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Is mental health contagious? Perspectives of lived experiences among Punjabi Patients in Pakistan

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Abstract

Objectives:

This study aimed to explore the common perspectives in favor and against mental illness being a communicable illness and describe the role of familial communicability and social communicability in transmitting mental illnesses among the sample.

Methods:

A descriptive qualitative design was used in the present study. Purposive sampling was used to gather data through in-depth interviews with registered patients (n=35) in the healthcare facilities of district Sialkot. Reflexive thematic analysis was used to analyze the data collected.

Results:

The results showed that the people who were in physical contact with individuals suffering from mental illnesses through caregiving, family dynamics, and social contact were proven to be at higher risk of vulnerability to mental ailments. The results were divided into three themes followed by their subthemes. The first theme was "Perspectives regarding the communicability of mental health" (Perspectives in favor of communicability of mental illness, Perspectives against

the communicability of mental illness). The second theme derived was "Familial communicability". The third theme drawn was the "Role of social forces in triggering mental illnesses" (Social Contact as a source of contagion, Family as a contagion, and Caregiving as a contagion).
Conclusion:
Mental health issues are seldom acknowledged and addressed in South Asian communities. The debate regarding mental illness being communicable has extreme potential if more empirical evidence surrounding the debate is achieved. This research will help raise awareness regarding the communicability of mental illness.
***Keywords**: Mental health, Contagious, Social communicability, Ecological communicability, Familial communicability, Traumas*

1. Introduction

Mental disorders are termed as non-communicable diseases by the World Health Organization (WHO). Still, there is a fragment of psychology literature that sheds light on the controversial debate of mental illnesses being communicable. As per the literature, mental illnesses can be communicated through three major pathways: ecological communicability, familial communicability, and social communicability. (Wainberg, et al., 2018).
An example of ecological communicability can be the direct relationship between urban living and psychotic disorders. As per a study conducted to understand the role of the urban environment in increasing psychotic disorders, it was found that children who tend to grow up in the urban environment are more likely to fall prey to psychotic disorders (Wainberg, et al., 2018). The reason can be the complexity of the urban setup. Urban lifestyle is difficult to cope with due to factors like competition, maintaining a standard of living, social isolation, etc. These factors added to the pressure to live up to the urban lifestyle give rise to symptoms of depression, anxiety, and stress, which in the long term turn into psychotic disorders. (Heinz, Deserno, & Reininghaus, 2013). A study conducted in three major cities in India found that rapid urbanization has given rise to urban isolation, mainly because of the factor sociability; less social interaction causes psychotic symptoms and cognitive problems (Ali & George, 2022). Another study found that people who have less social interaction in addition to a small living space are likely to experience mental health issues, such as psychotic symptoms (Allé & Berntsen, 2021).
Familial communicability is the major cause of psychiatric disorders (Koschorke et al., 2021). There is a familial component to nearly all the main psychiatric disorders, which may be impacted by shared environmental factors, genetics, or both (Ali, et al., 2021). Disorders like schizophrenia and autism have a hereditary prevalence rate of 11-3 % and1-2% respectively (Zheng et al., 2018). Depression and anxiety have a prevalence rate of 4.67% and 7.30%, respectively, and their heritability rates are 0.37-0.67 and 0.32-0.49, respectively (Shao et al., 2020). According to the research conducted on infant neurodevelopment, it was discovered that there is a strong relationship between a child and his/her social experiences (Ilyka et al., 2021). The stressors in both children and parents greatly contribute to brain development (Fitter et al., 2022). Neurological development is impacted by stress and trauma experiences, and the quality and nature of the social environment in which the child is being brought up influences' psychological growth. (Newman, et al., 2016).
Studies conducted in HICs and LMICs show evidence of mental illnesses being communicable. (Ramchandani, et al., 2008), (Velders, et al., 2011; Hadley, Tegegn, Tessema, & Asefa, 2008). As per a study conducted in the Netherlands on the impact of prenatal and postnatal depression on

the emotional stability of children, it was found that parental depressive symptoms amplified the risk of depressive disorders, leading to behavioral problems among the children. (Velders, et al., 2011). In LMICS, it was found that postnatal depression adversely affects the mental development of children, leading to physical and psychological developmental delays. (Patel, DeSouza, & Rodrigues, 2003;Hadley, Tegegn, Tessema, & Asefa, 2008).

According to a study on the effects of COVID-19 on the mental health of individuals, it was confirmed that the pandemic played a pivotal role in spreading mental illnesses across peers, caregivers, and family members. Precautionary measures like social distancing, quarantine, and lockdown subjected people to limited social activity and interaction, leading to depression and other psychological disorders (Choi et al., 2022).

Another factor that can make mental health communicable is the family structure (Lawrence & Adebowale, 2023). Single parents face various challenges that can affect their mental health negatively. Studies showed that single parents experience anxiety, social isolation, depression, and suicidal ideation, which can have adverse effects on the mental health of their children (Kim et al., 2023). As per a study, 11% of children with ADHD have single/Divorced families (Behere et al., 2017). Similarly, in Australia, a high prevalence of mental disorders was found in children of single parents as compared to children living in traditional families (Perales et al., 2017). The reasons for negative effects on mental health can be instability, stress, and lack of support (Schneiderman et al., 2005). Stress and instability affect the cognitive, emotional, and social development of a child and lead to depression, anxiety, and other disorders (Sandstrom & Huerta, 2013). Furthermore, a study conducted on Swedish children found that children from single-parent families are also prone to bullying, peer pressure, and academic difficulties that can also affect their mental health (Låftman et al., 2017; Lawrence & Adebowale, 2023). Moreover, the literature reveals that these childhood traumas were associated with low self-esteem, depression, and anxiety (Downey & Crummy, 2022).

Social communicability finds its roots in social psychology. Emotion contagion is a social psychology concept that asserts the notion that one person's emotion and subjective behavior may have an impact on others through conscious or unconscious channels (Reisenzein, 2022). An example can be visiting a funeral, which may invoke feelings of sadness in a person. Sensitivity to emotion contagion varies from person to person, as some people are likely to be more severely affected by social emotions than others. (Sonnby-Borgström, 2002) Emotions like happiness, sadness, anger, and anxiety may be socially contagious. However, negative emotions have a higher rate of transmissibility among strangers than among peers (Chuai & Zhao, 2022; Prikhidko et al., 2020). Recent studies show that people with high levels of emotional contagion ought to be more susceptible to traumatic events, which may lead to elevated anxiety levels (Trautmann, et al., 2018).

In recent years, a growing literature focusing on understanding the influence of social factors on psychological variables has been added to the research on social determinants of illness. Obesity, smoking habits, happiness, and loneliness have all been shown to spread through interpersonal and social connectivity over time in recent research (Holt-Lunstad, 2018; Leavell et al., 2019). It's critical to understand the differences between three processes (1) induction, in which one person's depression results in depression in peers (2) homophily, in which a person chooses his/her friends to share his/her trauma; or (3) confounding, in which connected people are exposed to the same situation at the same time (such as an economic crisis or general atrocities) (Humenny et al., 2021; Tam et al., 2023). These processes show a social linear structure as to

how social forces lead to depression among peers, neighbors, family members, coworkers, etc (Carrington, Scott, & Wasserman, 2005).

The developed countries have a fair recognition of mental illnesses and their odious consequences, but people residing in developing and culturally sensitive countries like the Middle East and Southeast Asia face severe impediments in seeking treatment and support related to mental illnesses. The inhabitants of these societies have been trained to disregard any ailments that are not bodily obvious or tangible. The people are also stretched mentally by the social and cultural strain, which adds to their psychological discomfort. Coping techniques from religion and culture have been used to ease suffering (Sahira, Fatima, & Yumna, 2021). A study conducted in Qatar confirmed the role of social stigma leading to negative social and cultural consequences as the major cause of people not seeking treatment for their mental illnesses. This led to people opting for cultural and religious alternatives, such as religious and cultural healers, etc. (Stirling, Hickey, Omar, & Kehyayan, 2019)

The research study is conducted in one such country.

Mental Illnesses in Pakistan: An Exemplar of Developing Countries.

In Pakistan, there is no established cultural standard regarding mental illnesses in general. Non-physical ailments are treated as stigmas and taboos in Pakistani society, which places little value on them. It has a greater rate of mental health problems than the West (Noreen, et al., 2020). An alarming incidence of 34 percent is reported by a mean estimate of the prevalence of anxiety and depressive disorders. Only 0.4 percent of health spending in Pakistan is given to mental health, according to the World Health Organization's Assessment Instrument for Mental Health Systems (WHO AIMS) from 2009. Despite such alarming figures, there are only 3729 mental health facilities, only 5 mental hospitals with a total of 5056 beds, and 342 psychiatrists (Hashmi & Saleem, 2020). As per a study conducted in Pakistan on the factors that hinder psychiatric/psychological treatment behaviour, it was found that people are subjected to social and cultural stigmas leading to social isolation and discrimination, limited growth opportunities, negative image portrayal, etc. Moreover, people in the Pakistani community are more inclined towards cultural and religious alternatives like traditional healers and the use of amulets and holy water. etc. (Ahmad & Koncsol, 2022)

This study determines the common perspectives in favor and against mental illness being a communicable illness or not, the diverse perceptions regarding familial communicability, and the role of social forces in the communicability of mental illnesses. The study explored the concept of social factors being pivotal agents in transmitting mental disorders. The concept of mental illness being a communicable disease is seldom highlighted in psychology literature. Pakistan, being a developing country, is still opening doors to the importance and necessity of addressing mental health problems. The present research is the first of its kind in Pakistan surrounding the debate regarding whether mental illness is communicable or not.

Aim/Objectives

The purpose of this study was to investigate the lived experience of the communicability of mental illnesses from the perspectives of Punjabi Patients with mental illness in Pakistan. More specifically, this study aimed to (1) explore the common perspectives in favor and against mental illness being a communicable illness or not, (2) describe the role of familial communicability and social communicability in transmitting mental illnesses among the sample.

2. Materials and Methods

2.1 Study design

A descriptive qualitative design with thematic analysis was employed to explore the various perspectives and illness experiences of the patients regarding the communicability of mental illnesses and how they describe, understand, and perceive the notion of mental illnesses being communicable.

2.2 Study setting

This study was conducted at two psychiatric healthcare facilities located in the district of Sialkot, Punjab, Pakistan. The hospitals are referred to as" Public healthcare facility" and "Private healthcare facility" in the study to ensure anonymity. Psychiatric staff serving in the two facilities were used to reach these patients. A single interview guide was drafted for all the respondents. The research included individuals with any diagnosis who met the inclusion criteria and were willing to participate.

2.3 Sample

Purposive sampling was used to choose the respondents. A total of 35 (n=35) respondents were selected to be interviewed. The maximum variation in the sample size was ensured by selecting patients of different ages, education, and clinical diagnoses. The sample size consisted of people who were registered as patients with psychological distress in their respective health facilities. This sampling approach also allowed for data saturation, in which the interviews ended when the ability to obtain new information was exhausted. Patients in the two healthcare facilities belonged to similar cultures with different religious beliefs. The patient's cultural and religious affiliations were primary influencers in shaping their perspectives and treatment-seeking decisions.

Table 1: Demographic Profile of Respondents

Respondent Code	Age Bracket	Healthcare Facility	Educational level	Clinical Diagnosis
R1	15-30	Public	Graduation	Depression
R2	15-30	Public	Primary Level	Depression
R3	31-50	Public	Elementary Level	Generalized Anxiety Disorder
R4	15-30	Public	Primary	Depression
R5	31-50	Public	Graduation	Panic Disorder
R6	15-30	Public	No education	Generalized Anxiety Disorder
R7	51-70	Public	Primary	Panic Disorder
R8	31-50	Public	No education	Depression/ Panic Disorder
R9	31-50	Public	Graduation	Depression
R10	51-70	Public	No education	Panic Disorder
R11	51-70	Public	No education	Generalized Anxiety Disorder
R12	51-70	Public	Primary	Generalized Anxiety Disorder
R13	15-30	Public	Elementary	Panic Disorder
R14	51-70	Public	Graduation	Depression
R15	31-50	Public	Graduation	Panic Disorder
R16	51-70	Public	Primary	Generalized Anxiety Disorder
R17	15-30	Public	Primary	Panic Disorder
R18	15-30	Public	Primary	Obsessive Compulsive Disorder

R19	51-70	Private	No education	Generalized Anxiety Disorder
R20	31-50	Private	Graduation	Obsessive Compulsive Disorder
R21	31-50	Private	Graduation	Obsessive Compulsive Disorder
R22	51-70	Private	Graduation	Depression/ Generalized Anxiety Disorder
R23	15-30	Private	Elementary	Depression
R24	31-50	Private	No education	Depression
R25	31-50	Private	Elementary	Generalized Anxiety Disorder
R26	15-30	Private	Primary	Panic Disorder/OCD
R27	15-30	Private	No education	Panic Disorder
R28	31-50	Private	Primary	Depression
R29	51-70	Private	Elementary	Depression
R30	15-30	Private	Graduation	Generalized Anxiety Disorder
R31	31-50	Private	Elementary	Depression
R32	51-70	Private	Graduation	Panic Disorder
R33	31-50	Private	No education	Generalized Anxiety Disorder
R34	15-30	Private	Primary	Panic Disorder
R35	51-70	Private	Elementary	Depression

2.4 Inclusion criteria

Patients were included in the study if they were (1) clinically diagnosed with psychological distress, (2) registered patients at the targeted healthcare facilities, (3) seeking treatment, and (4) had a severity of their psychological distress ranging from moderate to severe.

2.5 Interviews

After the ethical approval, the data were gathered between 21st April’2023 and 21st June 2023, during which numerous earlier trips to the target locations were made to distribute consent forms, and interviews were done during the later visit (the interview guide is attached as Appendix 1). Keeping in mind the confidentiality of the illness and the cultural taboos prevalent in the area, interviews were done via telephone or in-person outside of the target site, depending on the respondent's availability. The data was gathered from the respondents through in-depth interviews. The interview lasted between 30 to 50 minutes, and the medium of communication was bilingual (Urdu and English), depending on the respondents' comfort level. The respondents were informed of the research's aim and purpose before the interview. With the respondents' permission, the interviews were taped using a mobile device. They were made sure that their confidentiality would be maintained and that the interview would solely be used for research.

2.6 Analysis

The data collected was then transcribed and translated into English. Relevant themes were derived from the collected data using reflexive thematic analysis (Braun & Clarke, 2006). Coding was accomplished by combining fragments of text that were all about the same topic. Each theme included various viewpoints from respondents who belonged to the same group, i.e., patients who had experienced psychological imbalances throughout therapy. Themes and subthemes were later examined, amended, rejected, or substituted based on negotiations and comparisons with the original data set. A total of 39 codes were categorized, then separated into subthemes, and finally into three thematic areas. To explain and extend the theme, important quotes from these responders have been quoted directly in English. Pseudonyms were employed

to protect the respondents' privacy, as they had been informed. Researchers employed the naturalistic inquiry method of trustworthiness as an evaluation criterion for confirming the credibility of the data set. This was used to get a deeper understanding of the lived experiences of the respondents to ensure full representation of their opinions. (Ann Cutler et al., 2021; Braun & Clarke, 2006; Morrow, 2005).

3. Ethical Consideration

The study was approved by the Ethical Review Board of Bethania Hospital, Sialkot, Pakistan (Reference no: BHS-MH-23-003). Additional permission/approval was obtained from the administration of the targeted healthcare facilities. Informed verbal consent was taken from all the respondents before the interviews. Respondents were informed that their participation was voluntary, and their participation or withdrawal at any time from this study did not interfere with their treatments and/or follow-ups, and without any negative consequences as well.

4. Results

Psychology experts are divided in their opinions regarding the communicability of mental illness, with some suggesting that mental illnesses are not at all communicable. This belief about communicability further isolates people with psychological distress. Other opinions are also well grounded, including the familial transmission of mental illness, the transfer of conditions such as depression and anxiety during a child's early years from parents to children, and social interaction or contact with a psychologically distressed individual. To understand whether the debate surrounding mental illness is communicable or not, the respondents were asked through interviews about their views and how they interpreted the above statement. The respondents shared their opinions and experiences regarding the above-mentioned topic and how much they agreed or disagreed with this phenomenon.

4.1 Perspectives regarding the communicability of illnesses

The respondents were asked to provide their respective opinions regarding what they think about mental illness as communicable or not. The answers shared by the individuals are translated below.

4.1.1 Perspectives in favor of the communicability of mental illness

According to one respondent:

"I feel that mental illness is transferable, I don't know how but I have seen that people who are with mental patients, their attendants, etc., they are all going through some problems." (R1)

The respondents felt that people who have relatives or close ones having a mental illness are mostly at higher risk of mental illness and may even have them too.

"I have noticed that the people who have psychological distress, their mental health is evident but the people who are with them, they too suffer a lot, maybe they have the same problems as them." (R17)

While some of the respondents gave their examples to emphasize the statement that mental illness is communicable. As per the respondents, mental illness is very much communicable and impacts their lives in one way or another.

"I can talk about myself that mental health does have an impact on the surrounding people. I feel that due to my distress, my family has also suffered, my depression is reaching them as well, so I am sure that it is communicable." (R20)

Another respondent shared his opinion:

"I have already told this thing to my family that my mental health is affecting them as well, I have noticed that my wife is also getting symptoms of anxiety and this is very troublesome for me."(R27)

Most of the respondents who had experienced the communicability of their illness feared for their family and loved ones. They opined that thinking about the impact of their illness on their family members further deteriorates their mental health.

4.1.2 Perspectives against the Communicability of Illness

Some respondents held other, contrasting opinions regarding the statement. As per one respondent:

"I don't think it is transferable; there must be a reason that it is non-communicable. I don't know much, but I haven't experienced it, and nor have my family experienced it." (R4)

Another respondent opined:

"I haven't experienced this, and honestly, the person who has psychological distress, only he/she knows what pain he/she goes through; the rest of the people do not even support, feeling it is very difficult for them." (R34)

Some of the respondents believed that the debate regarding the communicability of mental illness and mental disorders is a myth. They further opined that people who blame social forces as reasons for their mental disorders may have other underlying psychological reasons not related to social relations.

4.2 Familial communicability

Family history plays a crucial role in the communicability of mental illnesses. According to the respondents, their family history has a role to play in their present psychological condition. Many of the respondents' psychiatric disorders travel from one generation to another, and this leads to an increased risk among people whose immediate family members suffered from mental illnesses in the past.

According to one respondent:

*"My family history has depression, my father has it, my grandfather has it, even my brother has it, but they don't believe in this. I think it transfers. I have been transferred this from my family." (*R30)

As per another respondent:

*"My mother has severe anxiety, maybe it has come from my grandfather. I feel there are a lot of people who have mental illnesses in the family. That is why there is a communicability factor." (*R12)

Some respondents shared their experience of familial communicability regarding their family and how they came to know about the illnesses in their respective families.

*"I went to a family gathering, I was very young, there my uncle had a panic attack, at that time I did not understand, then as time passed, I got to know that not only my uncle, but my father also has occasional attacks." (*R8)

According to another respondent:

*"My father used to get very angry, but one day, due to a fight at home, his anger got out of control, and he could not control it. He fell unconscious, and for a very long time, he remained in depression." (*R29)

While some of the respondents had different opinions regarding the communicability of mental illnesses.

As per one respondent:

*"I don't think it is transferred, now I have an anxiety disorder, but nobody in my family has it, everyone is completely fine." (*R17)

Familial communicability is one of the primary reasons for psychiatric disorders, and the respondents confirmed this. Some of the respondents had differing opinions, which shows the controversial nature of the statement.

4.3 Role of social forces in triggering mental illnesses

Psychological distress among people has risen to a threatening degree. According to most of the respondents, mental health is contagious and has been transferred most during the pandemic.

4.3.1 Social Contact as a Source of Contagion

As per one respondent:

*"If one person is depressed, then his/her state affects others as well. It has transferred in a lot of people during COVID. This has increased mental illnesses." (*R23)

The respondents opined that their contact with peers who had mental health problems led to disturbance in their mental health as well.

As per one respondent:

"Though I have been diagnosed with depression, even on days when I feel particularly well, if I meet a friend who is depressed, I feel the feelings of sadness sinking in me." (R6)

Social contact plays an important role in transferring mental illnesses among other individuals as per the respondents.

"When I was young, I had a friend who belonged to a dysfunctional family. I didn't even know what the term meant at that time, but I remember being sad and depressed whenever I used to hang out with him, and that played a vital role in disturbing my mental health." (R16)

The role of factors like social interaction and socialization has played a huge role in communicating mental health ailments among individuals, according to the respondents.

4.3.2 Family as a contagion

The role of family and the environment at home also plays a significant role in the communicability of mental health illnesses and disorders, according to the respondents.

As per one respondent:

*"I have felt this many a time that the cause of my depression is my home's environment. When everyone had corona, I was not affected much, but my brother had depression and seeing him made me depressed too." (*R18)

The relationships among family members, especially parents and siblings, shape the mental health of individuals. The respondents opined that their mental health was affected by the disrupted relationships among family members. The respondents shared that a dispute at home instilled in them feelings of sadness, anger, and hopelessness.

As per one respondent:

"*As a child, whenever my parents fought, I could feel the anger sinking in. I would reflect their reactions whenever I got the opportunity to, I believe this disrupted my mental health to a threatening degree."* (R5)

The environment at home sets the base for sound mental health, as per the respondents. They asserted that those people who have a conflicting environment at home face disturbance in mental health.

4.3.3 Caregiving as a Contagion

Looking after individuals with serious mental health ailments leads to the transferability of the mental illness among the caregivers, according to the respondents.

As per one respondent:

*"I got more depression when I was helping in the treatment of my mother, she had depression, I got symptoms of depression before her death, when she died, then I went into more depression." (*R10)

As per another respondent:

"I used to come to this facility with my father for his treatment of anxiety and panic, as he had terminal cancer. I was the primary caretaker for him, and with time, I realized that I had developed the same symptoms of anxiety that my father showed. I have been coming here for 5 years now." (R7)

Caregiving has been identified as one of the most common social factors contributing to the communicability of mental health illnesses and disorders, according to the respondents.

Table no 2: Thematic analysis; from code to major themes

Themes	Organizing theme	Codes
Mental illness as communicable	*I feel that mental illness is transferable, I don't know how but I have seen that people who are with mental patients, their attendants, etc., are all going through some problems.* Perspectives in favor of communicability *I don't think it is transferable; there must be a reason that it is non-communicable. I don't know much, but I haven't experienced it, nor have my family members.* Perceptive against communicability of mental illness.	1. Perception in favor 2. Perspectives against 3. Irrational thoughts 4. Family contagion 5. Caregiving 6. Social contagion 7. Personal experience 8. Medical categorization 9. Generational transfer
Familial communicability	*My family history has depression, my father has it, my grandfather has it, and even my brother has it, but they don't believe in this; I think it transfers. I have been transferred this from my family.* Communicability of mental illness within the family *I don't think it is transferred; now I have an anxiety disorder, but nobody in my*	10. Role of Family 11. Biological factors 12. Psychologically distressed parents 13. Family History 14. Family fears 15. Denial 16. Collective trauma experiences 17. Fear of conflict

	family has it, everyone is completely fine. Non-Communicability of mental illness within the family	
Role of Social Forces	*If one person is depressed, then his/her state affects others as well. It has transferred a lot of people during COVID. This has increased mental illnesses.* Social contact as a source of contagion	18. Social transfer of mental illnesses 19. Ailing Peers 20. Role of Covid 21. Ignorant behaviour 22. Social pressure to interact 23. Social expectation 24. Sharing of troubled thoughts 25. Social Contagion 26. Social expectation to socialize
Family as contagion	*As a child, whenever my parents fought, I could feel the anger sinking in. I would reflect on their reactions whenever I got the opportunity to, but I believe this disrupted my mental health to a threatening degree.*	27. Family environment 28. Family relationships 29. Dysfunctional family 30. Shared traumas 31. Collective experiences 32. Toxic home environment 33. Emotional trauma 34. Emotional dependence 35. Expectation
Caregiver as contagion	*I got more depressed when I was helping in the treatment of my mother, she had depression, I got symptoms of depression before her death, then I went into more depression.*	36. Ailing Family members 37. Caregiving environment 38. Patient attendant relationship 39. Emotional attachment

5. Discussion

This study aimed to explore the conflicting debate around whether mental illness is communicable or not. The results of the study showed an inclination towards the statement of mental illness being communicable. The findings were placed in three main themes, and two of the themes were further divided into two sub-themes, respectively. The first theme was "Perspectives regarding the communicability of mental health" (Perspectives in favor of communicability of mental illness, Perspectives against the communicability of mental illness). The second theme derived was "Familial communicability". The third theme drawn was the "Role of social forces in triggering mental illnesses" (Social Contact as a source of contagion, Family as

a contagion, and Caregiving as a contagion). An amalgamation of the mentioned factors contributed to the richness of the debate surrounding the communicability of mental illnesses. The people who were in physical contact with individuals suffering from mental illnesses through caregiving, family dynamics, and social contact were proven to be at higher risk of vulnerability to mental ailments (Marçal, 2021). This study used the inductive approach through qualitative data extracted from interviews and observation. (Burney & Saleem, 2008)

It has been found that assortative mating of two people suffering from psychiatric disorders may transfer the genes of psychiatric disorders to the offspring. This leads to an increase in illness communicability within families. Parenting styles and prenatal patterns also have a part in familial communicability. The offspring living in a family with mental disorders are reported to have poor mental health. Apart from genetics, the simple reason for the communicability of illness may be elevated stress levels during the initial formative years. Maternal depression is the mother's communicability of illness to the newborn either during the fetal stage or after birth (Raposa et al., 2014). Brain development is highly affected by maternal depression, anxiety, or stress (Severo et al., 2023). People who suffer from Post-Traumatic Stress Disorder (PTSD) have close contact with people who have suffered PTSD (Jones et al., 2004). Besides mothers, the mental health of the father also plays a vital role in the psychiatric health of the children. Living with a person suffering from any psychiatric illness leads to adverse effects on childhood. Alterations in gene makeup due to exposure to stress are a contributing factor to clustered psychiatric illnesses, which is termed transgenerational epigenetic inheritance and starts shortly after the gene of the baby is made (Wainberg, et al., 2018). This was confirmed in the present study, where most of the respondents were certain that the psychological distress or disparity in mental health they are facing is due to the phenomenon of mental illness being a transferable entity. However, the literature present in this regard is limited, but the experiences and perceptions of the respondents in the current study confirm the communicability of the illness.

Mental disorders can be transferred from one person to another, and people's opinions about the communicability of an illness strongly predict their inclination to interact with a person having that illness. However, the most common instrument of transmission for mental illness includes social interactions. People who go through a mental illness face a diversity of obstacles in their way, often encompassing social stigmas and cultural isolation. (Lombrozo, 2015). According to a study conducted to find the relationship between happiness and social contact, it was found that happiness among social connections is significantly connected across time and depends on a range of factors. Having a close friend who becomes happy, for example, is linked to a 25% increase in happiness, while having a next-door neighbor who gets happy is linked to a 34% increase in happiness (Arampatzi et al., 2018). In a similar study on the correlation between depression and social ties, it was found that there are even stronger links between depression and social bonds; having a close friend who is depressed is linked to a 118 percent increase in the chance of one's depression (Holtfreter et al., 2017). This was confirmed in the present study, which emphasized the role of social interactions such as social contact, caregiving, and family ties as important factors contributing to the communicability of mental health ailments.

The respondents confirmed the role of COVID-19 in spreading mental illnesses among their family members and peers. They opined that the restrictions in COVID-19 bound them to remain in social and communal isolation, which led to increased depression and the transfer of mental illnesses from one person to another. This is confirmed in a study conducted on the negative consequences of COVID-19 on the mental health of individuals. The study concluded that people who were locked up in their homes with little or no access to any outdoor social interaction gave

rise to feelings of loneliness. Furthermore, the individuals who were living with people suffering from any mental illness replicated the symptoms of the latter (Obeid et al., 2021.

Psychology literature has widely discussed the mechanisms that provide input into the discussion of social contact with a person suffering from poor mental health as an active contributor to the deterioration of mental health among other individuals (Humenny et al., 2021; Tam et al., 2023). The few instances in which negative emotions may be transferred to other individuals are firstly through empathizing; imagining and putting oneself in the place of the person suffering from poor mental health leads to experiencing the same negative, sad emotions (Reisenzein, 2022). The second instance may be when one feels obligated to provide support to another person, which may be rewarding in the short term, but in the longer term, the inability of the person to return the support and less enthusiastic energy may lead to poor mental health (F. Li et al., 2021; Wang et al., 2018). Another instance may be the negative feedback from a depressed friend or acquaintance, despite being supportive, which leads to feelings of sadness (Muschetto & Siegel, 2019). People instinctively replicate the facial gestures, sounds, actions, and behaviors of individuals around them, according to several types of research, and these bodily manifestations alter emotions (Reisenzein, 2022). Finally, social comparisons may cause contagion. Individuals may draw "upward" comparisons with more "successful" people to connect with them, but these comparisons can also lead to jealousy or a loss of self-esteem (Li, 2019). The respondents opined that people who openly discussed their distressed thoughts and situations exhibited feelings of hopelessness and sadness, which negatively impacted their mental health. This has been confirmed in a study conducted on the paradox of distress expression. The study concluded that frequent conversations concentrating on negative interpretations of troubled thoughts and feelings might aggravate the amount of discomfort among other individuals (Kidron & Kirmayer, 2019).

Social interaction may be the most vital to well-being, not only for those with mental illness and people who live with a mentally ill person. Studies show that in social relationships, the quantity is as important as the quality, and this influences the mental and physical health, as well as the risk (Holt-Lunstad, 2018). According to the respondents of the study, people who have family members suffering from mental health problems are more prone to mental health illness. A similar study conducted by Seager found that the environment at home and the relationships among family members may be the cause of the communicability of a mental illness among other family members. The most common instruments of transmission for mental illness involve factors such as sharing a common place to live, familial relationships, and common traumas that have existed for years rather than over a short period. (Seager, 2015). As per a study conducted on severe mental illness (SMI), it was confirmed that the individual suffering from SMI is not the only one affected; family members and the community to which the person belongs are also negatively impacted. These effects could be especially noticeable in low- and middle-income nations (LMICs), where there is a significant treatment gap for mental illnesses. In low- and middle-income countries (LMICs), family members or other close relatives' shoulder most of the patient's caregiving duties, with long-lasting effects (Fekadu, Mihiretu, Craig, & Fekadu, 2019)

The present study highlighted the factors that aided the communicability of mental health illnesses and disorders in the form of familial communicability and social forces. The study concludes that though the debate surrounding the communicability of mental illness is still ongoing with little empirical evidence, there is still some truth to the statement that mental illness is communicable.

6. Limitation:

Mental illness is a socially less discussed topic in Pakistani society, as people have a general fear of stigmatization. Therefore, the respondents were reluctant to share their experiences regarding mental illnesses although confidentiality was assured.

7. Recommendations

1) There is less empirical evidence of the debate surrounding the communicability of mental illnesses, therefore vigorous primary and secondary research needs to be brought to paper to address this complex topic
2) More awareness should be raised regarding mental health and its importance among the people of Pakistan. Therefore, policies should be made to include topics related to mental health in the academic curriculum, and campaigns explaining the importance of seeking psychiatric/psychological treatment should be brought into practice.

8. Conclusion

Mental health issues are seldom acknowledged and addressed in South Asian communities. The debate regarding mental illness being communicable has extreme potential if more empirical evidence surrounding the debate is achieved. This study is one of its kind, conducted within the premises of this debate in Pakistan, which is still learning to accept mental health issues as illnesses and not psychosomatic behaviors. This research will help to better understand how individuals perceive mental illness communicability, be it familial or social, and the role of social forces in transferring a mental health ailment and will aid in raising awareness and shedding light on this controversial debate.

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