, (3) risk factors (4) protective factors, and (5) awareness. The complex role of cultural, religious, environmental, social, educational, occupational, and familial factors was unveiled.

**Keywords:** Common mental health disorders, cultural perceptions, risk and protective factors, awareness, young adults

**Introduction:**
Youth act as a catalyst of evolution and are paramount to changing the dynamics of the world (Erskine et al., 2014; Sawyer et al., 2012). Increasing burden of mental health conditions like depression and anxiety among youth is debilitating their growth and performance (Sawyer et al., 2012). According to an estimation 16% disability adjusted life years could be attributed to mental health concerns globally in year 2019 (Arias et al., 2022). Depression is the second and anxiety is the sixth leading cause of Years Lost to Disability (YLD) (Ferrari et al., 2024; GBD 2021 Disease and Injuries collaboration, 2024). Around 70% of individuals exhibit mental health issues before they reach the age of 25 years (Kutcher & Venn, 2008; Kessler et al., 2005). Despite mental health concerns being evident in youth their voices are hardly ever been considered in conceptualization of mental health concerns and treatment (Lukoseviciute-Barauskiene et al., 2023; Meherali et al., 2021). There is need to include young person's voices in order to empower them to manage their needs, care, and treatment of mental health concerns (Lukoseviciute-Barauskiene et al., 2023; Bentley et al., 2014).

According to United Nations (2011), 91% of children and young people live in LMICs where they constitute 47% of their population as compared to 30% in developed countries (United Nations, 2011) Pakistan is one such developing country where the burden of mental health concerns is high among youth with very little research done. Pakistan being a developing country having limited resources carries more than 4% burden of mental health issues of the total disease burden of the country (WHO, 2024). Last few decades have witnessed a significant rise in mental health problems in Pakistani society due to frequent disruptions in social structures and the prevailing violence in the society (Gadit, 2005). Research indicates high levels of depression and anxiety experienced by general population in Pakistan. According to a study, around 27.4% individuals reported depression out of 2867 (Farooq et al., 2019). There are many sociocultural factors associated with depression and anxiety in Pakistan. These include illiteracy, female gender, the greater number of children, the practice of visiting faith healers, low level of education, financial issues, middle age of participants, relational conflicts, lack of social support and being a homemaker. Whereas, social support emerged as a protective factor against such disorders (Mirza & Jenkins, 2004). Further, exposure to traumatic events was found to be associated with severe mental health issues (Galea et al., 2003). Continuous exposure to violence and life-threatening experiences damaged the psychological health of individuals in general and influenced the Pakistani population in particular (Khalily, 2011). Pakistani youth are at an increased risk of experiencing mental health issues due to exposure to unique social and economic stressors and lack of adequate coping skills (Purgato et al., 2016).

Pakistan is among the top countries with a high ratio of young population (World Bank, 2021). Around 36 million people in Pakistan are in the age group of 20-24 years which forms 20% of the total population (Federal Bureau of Statistics Government of Pakistan, 2010; Islamabad Policy Research Institute, 2018). This age group is typically viewed as valuable human resource but due to growing insecurity, economic problems, disruption in social fabric and demographic transition this segment of the population is experiencing high levels of stress and anxiety and has become a highly vulnerable population group. For instance, 45.5% Pakistani medical students 45.5% (19 - 22 years age) experienced depression and anxiety symptom, which adversely affected their wellbeing and performance of youth (Hashim et al., 2014; Cheng & McCarthy, 2018). This has an appalling effect on the performance and increases suicide rates among youth; thus resulting in loss of the most productive human resource of Pakistan (Ahmed, et al., 2016; Khalily, 2011).

Youth have to face different challenges while going through several social roles on their way to growth and transition into an independent individual. (Malla et al., 2018 & Arnett, 2000). It has considerable impact on the mental health of youth (Weigle & Shafi, 2023). Recent changes in lifestyle and choices have made young adulthood an importance transitional phase with increased stressors. These include longer education, finding financial independence as early as possible and formation of stable romantic relationships (Gustavson et al., 2018; Arnett et al., 2014; Arnett, 2000). Mental health conditions such as depression and anxiety have been frequently associated with such life choices (Velten et al., 2018) thus making youth more prone to experiencing mental health problems.

As stated earlier, depression and anxiety are key concerns regarding mental health because of their long-lasting and influential impact (de Castro et al., 2023). Quantitative measures of the symptoms of depression and anxiety are highly comorbid and simultaneously co-occurring (Garber et al., 2016; Cole et al., 1998). Depression and anxiety also add significantly to the burden of general practice in medical and psychological settings (Kadam et al., 2001). These presentations are qualitative in nature when presented in a clinical setting and transformed into quantifiable terms for diagnostic and treatment purposes. In addition to this, despite the availability of many evidence based pharmacological and psychological therapies help seeking is low for depression and anxiety (Roness et al., 2004). Around 50% of the cases do not seek help (Heinig et al., 2021). On average there is 6 years delay between onset of anxiety and first contact with the professional help available (Heinig et al., 2021). This indicates that relevant treatment barriers have not been sufficiently understood and addressed. In this respect, research has frequently included the perspectives of professional service providers (Kadam et al., 2001).

The practitioner and research perspectives are primarily generated from the Western conceptualization of mental health conditions. Thus, ignoring the cultural nuances of how depression and anxiety are experienced in an indigenous context. Since help seeking is intertwined with sociodemographic (age, gender), need (severity and impairment) and enabling (knowledge and accessibility) factors of the sufferer, an indigenous conceptualization is imperative (Heinig et al., 2021). There is need to understand the perspectives, conceptualization and expectations of young adults that are end users of any service.

In conceptualization of any condition, cultural aspects play an important role. For instance, in collectivist cultures self is conceptualized as an extended self of family and kinship. This extended self is also reflected in presentation and attributed causes of depression (Benning, 2013). Similarly, research stresses the importance of including community and cultural protocols for conceptualization of mental health conditions (Nasir et al., 2021). Apart from cultural context, socioeconomic conditions play an important role in conceptualization of depression and anxiety (Freeman et al., 2016). As stated earlier, evidence has indicated that mental health concerns are a serious issue in developing countries (Leon & Walt, 2000). Despite this large amount of evidence, contextualization of this divide in accordance with indigenous circumstances is yet to be understood in depth. This is especially true for Pakistani youth considering their unique sociocultural profile (Khalily, 2011).

Thus, this study explored in depth the perspectives of youth as well as medical and mental health practitioners regarding conceptualization, perception understanding, causes, solutions and consequences of depression and anxiety among Pakistani youth. The study also explored role of family, religion, culture, gender and age.

**Methodology**

This qualitative study was conducted as part of a bigger study on development of indigenous guided self-help manual for reducing depression and anxiety as well as enhancing performance of Pakistani Youth. Focus group discussions (FGDs) were conducted to collect perspectives of youth (end users) and service providers (medical and mental health practitioners). The Institutional Ethics Review Committee (IREC) of Capital University of Science and Technology approved this study. Written informed consent was taken from all the participants. All FGDs were audio recorded and verbatim was transcribed by four team members. Each FDG lasted from 1 to 1.5 hours.

**Sample**

Participants were recruited through convenient sampling. The participants were invited to participate in the study through social media messages, through word of the mouth and invitations were sent to various universities, hospitals, research institutes and private clinics through email. Those who consented to be included in the focus groups were invited to participate, and all the FGDs took place within the university premises. Each FGD consisted of 8 to 10 individuals. The first FGD included seven young university students (above 17 years of age), the second FGD had eight working young individuals (above 17 years of age), the third FGD consisted of five medical practitioners (currently practicing), and the forth included six psychologists (currently practicing).

**Data Collection:**

A focus group guide containing open-ended questions was developed to maintain uniformity and comparability across FGDs. In each FDG, the discussions were moderated by a facilitator and a person taking notes. Three other team members were also present as observers throughout the FGDs. Before initiating FGD, written informed consents along with socio-demographic information were taken from the participants. Moreover, prior to commencing FGD, confidentiality regarding their information and data was assured. Participants encouraged to participate actively and were told that there were no right or wrong answers.

In the focus group guide, the initial few questions were about conceptualization and understanding of depression and anxiety. To inquire more, the symptoms of depression and anxiety were discussed. These discussions were followed by probing questions to elicit the responses from the participants. In addition to that, religious and cultural aspects were also considered and explored regarding depression and anxiety. Lastly, the participants were asked to suggest solutions and discuss consequences of depression and anxiety.
A team member and a facilitator also clarified the inconsistent, unclear and ambiguous responses of the participants, during and at the end of each FDGs session. Following each FGD immediate debriefing sessions were conducted with the team that allowed for early identification of potential issues and exploration of emerging outcomes and themes, which allowed for overlapping and new connections to specific aspect (e.g., demographic characteristics).

**Analysis**
FGDs audio recordings were transcribed and analysed using inductive thematic analysis. The audio recordings were played multiple times to obtain a sense of identification or familiarization with the data by three researchers. The verbatim transcription included all the speech in the audio exactly as spoken along with all pauses, and fillers (e.g., Umm, Uh, like). As all the discussions of focus groups were conducted in bilingual format hence, they were transcribed in bilingual format (Urdu and English). All transcriptions were proofread. The process of coding was initiated after thoroughly reading and reviewing the data. Line by line coding was done. Line by line coding of the transcriptions resulted in of 8312 codes.

For extracting themes researchers familiarized themselves with the data, broke the information into meaningful units for coding, identified similar patterns, common and recurring concepts in the data followed by clear and concise descriptions. Ultimately, the themes were reviewed, refined and merged for coherence and logical connection of the data. A thematic framework was developed in the form of a flow chart. The data of each focus group was shaded with a different colour, which aided in identification of the data relevant to a specific focus group. The main themes were identified in addition to subthemes and categories were also generated based on the transcribed data of the focus groups.

To facilitate extraction and remove redundant repetitions excel sheet was used. Similar codes in a focus group were merged within the focus group. For example, the repetition of the code "anxious" was repeated seven times, all of these similar codes were summed up into one code and the number of repetitions of each code in each focus group was written in front of the code by using parentheses. Later on, similar/ same codes were merged between the focus groups. For example, the number of repetitions of the code "anxious" in all the focus groups were added and total repetitions were mentioned in one code as "anxious (23)". The number 23 represented that the word anxious is repeated 23 times in the focus groups. These codes were shaded with blue colour to make them different from others to indicate that it is a summation of all codes from four FGDs. In the end, codes that were similar in nature or represented the same information in different words were also merged.

**Results**
This section presents an overview of the demographic characteristics of participants of four FGDs. This also presents the major themes emerged from FGDs.
Twenty-six participants were recruited for four FGDs. There were a total of seven females and eight males in FGDs conducted with young adults. Their age range was between 21 to 24 years. In FGDs conducted with medical and mental health practitioners there were nine females and two males. The detailed demographic information of each participant of FGDs is given in Table 1.1 – 1.4. Pseudonyms are used for the sake of maintaining confidentiality.

**Table 1.1** *Demographic Characteristics of FGD's young adult university student participants (N=7).*

| Name | Gender | Age in years | Education | Family System | Institute / Organization | Mental illness History |
|---|---|---|---|---|---|---|
| SA | F | 22 | BS English | Nuclear | Foundation University | Yes- No Details |
| SR | F | 22 | BS English | Nuclear | Foundation University | Yes- No details |
| AL | M | 22 | BS Psychology | Joint | NUML University | - |
| AI | F | 21 | BS | Nuclear | Riphah International University | Yes- my maternal cousin was suffering from some mental health issues. She is not going for treatment due to unsatisfactory responses/services. |
| MA | F | 23 | BS Psychology | - | NUML University | Yes- Grandfather had a memory loss issue. |
| HU | F | 21 | BS English | Nuclear | Foundation University | - |
| MR | F | 21 | BS Media | Nuclear | Riphah International University | Yes- paternal grandmother and her daughter (aunt) are suffering from depression. Grandmother is taking medication for depression. |

F= Female, M= Male

**Table 1.2** *Demographic Characteristics of FGD 2 consisting of Working youth (N=8).*

| Name | Gender | Age in years | Education | Family System | Profession | Mental illness History |
|---|---|---|---|---|---|---|
| AD | M | 20 | - | - | Call Centre | - |
| MA | M | 23 | BS Electronics | - | Real Solution Pvt | Yes- No details |
| HA | M | 21 | BS - CS | Joint | CSR | No |
| AR | F | 25 | MS Physics | Nuclear | Operation Lead | No |
| SH | M | 21 | BS - CS | Joint | CSR | No |
| RA | M | 22 | BBA | Nuclear | Private Builder | Younger brother suffering from epilepsy |
| AD | M | 24 | BBA | Nuclear | Digital Marketing and VA | - |
| AH | M | 23 | BS | Joint | Part-Time Job | - |

F= Female, M= Male

**Table 1.3**. *Demographic characteristics of participants in FGD 3 consisting of Medical Practitioners (N=5).*

| Name | Gender | Age in years | Profession | Experience | Family system | Specialization | Mental illness history |
|---|---|---|---|---|---|---|---|
| HI | F | 28 | Doctor | 3 years | Joint | Neurosurgeon | Yes, multiple relatives experienced depression financial stress, and heart issues (chronic disease), the most common reasons. |
| RA | M | 66 | **Acupuncture** | 29 years | Joint | Pain relief and psychological issues | No |
| SA | F | 63.5 | Doctor | 31 years | Nuclear | MBBS, Retire PWMO Gynae at DHQ | No |
| SO | F | 25 | Doctor | 1 year | Nuclear | General Practitioner | - |
| HA | M | 32 | Doctor | 8 years | Joint | Medical specialist | - |

F= Female, M= Male

**Table 1.4**. *Demographic characteristics of participants in FGD 4 consisting of Mental Health Practitioners (N65).*

| Name | Gender | Age in Years | Family system | Profession | Specialization | Experience in years | Mental illness history |
|---|---|---|---|---|---|---|---|
| AN | F | 30 | Nuclear | Psychologist | Counselling | 6 -7 | No |
| AM | F | 33 | Nuclear | Clinical Psychologist | Counselling | 12 - 15 | No |
| SA | F | 27 | Nuclear | Psychologist | Behavioral analyst | 6 | Maternal grandfather has dementia |
| NA | F | 29 | Joint | Psychologist | Teaching | 2 | No |
| AB | F | 32 | Joint | Clinical Psychologist /Psychotherapist | Speech, language & behavioral therapy, assessment & treatment for special children | - | Depression & anxiety |
| AQ | F | 35 | Nuclear | School psychologist | Counselling | 8 - 9 | One relative has substance induced psychosis |

F= female, M=male

All of the FGDs participants were educated and belonged to middle and upper socioeconomic class. Table 2 presents the major themes and subthemes emerged from FGDs.

**Table 2.** *High order themes and subthemes the emerged from four FGDs*

| Major Themes | Subthemes level 1 | Subthemes level 2 |
|---|---|---|
| 1. Conceptualization of Depression and Anxiety | _ | _ |
| 2. Signs and Symptoms of Depression and Anxiety | _ | _ |
| 3. Risk Factors/ Causes of Depression and Anxiety | 3.1 Educational & Occupational Factors | ***3.1 Educational & Occupational Factors*** |
| | 3.2 Social and Cultural Factors | 3.1.1 Stress or Pressure due to Studies |
| | 3.3 Biological Factors | 3.1.2 Stress of Job & Earning |
| | | 3.1.3 Part-time Job (or Call Center Job) & studies |
| | | 3.1.4 Management Issues |
| | | 3.1.5 Over burden |
| | | 3.1.6 Financial Issues |
| | | ***3.2 Social and Cultural Factors*** |
| | | 3.2.1 Social Interaction |
| | | 3.2.2 Psychological and Physical Abuse |
| | | 3.2.3 Criticism |
| | | 3.2.4 Adjustment Issues |
| | | 3.2.5 Role of Family (Parenting & Parenthood) |
| | | 3.2.6 Relationship Issues |
| | | 3.2.7 Comparison |
| | | 3.2.8 Age |
| | | 3.2.9 Use of mobile phone |

| Major Themes | Subthemes level 1 | Subthemes level 2 |
|---|---|---|
| | | 3.2.10 Gender |
| 4 Protective Factors of Depression and Anxiety | 4.1 Education with part-time Job | _ |
| | 4.2 Religion as a Protective Factor | |
| | 4.3 Coping | |
| | 4.4 Sharing and Expressing Emotions | |
| | 4.5 Role of Family | |
| | 4.6 Guidance and Support | |
| | 4.7 Therapeutic Interventions | |
| | 4.8 Medications | |
| | 4.9 Solutions | |
| 5 Awareness & Knowledge about Depression and Anxiety | 5.1 Role of Government | _ |
| | 5.2 Educated and Uneducated People | |
| | 5.3 Consequences | |

The major themes the emerged from FGDs are described in the preceding table 2 along with the main subthemes. Following is the brief description of themes and subthemes. Respondents' quotes are included in Roman Urdu. There was an overall difference in the way youth and practitioners expressed their concepts, and perceptions related to depression and anxiety. Youth were more focused on narrating stories and anecdotes or real life examples to explain their point of views. Practitioners were more focused on using professional terminology to express their understanding. However, their point of views were similar in many respects. Thus, an overall summary of themes is presented here.

Wherever there was difference in opinion of youth and practitioners, it is highlighted.

**1. Conceptualization of Depression & Anxiety**

Respondents' conceptualized *depression* in terms of holding on to past experiences and events that are painful and traumatic. According to their perspective, people often experience feelings of sadness or daily distress, which they identify as depression.

Respondents defined *anxiety* as a feeling of worry about their future, overwhelming automatic thoughts (uncontrollable) and excessive worries. It was understood that some level of anxiety is a normal response to stress. In addition to definition, respondents' mentioned about positive and negative anxiety. Respondents associated depression and anxiety as grow conflict between familial, relationships and cultural expectations and their modern view of the world and their life aspirations. The terms used for conceptualization of depression and anxiety by the youth were different from practitioners. Youth focused more on observable symptoms and situation based; such as, 'shut themselves in the house' or 'meet friends less often'. Whereas more textbook terms were used by practitioners.

**2. Signs & Symptoms of Depression & Anxiety**

The mentioned symptoms of *depression* were hopelessness, helplessness, restlessness, worthlessness, negative thoughts, negative feelings, lack of interest, insomnia, irritability, low energy, low mood, social withdrawal, disturbance in daily life functioning, suicide and self-harm. Others included lethargy, fatigue, joint pain, sadness, disturbed eating patterns, disturbed mental state, suicidal thoughts, denial, and decline in performance and motor activities, The reported symptoms of anxiety include nervousness, sweating, shivering, suffocation, panicking, panic attacks, feelings of anxiousness, stomach aches and body pain, decline in performance, joint pain, stomach pain, suicidal thoughts, mania & hypomania, psychotic symptoms like hallucinations, delusions and schizophrenia.

Again, here textbook terms were used by mental health practitioners. Medical practitioners used terminology for different mental disorders as symptoms for depression and anxiety. Youth used many of the technical terms for symptoms as layman terms to express their opinion. For instance, "panic", "nervousness', and "worry" were used interchangeably. "Daily distress" was used interchangeably with "being depressed".

**3. Risk Factors/ Causes of Depression & Anxiety**

For risk factors, youth were of the view that external factors primarily parents and societal standards are major contributors of depression and anxiety. Practitioners recognized that generation gap, communication gap and conflict in thinking and choices of youth is important. They focused more on biological factors, age and gender as risk factors whereas youth did not consider their factors.

**3.1. Educational & Occupational Factors**

***3.1.1. Stress or Pressure due to studies***

Respondents believed that many young students suffer from depression and anxiety due to their studies. Students' interest, academics (e.g., exams), professional choices, and career decisions significantly affect their mental health. Competition for high grades and GPAs lead towards depression and anxiety. They stated that in this competitive race, everyone is running for the "Battle of Best" for grades, job, degree, financial stability, etc. Respondents reported that, educational failure is the most common cause of depression and anxiety.

***3.1.2. Stress of Job/ Earning***

Young graduates face challenges for employment as they navigate the job market after degree and their struggle and continuous failure to get a job may lead to depression. Limited job opportunities with low income cause feeling of inadequacy, self-doubt and lack of confidence. People in jobs are predisposed to depression and anxiety if they switch

their jobs more often and due to workload. For instance participant's reported that:"*Job k sath tension hoti hai main ny parhna hai, udr job walon ka b kam karna hai, or jin k pass job nahi hai unko b tension hai ke mery pass job nahi ha humein job kesy mily gi, hum kia krin gy?both are suffering".* (English: With job its stressful that I have to study and on the other hand do work for employer. And those do not have job are also stressed that they do not have job. How will we get a job? What will be do? Both suffer). Participants also reported that in job setting inability to complete assigned tasks and targets resulted in depression and anxiety.

#### *3.1.3. Part-time Job (or Call Centre Job) & Studies*

University students are increasingly working at jobs like call centres, considering as last option to get part-time job. Call centre jobs are difficult and stressful, especially their hectic and demanding time schedule. Management of part-time job alongside studies becomes a challenge for students, as it may affect their academic performance.

#### *3.1.4. Management Issues*

Unable to manage duties and responsibilities is exhausting, such as studies, job, daily life activities, and relationships. Participants viewed that males are more stress as males face more challenges while managing, because they have to carry burden of responsibilities due to assigned role of male gender in the society.

#### *3.1.5. Overburden*

Overburdened due to study and job negatively impact students' physical and mental health (disturbed eating and sleeping patterns).

#### *3.1.6. Financial Issues*

People struggle for needs and desires as a consequence of financial crises. Individuals with strong financial family background face fewer obstacles in their career building as compared to those with weak financial family background.

### 3.2. Social & Cultural Factors

Many social and cultural factors were identified as causal factors including chronic illness, lack of motivation, adverse life events, parents separation, financial responsibilities, stressful working environment, adjustment issues, expectation from society, social status, controlled environment and socio-economic status. Others identified reasons included domestic violence, violence, trauma, vulnerability of specific gender roles, age, and biological factors, genetics and biochemical reasons. Some of these are explained in detail in the following subthemes.

#### *3.2.1. Social Interaction*

Respondents described, how social interaction influence people positively and negatively such as experiencing bullying, criticizing, negative judgment, and excessive jealousy from peers and friends which in turn leads to mental health concerns. The continuous efforts to be socially acceptable and fear of being judged and left out in their rapidly evolving social world are perceived as most prominent factors of stress. It becomes even more stressful if their families not approve of their adopted social trends which results in depression and anxiety.

#### *3.2.2. Psychological Abuse and Physical Abuse*

Respondents indicated that humiliation, criticism, bullying, leg pulling, back biting, body shaming, and labelling adversely impact mental health, leading to isolation, low self-esteem, anxiety, depression, and other serious emotional challenges. Stigmatizing and labelling of individual suffering from mental health concerns as *"Pagal hai"* (mental case) also negatively impact youth. Many respondents reported that abuse, child neglect, child abuse and sexual abuse are important to be known for identifying the reasons of depression and anxiety.

#### *3.2.3. Criticism*

Criticism in personal and professional life builds numerous hurdles in the way to achieve targeted goals. When an individual fails to achieve a goal, the failure leads to stress and depression. Parents and teachers should strive to understand children instead of criticizing them (e.g., a child facing difficulty in academics faces criticism from family and teachers). Academic difficulties were labelled as "low IQ" by the participants.

#### *3.2.4. Adjustment Issues*

It was reported that while changing to a new environment people face adjustment challenges, prompting comparisons with stable individuals and developing self-doubt about achieving stability like others. In such cases, they develop psychological issues like lack of self-confidence, boundary issues, communication gaps and feeling of isolation that constitute their depression and anxiety.

#### *3.2.5. Role of family (Parenting & Parenthood)*

Respondents reported that lack of appreciation and affection from surroundings has a negative impact on an individual's mental health. Individuals experience depression and anxiety when parents have high expectations and impose their decision without considering their children's opinions. In addition to these lack of understanding and acknowledgement, controlling or abusive parenting style, and separation and abusive relationship among parents also contributes to individuals mental health.

***3.2.6. Relationship Issues***

Information extracted from the respondents' showed that family issues and love stories (romantic relationships) are a common concern among youth that causes depression.

***3.2.7. Comparison***

*Comparison* among children is a major risk factor for depression and anxiety that comes from parents and society. Respondents also reported that comparison results from peer pressure and societal pressure that certainly cause mental health challenges that can lead to depression and anxiety.

***3.2.8. Age***

In the FGDs, it was identified that *age* is an important factor contributing to depression and anxiety. Individuals at the age of 18-25 years are more vulnerable to stress, anxiety and depression. According to practitioners, people are more affected by depression and anxiety at the age of late teens and mid-twenties. It was also notified that people can be affected by depression at any age. Practitioners recognized anxiety to be very common in teenagers. It was also discussed that at the age of 16-25 years their learning and social interaction increase and they strive to become stable in their life.

***3.2.9 Use of Mobile Phone***

Respondents also stated that youth are suffering more from anxiety due to excessive use of mobile phones. Its use is consuming most of their time and also leads them to unreal expectations and social comparisons.

***3.2.10 Gender***

Practitioners reported that the vulnerability of both genders is due to different type of factors associated with their gender roles. Majority of practitioners reported that males are considered to be more vulnerable because they have to earn money and support their families, whereas females do not have such responsibilities. Few practitioners said that both genders are equally vulnerable to depression and anxiety. Practitioners reported that biases in terms of gender roles and stigmas related to genders like men do not cry and associated taboos results in depression and anxiety.

**3.3. Biological factors**

*Genetics and biochemical factors* are one of the major factors reported as cause of depression and anxiety. Others include chronic illness and medical diseases (malignancy and carcinoma disease). This was only discussed by practitioners.

**4. Protective Factors of Depression and Anxiety:**

**4.1. Education with Part-Time Job**

Where at one point part time job was considered as risk factor its beneficial role was also recognized. According to the participants of FGDs part-time job with studies is beneficial for students as it will provide opportunities for both professional and personal development and also provide financial support. All of these serve as protection against mental health concerns. Thus, an ambivalent perspective about part-time jobs with education was presented.

**4.2. Religion as a Protective Factor**

According to respondents, religion is one of the strongest protective factors as it gives multiple ways to deal with negative thoughts and hopelessness. Participants reported that religion is very effective in preventing suicidal thoughts and behaviour as these are prohibited in Islam. One of the respondents believed that "Religion serves as a protective factor only for those who practice it wholeheartedly."

**4.3. Coping**

Common coping strategies identified by the respondents included crying alone, talking to friends, watching movies, book reading, journaling, and diverting the mind into other daily life activities.

**4.4. Sharing & Expressing Emotions**

This subtheme outlines the importance of sharing with parents, spouse and friends. It was also reported that sharing with strangers also helps individuals. The respondents also emphasized the importance of expression of emotions. They reported that the ways of expression may vary from person to person but they are helpful in preventing mental disturbances.

**4.5. Role of Family**

Family plays an important role in the indication and protection of depression or anxiety. Respondents mentioned that parents should keep their eye on their children, and they should give them confidence to resolve their issues e.g., body shaming, bullying etc.. Similarly, they reported that, when a spouse is supportive, the life of the working individual becomes easy.

**4.6. Guidance & Support**

Social gathering defines and builds a person's character. A good friend circle will be supportive and helpful in coping with many issues. Guidance and support empower an individual to navigate through hardships and alleviate themselves through effectively managing difficult mental situation.

**4.7. Therapeutic Interventions**

This subtheme focused on role of seeking professional help if the issues are not resolved at initial steps of sharing and expressing. Along with that an individual's willingness and determination for treatment play a significant role. Respondents also mentioned counselling as more effective than medication but in severe cases both are required. Furthermore, FGDs revealed high demand of counselling services at basic level for parents and students at educational institutes. They reported that the dilemma is dissatisfaction regarding treatment with therapy; their preference is for medication and injections. Additionally, it is reported that they are not getting quality services from mental health professionals (judgemental, novice & unprofessional). Respondents stressed these factors should be considered prior to delivering therapeutic treatment. Practitioner may pay heed to incorporating cultural, family and social dynamics.

**4.8. Medication**

It was revealed from the discussion that people use self-medication e.g., sleeping pills to reduce stress and tension. Participants believed that medications are helpful when prescribed accurately. Furthermore, they clarified that long-term use of medication leads to addiction. It was reported that people ask for medication for their mental health issues when they visit psychologist, they prefer pills over talk therapy.

**4.9. Solution**

The main solution reported in FGDs were avoiding overthinking, engaging in different activities, treatment of chronic physical conditions, using coping like music, adopting healthy life style, increasing social interaction. It was recommended to avoid overthinking. However, no specific targeted actions or activities were recommended for avoiding over thinking.

**5. Awareness and Knowledge about Depression & Anxiety:**

**5.1. Role of Government**

It was suggested that the government should facilitate and support to promote awareness about mental health issues. Thus, a state level action was recommended to bring an effective change. This was primarily stressed by the practitioners.

**5.2. Educated and Uneducated People**

FGDs illustrated the influence of education on people's thinking, perception and behaviour. It is believed that an educated person has more awareness about mental illness, most of the time they seek help once they identify that they are suffering from any mental health issue. Apparently, educated people report more about mental health problems as compared to uneducated one. However, respondents believed that the rate of suicide is higher in educated people than in uneducated people.

**5.3. Consequences:**

Participants of FGDs reported that people suffering from depression are unable to perform effectively in their daily life activities, education, and occupation. Depression and anxiety affect in many ways like behavioural dysfunctions, issues in personal and professional life; and cause low confidence, aggression, low interest, and poor decision-making. Suicide and/or self-harm are the result of severe depression. They also elaborated that suicidal ideation or self-harm is the last stage of depression.

**Discussion**

The aim of this study was to explore definitions, perceptions, understanding, causes, solutions and consequences of depression and anxiety among Pakistani population. Other vital factors explored in this study included role of family, religion, culture, gender and age.

The obtained data of FGDs was structured into five major themes: conceptualization, signs and symptoms, risk factors, protective factors, and awareness about depression and anxiety. The results of this research study provided valuable information from respondents' insights and show complex underlying role of cultural, religious, environmental, social, educational, occupational, and familial factors that contribute to the development and exacerbation of depression and anxiety.

Different regions and cultural backgrounds influence how people perceive and understand symptoms. Culture plays a significant role in formulating the conceptualization of CMDs (Selim, 2010). Similarly, FGDs conducted in Pakistani context reflected the cultural evolution and its effect on experiencing depression and anxiety.

In FGDs, commonly reported psychological symptoms of depression included sadness, lack of social interaction, negative feelings, hopelessness, helplessness, worthlessness, social withdrawal or isolation, irritability, disturbed daily functioning, decline in performance and lethargy. Somatic symptoms were decline in motor activities, fatigue, body pains, joint pain, stomach pain, insomnia, while specified intense depressive conditions or symptoms were suicidal thoughts, mania and hypomania. Psychotic symptoms like hallucinations and delusions were mentioned as schizophrenia. Beginning of early stage of depression was recognized as people continuously report that they are sad. Most of the symptoms mentioned here constituted universal elements of depression and anxiety and thus are reported in existing literature as well. (e.g., Mirza & Jenkins, 2004; Galea et al., 2003).

The symptoms reported in FGDs are similar to those reported in other studies. For example, a qualitative research study was conducted to explore the understanding of depression and anxiety, the identified common symptoms of depression were low mood, lack of interest, negative thinking, isolation, social withdrawal, lethargy, worthlessness, disturbed sleeping patterns, low self-esteem, low motivation, disturbed eating patterns, suicidal thoughts and disturbed daily functioning

(e.g., difficulty in attending university). The additional symptoms that were not conversed in FGDs of the present study are dysphoria, poor self-care and difficulty in leaving home (Bear et al., 2021).

The symptoms of anxiety extracted from FGDs were nervousness, panic attack, shivering, sweating, anxiousness, aches, phobias, nausea, and palpitation. Similarly, Bear and colleagues (2021) reported that common anxiety symptoms comprised of irrational thoughts, overthinking, sweating, shivering, nausea, palpitation, difficulty in breathing, low-self, and isolation, self-harm, loneliness, and other.

In FGDs, multidimensional causation of depression and anxiety was attributed to educational, occupational, social, cultural, and biological factors. Our study also identified that the current issues of Pakistani youth are related to academics particularly exams, competition, high grades, criticism, labelling, bullying, back biting, leg pulling, body shaming, comparison, neglect, abuse, sexual abuse, child abuse, These results are similar to Chew-Abdullah and colleagues' qualitative study (2023) conducted on the impact of culture and religion on anxiety. Childhood trauma, adverse life events, stress, parental neglect, and poor parenting were the environmental factors that increased the probability of depression and anxiety (Kalin, 2021). Similar to Georgakakou-Koutsonikou and Williams (2017) in the present study youth was aware of causal factors leading towards depression and anxiety.

It must also be noted here that the medical practitioners lacked an understanding of depression and anxiety and were not successful in distinguishing it from other more severe mental health conditions. Thus, they used names of different disorders to explain symptoms of depression. Thus, a requirement for training of medical professionals to recognize referral needs for mental health treatment is called for by the results of this study.

A systematic review and narrative meta synthesis on conceptualization of depression among children and youth based on thirty-six quantitative and qualitative research studies depicted that 50% youth are able to identify depression. It was also found that the recognition of depression increased due to manifestation of severe symptoms (e.g. suicide) (Georgakakou-Koutsonikou & Williams, 2017). In the present study, results of FGDs with youth showed that young people were able to recognize depression and anxiety accurately. However, the expression of these symptoms through storytelling and using anecdotes is a cultural specificity. Thus, it is concluded here that the symptoms of depression and anxiety are identifiable by youth however, their expression vary in accordance with Pakistani cultural context.

Protective factors for depression and anxiety including religion, coping, sharing and expressing emotions with family and peers, therapeutic interventions, and solutions were identified. Role of religion was stressed in the discussions. Existing research indicates that religious practices help in building strength, resilience, and motivation, hence they act as protective factor and coping mechanism for depression and anxiety (Chew-Abdullah, et al., 2023; Kasi et al., 2012).

**Limitations**

There are several limitations of the study. Firstly, as mental health is a stigmatized in Pakistan the responses of participants might be affected by social desirability bias. An effort was made to neutralize this by adopting a neutral approach (tone and words) by the facilitator. Secondly, selection bias may have operated in gauging the opinions of the participants as convenient sampling was employed in participant recruitment. Those participants who were more aware or more concerned about mental health issues were more likely to participate. Hence, the results of the study are not generalizable to general public. Nevertheless, the information obtained was coinciding with existing literature; that is indicative of minimal selection bias. Thirdly, the sample was homogenic in terms of participant socioeconomic background. All of the participants were educated and belonged to middle or upper class. Future research endeavours may include more heterogenic sample.

**Conclusion**

This study highlighted indigenous as well as universal components of conceptualization and determinants of depression and anxiety. A total of five themes with 14 main subthemes emerged. Findings from this study suggest that psychoeducation programs and awareness among public is useful for timely identification of mental health issues and act as an encouragement to seek professional help. Such endeavours also help in increasing knowledge among general public (Matsubayashi et al., 2014; Iglhaut et al., 2024; Beldie et al., (2012). In accordance with the results of this study, there is dire need for psychoeducation programs not only for youth but also for medical practitioners. Many of the young adult participants used technical terms to discussion depression and anxiety. Thus, it is emphasized to consider cultural conceptualization of depression and anxiety for avoiding false positive and false negative cases. Considering the awareness level of youth and their ability to recognise symptoms of depression and anxiety as well an effort to suggest coping strategies, self-help interventions can be utilized for improved and easy access to mental healthcare. Thus, based on the codes and themes generated through FGDs in this study an intervention is designed for reducing depression and anxiety as well as enhancing performance and wellbeing of youth. The process of development of this intervention and its effectiveness are presented in other articles. Lastly, a need for a sound training program for mental health practitioners and licensure is also identified for quality service provision and reduction in barrier to accessing mental health services.

**Declaration:** We confirm that the manuscript has been read and approved by all the authors. The requirements for authorship as stated earlier in this document have been met, and that each author believes that the manuscript represents honest work.

**Authors' contribution SH:** Conceptualization; data curation; formal analysis; investigation; methodology; writing – original draft; writing – review and editing.

**NS:** data curation; data analysis; investigation; writing – original draft; writing – review and editing. **MK:** Conceptualization; data curation; data collection; project administration **TF:** Conceptualization; data curation methodology; data collection, writing – review and **IY:** project administration; resources, data collection

**Ethical policy and institutional review board statement:** The study was approved ethically by the Institutional Ethical Review Board at Capital University of Science and Technology (reference no CUST/ORIC/IERC 2023-03).

**Declaration of patient consent:** The authors certify that they have obtained all appropriate consent forms. In the form the participant(s) have given his/her/their consent for his/her/their information to be reported in the journal. The participants understand that their names and initials will not be published, and due efforts will be made to conceal their identity.

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## REFERENCES

1. Ahmed, B., Enam, S. F., Iqbal, Z., Murtaza, G., & Bashir, S. (2016). Depression and Anxiety: A snapshot of the situation in Pakistan. International Journal of Neuroscience and Behavioral Science, 4(2), 32–36. https://doi.org/10.13189/ijnbs.2016.040202
2. Arias, D., Saxena, S., & Verguet, S. (2022). Quantifying the global burden of mental disorders and their economic value. EClinicalMedicine, 54, 101675. https://doi.org/10.1016/j.eclinm.2022.101675
3. Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. American Psychologist/˜the œAmerican Psychologist, 55(5), 469–480. https://doi.org/10.1037/0003-066x.55.5.469
4. Arnett, J. J., Zukauskiene, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18–29 years: implications for mental health. ˜the œLancet. Psychiatry, 1(7), 569–576. https://doi.org/10.1016/s2215-0366(14)00080-7
5. Chew-Abdullah, A., Olagoke, S. M., Razak, A. A., Perveen, A., Pang, N. T. P., Wider, W. & Abdullah, D. N. C. (2023). Influence of Culture and Religion on Anxiety Patients: A Qualitative Study in Sabah. Journal for ReAttach Therapy and Developmental Diversities, 6(1), 43–48. Retrieved from https://jrtdd.com/index.php/journal/article/
6. view/1178
7. Bear, H. A., Krause, K. R., Edbrooke-Childs, J., & Wolpert, M. (2021). Understanding the illness representations of young people with anxiety and depression: A qualitative study. Psychology and Psychotherapy, 94(4), 1036–1058. https://doi.org/10.1111/papt.12345
8. Beldie, A., Boer, J. a. D., Brain, C., Constant, É., Figueira, M. L., Filipčić, I., Gillain, B., Jakovljević, M., Jarema, M., Jelenová, D., Karamustafalıoğlu, O., Plesničar, B. K., Kovacsova, A., Látalová, K., Marksteiner, J., Palha, F., Pečeňák, J., Praško, J., Prelipceanu, D., . . . Wancata, J. (2012). Fighting stigma of mental illness in midsize European countries. Social Psychiatry and Psychiatric Epidemiology, 47(S1), 1–38. https://doi.org/10.1007/s00127-012-0491-z
9. Benning, T. B. (2013). Western and Indigenous conceptualizations of self, depression, and its healing. *International Journal of Psychosocial Rehabilitation, 17*(2), 129-137.
10. Bentley, N.; Hartley, S.; Bucci, S. (2009). Systematic Review of Self-Report Measures of General Mental Health and Wellbeing in Adolescent Mental Health. Clin. Child Fam. Psychol. Rev.**,** 22, 225–252.
11. Cheng, B., & McCarthy, J. M. (2018). Understanding the dark and bright sides of anxiety: A theory of workplace anxiety. Journal of Applied Psychology, 103(5), 537–560. https://doi.org/10.1037/apl0000266
12. Cole, D. A., Peeke, L. G., Martin, J., Truglio, R., & Seroczynski, A. D. (1998). A longitudinal look at the relation between depression and anxiety in children and adolescents. Journal of Consulting and Clinical Psychology, 66(3), 451–460. https://doi.org/10.1037/0022-006x.66.3.451
13. de Castro, F., Cappa, C., & Madans, J. (2023). Anxiety and depression signs among adolescents in 26 low- and middle-income countries: Prevalence and association with functional difficulties. Journal of Adolescent Health, 72(1). https://doi.org/10.1016/j.jadohealth.2022.03.022
14. Erskine, H. E., Moffitt, T. E., Copeland, W., Costello, E. J., Ferrari, A. J., Patton, G. C., Degenhardt, L., Vos, T., Whiteford, H., & Scott, J. G. (2014). A heavy burden on young minds: the global burden of mental and substance use disorders in children and youth. Psychological Medicine, 45(7), 1551–1563. https://doi.org/10.1017/s0033291714002888
15. Farooq, S., Khan, T., Zaheer, S., & Shafique, K. (2019). Prevalence of anxiety and depressive symptoms and their association with multimorbidity and demographic factors: a community-based, cross-sectional survey in Karachi, Pakistan. BMJ Open, 9(11), e029315. https://doi.org/10.1136/bmjopen-2019-029315
16. Federal Bureau of Statistics. Government of Pakistan. (2010). Labor force survey 2009-2010. Retrieved August 7, 2018. from http://www.pbs.gov.pk/content/labour-force
17. Ferrari, A. J., Santomauro, D., Aali, A., Abate, Y. H., Abbafati, C., Abbastabar, H., ElHafeez, S. A., Abdelmasseh, M., Abd-Elsalam, S., Abdollahi, A., Abdullahi, A., Abegaz, K. H., Zúñiga, R. a. A., Aboagye, R. G., Abolhassani, H.,

Abreu, L. G., Abualruz, H., Abu-Gharbieh, E., Abu-Rmeileh, N. M. E., . . . Ashraf, M. (2024). Global incidence, prevalence, years lived with disability (YLDs), disability-adjusted life-years (DALYs), and healthy life expectancy (HALE) for 371 diseases and injuries in 204 countries and territories and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. Lancet. https://doi.org/10.1016/s0140-6736(24)00757-8

18. Freeman, A., Tyrovolas, S., Koyanagi, A., Chatterji, S., Leonardi, M., Ayuso-Mateos, J. L., Tobiasz–Adamczyk, B., Koskinen, S., Rummel-Kluge, C., & Haro, J. M. (2016). The role of socio-economic status in depression: results from the COURAGE (aging survey in Europe). BMC Public Health, 16(1). https://doi.org/10.1186/s12889-016-3638-0
19. Gadit, A. A. (2007). Is there a visible mental health policy in Pakistan? JOURNAL PAKISTAN MEDICAL ASSOCIATION, 57(4). https://www.jpma.org.pk/
20. PdfDownload/1079.pdf
21. Galea, S. (2003). Trends of probable post-traumatic stress disorder in New York City after the September 11 terrorist attacks. American Journal of Epidemiology, 158(6), 514-524. https://doi.org/10.1093/aje/kwg187
22. Garber, J., Brunwasser, S. M., Zerr, A. A., Schwartz, T., Sova, B. S. K., & Weersing, V. R. (2016). Treatment and Prevention of Depression and Anxiety in Youth: Test of Cross-Over Effects. Depression and Anxiety, 33(10), 939–959. https://doi.org/10.1002/da.22519
23. Georgakakou-Koutsonikou, N., & Williams, J. (2017). Children and young people's conceptualizations of depression: a systematic review and narrative meta-synthesis. Child Care Health and Development/Child, Care, Health and Development, 43(2), 161–181. https://doi.org/10.1111/cch.12439
24. GBD 2021 Disease and Injuries collaboration. Global Burden of Disease Study 2021 (GBD 2021) Demographics 1950-2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2024
25. Gustavson, K., Knudsen, A. K., Nesvåg, R., Knudsen, G. P., Vollset, S. E., & Reichborn-Kjennerud, T. (2018). Prevalence and stability of mental disorders among young adults: findings from a longitudinal study. BMC Psychiatry, 18(1). https://doi.org/10.1186/s12888-018-1647-5
26. Hashmi, A. M., Aftab, M. A., Naqvi, S. H., Sajjad, W., Mohsin, M., & Khawaja, I. S. (2014). Anxiety and depression in Pakistani medical students: a multicenter study. Health Med, 8(7), 813-20.
27. Heinig, I., Wittchen, H., & Knappe, S. (2021). Help-Seeking Behavior and Treatment Barriers in Anxiety Disorders: Results from a Representative German Community Survey. Community Mental Health Journal, 57(8), 1505–1517. https://doi.org/10.1007/s10597-020-00767-5
28. Iglhaut, L., Primbs, R., Kaubisch, S., Koppenhöfer, C., Piechaczek, C., Keim, P., Kloek, M., Feldmann, L., Schulte-Körne, G., & Greimel, E. (2024). Evaluation of a web-based information platform on youth depression and mental health in parents of adolescents with a history of depression. Child and Adolescent Psychiatry and Mental Health, 18(1). https://doi.org/10.1186/s13034-023-00703-x
29. Islamabad Policy Research Institute. (2018). Pakistan's youth Bulge: Human Resource development challenges. Retrieved July, 27, 2018. From http://www.ipripak.org/
30. Kadam,
31. Kadam, U., Croft, P., McLeod, J., & Hutchinson, M. G. (2001). A qualitative study of patients' views on anxiety and depression. PubMed, 51(466), 375–380. https://pubmed.ncbi.nlm.nih.gov/11360702
32. Kalin, N. H. (2021). Anxiety, depression, and suicide in youth. ˜the œAmerican Journal of Psychiatry, 178(4), 275–279. https://doi.org/10.1176/appi.ajp.2020.21020186
33. Kasi, P. M., Naqvi, H., Afghan, A. K., Khawar, T., Khan, F. H., Khan, U. Z., Khuwaja, U. B., Kiani, J., & Khan, H. M. (2012). Coping Styles in Patients with Anxiety and Depression. ISRN Psychiatry, 2012, 1–7. https://doi.org/10.5402/2012/128672
34. Kessler, R. C., Berglund, P. A., Demler, O. V., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593. https://doi.org/10.1001/archpsyc.62.6.593
35. Khalily, T. (2011). Mental health problems in Pakistani society as a consequence of violence and trauma: a case for better integration of care. Int J Integr Care. 11, e128.pakistans-youth-bulge-human-resource-development-hrd-challenges/
36. Kutcher, S., & Venn, D. (2008). Why youth mental health is so important. PubMed. https://pubmed.ncbi.nlm.nih.gov/19242581
37. Leon, D. A., & Walt, G. (2000). Poverty, inequality, and mental health in developing countries. In Oxford University Press eBooks (pp. 247–262). https://doi.org/10.1093/acprof:oso/9780192631961.003.0012
38. Lukoseviciute-Barauskiene, J., Zemaitaitytė, M., Sumakarienė, V., & Smigelskas, K. (2023). Adolescent Perception of Mental Health: It's Not Only about Oneself, It's about Others Too. Children, 10(7), 1109. https://doi.org/10.3390/children10071109
39. Malla, A., Shah, J., Iyer, S., Boksa, P., Joober, R., Andersson, N., Lal, S., & Fuhrer, R. (2018). Youth Mental Health should be a top priority for health care in Canada. The Canadian Journal of Psychiatry, 63(4), 216–222. https://doi.org/10.1177/0706743718758968
40. Matsubayashi, T., Ueda, M., & Sawada, Y. (2014). The effect of public awareness campaigns on suicides: Evidence from Nagoya, Japan. Journal of Affective Disorders, 152–154, 526–529. https://doi.org/10.1016/j.jad.2013.09.007
41. Meherali, S., Punjani, N. S., Louie-Poon, S., Rahim, K. A., Das, J. K., Salam, R. A., & Lassi, Z. S. (2021). Mental health of children and Adolescents amidst COVID-19 and Past Pandemics: A Rapid Systematic review. International

Journal of Environmental Research and Public Health/International Journal of Environmental Research and Public Health, 18(7), 3432. https://doi.org/10.3390/ijerph18073432
42. Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: A Systematic Review.BMJ, 328(7443), 794. https://doi.org/10.1136/bmj.328.7443.794
43. Nasir, B., Brennan-Olsen, S., Gill, N., Beccaria, G., Kisely, S., Hides, L., Kondalsamy-Chennakesavan, S., Nicholson, G. C., & Toombs, M. (2021). A community-led design for an Indigenous Model of Mental Health Care for Indigenous people with depressive disorders. Australian and New Zealand Journal of Public Health, 45(4), 330–337. https://doi.org/10.1111/1753-6405.13115
44. Purgato, M., Gastaldon, C., Papola, D., Van Ommeren, M., Barbui, C., & Tol, W.A. (2016). Psychological and Social Interventions for the Prevention of mental Disorders in People Living in Low and Middle-income Countries Affected by Humanitarian Crisis. Cochrane Database of Systematic Reviews, 11. Doi: 10.1002/14651858.CD012417.
45. Roness, A., Mykletun, A., & Dahl, A. A. (2004). Help-seeking behaviour in patients with anxiety disorder and depression. Acta Psychiatrica Scandinavica, 111(1), 51–58. https://doi.org/10.1111/j.1600-0447.2004.00433.x
46. Sawyer, S. M., Afifi, R., Bearinger, L. H., Blakemore, S., Dick, B., Ezeh, A., & Patton, G. C. (2012). Adolescence: a foundation for future health. Lancet, 379(9826), 1630–1640. https://doi.org/10.1016/s0140-6736(12)60072-5
47. Selim, N. (2010). Cultural Dimensions of Depression in Bangladesh: A qualitative study in two villages of Matlab. Journal of Health, Population and Nutrition, 28(1). https://doi.org/10.3329/jhpn.v28i1.4528
48. So, M., Freese, R., & Barnes, A. J. (2023). Pushed out and drawn in: Exclusionary discipline, mental health, and protective factors among youth in public schools. Journal of School Health, 94(2), 128–137. https://doi.org/10.1111/josh.13405
49. Velten, J., Bieda, A., Scholten, S., Wannemüller, A., & Margraf, J. (2018). Lifestyle choices and mental health: a longitudinal survey with German and Chinese students. BMC Public Health, 18(1). https://doi.org/10.1186/s12889-018-5526-2
50. United Nations. (2011). World Population Prospects – The 2010 Revision. New York: United Nations.
51. Weigle, P. E., & Shafi, R. M. (2023). Social media and youth mental health. Current Psycchiatry Reports/Current Psychiatry Reports, 26(1), 1–8. https://doi.org/10.1007/s11920-023-01478-
52. World Bank Open Data. (2021). World Bank Open Data. https://data.worldbank.org/indicator/SP.POP.1564.TO.ZS?locations=PK
53. WHO. (2024). Pakistan. Retrieved April 30, 2024. From https://www.emro.who.int/pak/
54. pakistan-news/who-pakistan-celebrates-world-mental-health-day.html