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ORIGINAL PAPER

Tension Among Women in North India: An Idiom of Distress and a Cultural Syndrome

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Abstract The existing literature on Indian ethnopsychology has long asserted that somatization is a key aspect of experiences of distress. The study of idioms of distress arose out of work done in India (Nichter in Cult Med Psychiatry 5(4):379–408, 1981), but ironically, little subsequent work has systematically explored idioms of distress in this part of the world. This ethnographic study focused on the term *tension* (tenśan) and its relation to a cultural syndrome among women in urban North India. This syndrome appears to involve rapid-onset anger, irritation, rumination, and sleeplessness as key symptoms. It is often linked to specific circumstances such as domestic conflict and is associated with the stresses of modern urban life. People who report more symptoms of tension had consistently higher scores on the Hopkins Symptoms Checklist-25 for depression and anxiety. In this cultural context where psychiatric care is highly stigmatized, the language of tension can aid providers of mental healthcare (many of whom, in India, are not psychiatrists or psychologists) to identify and communicate effectively with potential patients whose mental healthcare needs might otherwise go unaddressed.

Keywords Idioms of distress · Ethnopsychology · India · Mental health

Introduction and Cultural Framing

There exists a robust characterization of Indian ethnopsychology, and it centers primarily around two themes: 1. conceptions of personhood, which are generally deemed collectivist (as opposed to individualist); and 2. somatization as a central

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form of psychological complaint. Scholars have long suggested that there is "an Indian way of thinking" (Ramanujan 1989). Dumont (1966) famously focused on how Indians stress the opposition of purity and pollution as the organizing principles of the hierarchies central to their societies, while Marriott (1976) and Marriott and Inden (1977) described Indian notions of personhood as "dividual" (rather than individual)—that is, permeable, constituted by and from the substances and other people with which they come into contact. Working in North India, Derne (1995) referred to a "collectivist" ethnopsychology as well but allowed for an individualistic conception of action that opposes this collectivism, especially among subjugated groups such as women and people of lower castes. Recently, however, scholars have argued against the exoticization implicit in these characterizations because it "thwarts the comparative enterprise of anthropology and sociology, since Indians are represented as being so different as to preclude comparison" (Natrajan 2005:227).

The second, and more recent, thread dominating Indian ethnopsychology has been somatization, and authors working in this realm have been more sensitive to the similarities and differences between Indian and other ethnopsychiatries. The first study of idioms of distress emerged out of work done in India (Nichter 1981). This work found that somatization was a particularly important way for Havik Brahman women to express distress. Nichter dubbed this somatization an "adaptive response" to circumstances in which non-somatic expressions of distress were considered unacceptable and coined the term "idiom of distress" to describe this behavior (Nichter 1981, 2010). More recently, several studies have explored the connections between somatic complaints and distress (Kielmann and Bentley 2003; Pereira et al. 2007; Rashid 2008). Rashid's (2008) study of women in a Bangladeshi slum explored how women connect the nonspecific physical health complaint of white vaginal discharge to the profound sources of stress in their lives, including food insecurity, financial strain, and marital problems. Women frequently sought medical treatment for white discharge, believing it to be indicative of a dangerous loss of calcium and vitality from the body. Patel et al. (2005) report a similar use of white discharge as an expression of distress in India. My own work among healthcare providers in North India suggested too that patients frequently connect symptoms of distress with physical symptoms of ill health (Weaver 2014).

Very few studies have, however, explored the meanings and uses of specific expressions of distress in India, nor considered how they might map onto mental illness. The study of idioms of distress, or cultural syndromes, as they are sometimes described (Nichter 2010), is valuable because it facilitates the identification of culturally specific forms of suffering (Hinton and Lewis-Fernandez 2010; Kaiser et al. 2014; Kohrt and Hruschka 2010). Idioms of distress often overlap with Western psychiatric categories and may more effectively identify those suffering in places where biomedical psychiatry is not dominant (Bolton 2001; Kaiser et al. 2014; Kohrt and Harper 2008; Kohrt et al. 2004; Nichter 2010; Weller et al. 2008). A classic example is *susto*, or fright, one of the earliest-identified cultural syndromes found throughout Latin America (O'Nell and Shelby 1968; Weller et al. 2008). More recent examples include Kaiser et al.'s (2014) study of *reflechi twop*, a syndrome of rumination without finding a solution to problems in Haiti, as well as

Betancourt et al.'s (2011) investigation of a variety of idioms in Rwanda, including *guhangayika,* a state of constant worry that comprises both anxiety-like and depression-like symptoms. Cultural syndromes may be successfully incorporated along with psychiatric interventions to improve their effectiveness (Nichter 2010), as has been shown in trauma management interventions among Cambodian, Liberian, and Sierra Leonean refugees (Hinton and Lewis-Fernandez 2010; Stepakoff et al. 2006).

This study took the South Asian expression *tension* (pronounced *tenśan*, sometimes written as *tenshun*, since it is an English word transliterated into South Asian languages) as its primary object of inquiry. The expression is found in a wide range of linguistic, cultural, and national groups, including Hindi speakers in North India, Malayalam speakers in Kerala, Marathi speakers in Maharashtra, Bengali speakers in Bangladesh, and Konkani speakers in Goa (Chua 2014; Cohen 1998; Ecks 2014; Halliburton 2005, 2009; Kielmann and Bentley 2003; Pereira et al. 2007; Ramasubban and Singh 2001; Rashid 2008; Rodrigues et al. 2003; Snell-Rood 2015; Weaver 2014; Weaver and Kaiser 2014). Anecdotal evidence from clinical settings catering to immigrants in the United States suggests it may even extend to other parts of Asia, including China, Cambodia, and Vietnam (A. Fiskin, personal communication, 2016). Although the word comes from English, it is embedded in Hindi (or other language) sentences and takes on a meaning that is distinct from its English origin.

Linguistically speaking, in Hindi, *tension* is described as something that happens to a person (*Mujhe tenśan lag rahā hai*; Tension is happening to me (lit. 'sticking to me')) or is something that someone or something gives to you *(Voh mujhe tenśan de rahā hai*; He is giving me tension). It is rarely articulated as something one actively does, except in cases where someone is being chided by others for allowing oneself to take too much *tension* (e.g., *Āp bahut zyādā tenśan lete hain*; You take too much *tension*). The expression is used by men and women, young and old, but in this study I focus specifically on its use by middle-aged urban women.

Strikingly, there exist no published studies focusing on *tension* as the primary objective of inquiry; uniformly, when *tension* appears in scholarly works, it does so secondary to a different concern. For instance, in Cohen's (1998) case, the primary focus of study is Alzheimer's disease; in Solomon's (2016) case, type 2 diabetes, in Rashid's (2008) case, complaints of white discharge, and in Rodrigues et al.'s (2003) case, post-natal depression. The term comes up briefly, for instance, in Rashid's (2008:118) work on white vaginal discharge complaints among slum-dwelling women in Bangladesh, where two informants use it to describe their life difficulties. Rashid remarks summarily, "Many of the statements by the young women make references to bodies breaking, wasting away, *tension* and burdens, and the loss of well-being because of a lack of food" (2008:120). Rodrigues et al. even report an informant stating that *tension* is an illness in and of itself (2003:1802), but they present this information in the context of indigenous recognitions of postnatal depression, thus equating *tension* with a clinical diagnosis. More recently, Solomon's (2016) monograph briefly discusses *tenshun* as an agent of disease and even a mode of diagnosis, a conclusion that Cohen (1998) and Rodrigues et al. (2003) also reach. Halliburton (2009) suggests that *tension* may serve as an idiom of

distress borrowed from Western psychiatric terms. These more recent works hedge increasingly close to the idea that *tension* is a disease category of its own, but this is where the existing analyses stop.

Despite the near ubiquity of *tension* in South Asia, very little research has taken seriously the idea that it may be an important and potentially unique lens through which South Asians express and experience distress. This is so despite its demonstrated associations with health problems and distress. Like many other scholars who have commented upon *tension* in their work, I stumbled upon it while studying another illness, type 2 diabetes. Given its centrality to the people with whom I worked, I developed a study of *tension* nested within my larger work on diabetes.

This study was designed to assess the possibility that *tension* may be a unique cultural syndrome in South Asia. There are several reasons to suspect that this is the case. First, biomedical psychiatric treatment is highly stigmatized in India (Conrad and Pacquiao 2005; Desjarlais et al. 1995; Raguram et al. 1996) and virtually unavailable in many parts of the country, with the result that psychiatric terms such as "depression" have not become part of the *lingua franca* as they have done in the USA and other countries where biomedical psychiatry is more widely available. Second, there is a Hindi term for tension (*tanāv*) but it is rarely if ever used. Third, as mentioned above, *tension* is used in Indian languages in a manner that is distinct from its use in English. Finally, the existing literature on *tension*, though rather sparse, points consistently to a connection between *tension* and health, and even to the idea that *tension* may be a disease in its own right.

Methods

This study used a multi-stage process of mixed qualitative and quantitative methods to develop a locally derived definition of *tension* and a scale to quantify its presence in women's lives. It then compared levels of *tension* to conventional measures of depression and anxiety symptomatology, and in analysis, identified case studies that illustrated the emergent themes of *tension*. Verbal informed consent was obtained from participants prior to their participation in each phase of the study. All study procedures were preapproved by the Institutional Review Board of Emory University and locally by the University College of Medical Sciences, New Delhi, and the Indian Council of Medical Research.

Qualitative Methods: Freelists, Semi-structured Interviews, and Unstructured Interviews

Sixty-two freelists were elicited from a convenience sample of women recruited from 14 public and private medical clinics around New Delhi, India. Because the larger study was about type 2 diabetes, half of these women had diabetes. The other half, however, were not sick but were there accompanying ill relatives; this was quite common since people rarely go to the doctor alone in India. Women were interviewed while they, or their companion, were waiting to see the physician, and

were asked to list as many symptoms or characteristics of *tension* as they could while the interviewer noted down responses. Simple frequency counts were conducted on the lists, and items mentioned by 3 or more women were retained in a "master definition" comprising a locally derived list of *tension* items; this resulted in 20 items. These items were subsequently reviewed one-by-one with three laypeople and two mental health professionals for validity. Six items were removed or combined because they were deemed nearly universal (e.g., "disappointment due to unmet expectations") or nearly identical (e.g., combining "general anxiety" with "general stress/lack of relaxation").

Twelve semi-structured interviews were conducted with healthcare providers, including general physicians, psychiatrists, psychologists, endocrinologists, cardiologists, and Ayurvedic, Unani, and homeopathic healthcare practitioners. These interviews inquired about local conceptions of mental health and illness, the availability and quality of mental health care, the most common problems in their patients, and patients' attitudes, perceptions, and usage of mental healthcare services.

Finally, unstructured conversations with community members, including shop owners, autorickshaw drivers, friends, and neighbors naturally involved *tension* because the expression is so common, and field notes were taken immediately after these interactions.

All formal interviews were audio recorded, translated into English, and transcribed by the researcher and a native-Hindi-speaking research assistant. Interview transcripts and field notes were analyzed using MaxQDA 10 textual analysis software. Lexical searches identified passages mentioning *tension*, stress, depression, *cintā* (worry), or *gabrāhat* (nervousness, restlessness) (all synonyms sometimes substituted for tension, although *tension* was the most common term used) (Ryan and Bernard 2003). These potentially relevant passages were then coded for emergent themes using open coding based on repetition of themes, followed by selective coding (Corbin and Strauss 2007). Finally, following Kaiser et al. (2014), coded segments were classified as relating to characterization, recognition, causation, or consequences of *tension* and examined for similarities and differences. Individuals who discussed *tension* with particular detail, richness of description, or comparison with psychiatric diagnoses served as case studies.

Quantitative Methods: Questionnaires

The 14 items in the "master definition" of *tension* were converted into a *tension* measurement scale with the prompt "In the past two weeks, to what extent have you felt the following mood-related items?" with three response categories: not at all, somewhat, and a lot. The resulting *tension* scale was piloted with 30 women with diabetes; also piloted at this time was a culturally adapted Hindi Hopkins Symptoms Checklist-25 (HSCL-25) for depression and anxiety (Weaver 2011). The goal of this pilot phase was to establish baseline internal consistency and face validity of each instrument, and the criteria for acceptability were surpassed in each case (Weaver 2011, 2014).

Using the same clinic-based recruitment strategy described in the qualitative methods section, 280 questionnaire-based interviews were conducted with women

with and without diabetes (n = 184 with diabetes) about a wide range of health topics, including their past experiences of illness, their everyday activities, and their current health. The *tension* scale and the HSCL-25 were administered to assess mental health, and basic demographic data were collected. These data served as the source of the quantitative analyses presented below.

Univariate and bivariate statistics (means, proportions, correlations, and cross-tabulations) were calculated in SPSS 18.0.2 to explore the range, variation, and basic relationships of *tension*, HSCL-25 scores, and other study variables. Two-sample *t* tests were used to examine differences in mean HSCL scores for depression and anxiety symptoms between individuals who endorsed or did not endorse each item on the *tension* scale. A principal components analysis (PCA) using direct oblimin rotation was used to assess the underlying constructs being measured by the *tension* scale and the Hindi version of the HSCL-25.

Results

Case Study

Nirmala is a middle-class work-at-home mother in her early 40s who lives in a government quarter with her husband and three children. Her husband is a lower-level government employee, a highly coveted job for the aspiring middle classes because of the job security, government housing, and (in some cases) the substantial extra income that such positions provide through bribes. Despite her slim figure and active lifestyle, Nirmala has type 2 diabetes. When asked why she thought she had gotten the illness, she replies in Hindi, "I think it must have been because of *tension* because there wasn't anything very unusual about my diet. Actually, the *tension* was that my children were very young, and my husband was posted outside Delhi to Shimla. I mean, my three children were so young and my husband was in Shimla, so everything was in a big mess. From that *tension*, *tension, tension*, maybe—I was alone. I was managing everything alone. I had a lot of *tension*." Nirmala fell into what she calls a deep "depression" (using the English word) during this time. "I had a lot of *tension* at that time, but now I'm feeling better. In those days when I was really depressed, then I felt [suicidal]," she explained. Although she recovered from her depression and her husband eventually returned to Delhi, Nirmala still reports *tension* in her daily life, primarily due to ongoing marital discord and concerns about her children's education. "I needed emotional support but he didn't give it to me. He said, 'The whole world stays alone, so what's your problem?' Other people appreciate how I managed all alone, but instead of showing me some emotional support he just harshly said this to me, that everyone stays alone." Nirmala reports that she tries to cope with her distress proactively. "At times I still feel sort of depressed. When that happens I don't feel like going out. But when I feel depression, I make an effort to go out and see a good friend, then I feel fresh. …I try to make a change. I read a book or visit my parents."

Though unusual in the sense that Nirmala employs the term "depression"—something only 10 out of the more than 300 women who participated in the various

phases of the study did—her experience typifies many aspects of *tension* that cut across the sample. Like many others, Nirmala connects her *tension* to her physical health. Also like many others, she attributes her *tension* to a failed social relationship, and particularly to being alone at a time in her life where she should not have been alone according to Indian life-course models (Tilak 1989). She describes self-diversion as an effective means of dealing with *tension*.

Characterization and Recognition

A striking feature of *tension* was the wide range of worries and concerns that it can describe. Some women used *tension* to talk about everyday hassles or infrequent events. As one middle-aged homemaker complained, "*Tension* happens. I get *tension* about little things, like when the gas [cooking cylinder] is empty, or if something isn't delivered to the house that should be." Others described *tension* as an inescapable fact of life. "No one wants it [*tension*], but it happens," explained one older woman. Yet, others, including Nirmala, above, used *tension* to talk about what appeared to be very profound and chronic distress; as one impoverished woman said while crying, "There was no [land]; we just had a house, and I've sold that off now…. Sometimes I even feel like dying when I'm in *tension*…. I have a lot of *tension*, just *tension*." Thus the term is used to describe a wide range of stresses, from everyday irritation to profound distress (Weaver and Kaiser 2014). There appears to be no distinct point where people determine that *tension* is serious enough to require treatment-seeking, however.

When asked in freelist interviews about the most common features of *tension*, the single most frequently-mentioned item was anger (*gussā*), and indeed, many of the items on the locally derived *tension* scale related to anger (see Table 1): feeling troubled, feeling irritated, blaming others, and feeling like hitting someone, for

Table 1 Items from the *tension* scale

1. Feeing angry (*gussā*)
2. Feeling troubled or upset (*pareśān honā*)
3. Feeling weak or tired out (*kamzorī yā thakān mahasus karnā*)
4. Feeling irritated or being oversensitive (*cidcidā ho jānā ya bahut zyādā bavuk ho jānā*)
5. Restlessness (*gabrāhat ya becenī honā*)
6. Blaming others, taking out your anger on them (*dusaron ko dos denā yā unpar gussā nikālnā*)
7. Feeling like hitting someone, or actually hitting them (*kisī ko mārne kā man karnā yā mārpīt karnā*)
8. Feeling bad for no particular reason (*binā vajah acchā mahasus nahīn karnā*)
9. Mood swings (*man ki hālat kā bār-bār badalte rahenā*)
10. Not feeling like doing anything or talking to anyone (*kuch bhī karne kā man nahīn karnā yā kisī se bāt karne kā man nahīn karnā*)
11. Inability to sleep (*nīnd nā ānā*)
12. Feeling stressed, unable to relax, thinking too much, or worrying (*tenśan honā, ārām nā milnā, bahut zyādā socnā, cintā karnā*)
13. Stomach pain, gas, or digestion problems (*pet men dard yā ges honā, hāzmā thīk nā rahenā*)
14. Negative thinking (*burā socnā*)

instance. Other common affective symptoms included nervousness or restlessness (*gabrāhat* or *becenī*). "Sometimes I get scared, nervous with no reason," remarked one woman. "Why does that happen? Nothing happens, but I get scared. I take *tension* about little–little things. I need to get my older daughter married. Then I feel scared, that they'll both leave me someday for their in-laws' houses. I sit in fear, thinking that my daughters are going to leave someday. It's just this one fear."

As this woman's remark suggests, rumination was another common feature of *tension*. Several women mentioned that when they kept busy with work or other activities, such as watching television or praying, they did not feel *tension*. "When I'm working in my job during the day, I don't think about any of this. But when I come home after work, I get *tension*. When I'm heading home after work, I always start feeling restless [*becenī*]. I start thinking, what will happen? How will it happen?"

Tension also involved a temporal component; many women emphasized how they "take *tension* quickly" or "get *tensed* quickly" over small things. "I get *tension* very quickly, because I take depression medicines, right? So I take *tension* quickly over small issues," remarked one of the very few women under regular psychiatric care and on an antidepressant. There is a certain rapidity of onset associated with *tension*, as if it is a knee-jerk reaction. Indeed, many women described *tension* as something involuntary that comes up and overwhelms oneself. "I don't want to take *tension*, but it comes up anyway," explained one woman, while another said, "I don't intentionally feel that I am thinking about things, I just take God's name, but still I feel *tension* in my heart if something happens at home [that is, if there is a quarrel between family members]. I don't do it intentionally, but it seems to me that sometimes I take *tension* if there's something happening in the house." Not only is *tension* associated with rapid onset, it is also often considered involuntary.

Tension was frequently associated with somatic symptoms such as insomnia; many women described *tension* as the feeling of having one's mind running uncontrollably at night, having palpitations or a racing heart, and not being able to sleep because of these. Lack of appetite was another somatic symptom frequently associated with *tension*. In a paired interview, a daughter-in-law described her mother-in-law's *tension* as frequent, recurrent, and creating a situation where the woman could not sleep and had to be cajoled into eating. "She takes *tension* over very small things," said the daughter-in-law. The mother-in-law agreed, "In between it [*tension*] ended, but now it's started again. For the last two nights I haven't been able to sleep. I don't know why." By way of explanation, the daughter-in-law said, "There's a little problem with the family business, a little of this, but the problems have become less and she takes too much *tension*. Because of being caught up in *tension*, she hasn't eaten anything for the past two days. I had to force her to take something this morning." A third somatic symptom associated with *tension* was a reported "feeling" of high blood pressure, which many women mentioned. One woman asserted, "My BP problem is because of *tension*. Because the doctor told me, 'You think a lot. If some small thing happens to you, then you think too much about it. Because of this thinking you have gotten BP, otherwise you wouldn't have it.' When I went to get my daughter checked up, he told me, 'You're

losing some control of your body. You take *tension*, and because of this you are having some control loss. Everything else is okay, you don't have any other problems.'" Another stated, "Sometimes if I get *tension*, then my BP goes high…. Besides my daughters' marriages, there are a lot of other things. They're having some *tensions* in their in-laws' homes. In-laws are in-laws."

Causation

Women mentioned many causes of *tension*, but these could generally be grouped into three broad categories: social relationships (especially family relationships) that do not conform to existing cultural expectations, acute need among impoverished informants, and what can be termed "problems of modernity."

The first category, family relationships, was strikingly common and involved women's reports of husbands who were absent or unsupportive, as in Nirmala's case; children who refused to study or lived far away and did not stay in adequate touch; and daughters-in-law who were disrespectful or who insisted on living away from the joint family. Especially common causes of *tension* were women's concerns about getting their children "settled"—by which they usually meant in a career and with a suitable marriage partner for sons, or placed through marriage into a good family for daughters. As one woman explained, "That stays. With children *tension* is always there. Until they've studied and gotten into some job, you'll be in *tension*…. Worrying will happen; the students will study and until they're settled, worry will always be there." Daughters' marriages were an especially *tension*-producing concern, in part because brides' families typically pay the very high costs for weddings in North India. "One of my daughters is unmarried, so I have some *tension* because of her. I need to fulfill this responsibility, then I'm done," remarked one older woman.

Feeling alone or unsupported was another key cause of *tension* in women's lives, and this often arose because of what women perceived as non-ideal family arrangements. As one woman succinctly put it, "*Mere āge-pice koi nahīn hai*" (literally "I have no one ahead or behind me," indicating that she has no one to support her). The "norm" against which most women in this study compared their situation is a joint family in which sons (or at least one of them) remain living with their parents after marriage, and the daughter(s)-in-law care for the parents as they age. Although joint families are becoming less common, especially in cities where physical and social mobility mean that children may live far away, half of the women in the sample still lived in joint families, and most of them grew up in such an arrangement. For instance, one woman blamed her *tension* on a daughter-in-law with whom her frequent conflict eventually led to a split in the joint family. When asked what caused her *tension*, she explained, "Our daughters-in-law live separately. One of my daughters-in-law lived with us for 10 years; we were all together when I retired. Then one got a job in this place, one got a job in that place, and they left. The eldest one left because the children's school was far away. The second one insisted on staying separately. Because of her, I got *tension*." For wealthier families, who often had children living abroad or in another part of the country for study or work, missing a more traditional family structure was a

common complaint. "My sons left home, and my daughters were married. Now I am living alone, so I keep thinking all the time," said one woman who had *tension* about who would care for her in her old age. Widows also described great *tension* arising from the burden of responsibility they faced without a husband. As one young widow commented, "Sometimes I think to myself, 'What kind of a life is this?' There's so much struggle. I have two girls to educate and raise by myself. Everything is my responsibility; because of this I feel some *tension*…. Sometimes I feel that I won't be able to do anything for them. Sometimes I worry if I can manage everything for them by myself, can I make them good, can I educate them properly?"

The second major category of causes of *tension* was acute need among the lower-socioeconomic-status informants in the study. Like the woman who had to sell her house to get her daughters married, concerns about food and housing insecurity, having to work a job and keep house, and debt were frequent causes of *tension*. Some described the frustrations of having relative financial security but still having to "think twice" before consulting a doctor for an illness. Widows again emerged as an important group who especially felt a heavy burden of responsibility for their children, especially for daughters whose costly marriages presented a real financial hurdle. One widow with six daughters and no sons lamented, "There's no man of the house to earn for us…. Even a monthly rental rate of 600 rupees is too much for me to bear…. Last year there was one girl whom I got married. It took 20,000 rupees."

The third major category of causes of *tension* was "problems of modernity." Although this rarely came up in individuals' testimonies about their *own tension*, critiques of modern urban living were the most common explanation people provided for the perceived *general* increase in *tension* in the present generation. *Tension* was modern in its association in people's minds with the stresses of big-city living; it often (but not always) seemed to stem from quintessentially modern pursuits: for example, going to movie theaters, driving in traffic, eating at restaurants, waiting in long lines. *Tension* also arose from the perception that in cities, the social fabric was deteriorating. For instance, when I asked about *tension* in the city, one autorickshaw driver explained, "Here [in Delhi] are people from all states. In villages people are of the same kind. They know each other. So when there is a fight, it's resolved with love (*prem se*). Here that doesn't happen. Nobody knows each other." Another acquaintance, a highly educated artist, connected *tension* with consumerism. "I think [it is because of] all this unnecessary consumerism that has been introduced along with capitalism. We want, and we think we have to buy. People are reaching. There were fewer opportunities in our parents' generation and less population also, so they didn't think too much. Now it's all there to see on Facebook and Instagram; now I can see what is your life like in U.S.; the food you eat, the clothes you wear. Before I had no idea. People are aspiring, and there are no social services also." Some respondents even suggested that having a lot of *tension* was itself a way to participate in modernity, a sort of bragging right belonging to those whose lives are full of the demands of modern living. In short, people consistently connected *tension* with the consequence of contemporary city life, with its fast-paced lifestyles, crowding, anonymity,

connectivity via Internet media, and emphasis on consumerism, and in this sense we might consider *tension* a "disease of modernity" (Omran 1971).

Relationship to Somatization

The "master list" of *tension* items (see Table 1) included affective and cognitive symptoms as well as somatic ones. In narrative interviews, women described, as noted above, sleeplessness, racing or palpitating heart, and lack of appetite as symptoms of tension. In freelists they also mentioned tiredness or weakness and general stomach problems, as well as restlessness (*becenī*) or nervousness (*gabrāhat*). "When I get *tensed* about something suddenly, my heart will race. When I get *tension* I feel restless (*becenī*) and can't sleep," commented one woman. Another woman who reported frequent chest pains said, "My heart is totally fine, there's no problem. But it's just that—I don't know—I think too much, or maybe I'm too sensitive. Maybe [it's] because of so much thinking. The *tension*—whatever *tension* I have, it affects my nerves, and that effect reaches my heart." Another woman explained, "I get *tension* because my husband drinks so much. I'm sure I've got a BP problem because of it. Yes, I have a lot of *tension*, and it seems to me that I've developed a BP problem because of it. I also get dizzy sometimes." Importantly, women with diabetes quite frequently connected *tension* with high blood sugar. Accounts of controlled blood sugar that inexplicably spiked when women were feeling stressed, despite no lapses in diet or medication, were exceedingly common. Even so, somatized symptoms were only one dimension of *tension*, and the syndrome should not be reduced to a somatized version of depression or anxiety symptoms.

Proposed Resources and Supports

Women never reported seeking biomedical help for *tension* specifically, although they might discuss it with their doctor if the information was solicited. Rather, efforts to manage *tension* centered around actively attempting to reframe one's thinking about it using locally appropriate means, or diverting one's mind with other activities.

As for reframing, one Unani doctor commented, "People say they have *tension* about not having a job, oh, I'm having this problem. If you keep this *tension* and sit with it, will it end? What will the doctor do? He'll give you a sleeping tablet and knock you out. It won't get rid of your *tension*. *Tension* will only go when you change your nature. You have to think less about these things and think instead, 'Whatever will happen will happen.'" Indeed, several women reported that they worked consciously to decrease their rumination about negative events. "When I get angry I think a little, then I get it out of my head. I don't feel *tension* about things. We'll see what happens (*jo hogā dekh lenge*; an expression roughly equivalent to the Unani doctor's comment, "Whatever will happen will happen)." Women frequently reported using *pūja* (Hindu prayer), *bhajan* (religious singing groups), or meditation to reframe their thinking, practices that are a central part of the religious landscape of North India. One particularly pious older woman reported, "I don't

even have one percent *tension*…. I stay happy in peace. I just pray to God, nothing else."

Those who attempted to divert their minds reported forcing themselves to engage socially, retreating to watch TV or read, or working outside the home in a job as effective remedies for *tension*. As Nirmala commented in the case study above, even when she felt depressed and did not feel like socializing, "I make an effort to go out and see a good friend, then I feel fresh. …I try to make a change. I read a book or visit my parents." One woman, a health insurance salesperson, commented, "I take out my time [to meet neighbors and friends]. That's a big priority, to interact with people, so that I stay away from my worries and *tensions*. And I have a pet also, so my stress-busters are there." A mid-life mother who had not worked outside the home for many years commented, "Now I feel like I would like to do some work to keep *tension* away. Sitting at home all day, I think all the time about my children. I think it would be good for me to do some work." Yet, this strategy was not always successful. As one woman mentioned, "I try to divert my mind from it, but still I think about it a lot. I do *pūja*."

Quantitative Association with Depression and Anxiety

For groups with and without diabetes, there was a strong positive correlation between women's summed responses to the HSCL-25 and their summed responses to the *tension* scale ($r = 0.778$, $p < 0.01$ for women without diabetes; $r = 0.807$, $p < 0.01$ for women with diabetes). When the total HSCL-25 scores were disaggregated into their anxiety and depression components, all correlations with *tension* scores remained significant and positive (all above 0.70, $p < 0.01$). This suggests, firstly, that women with and without diabetes have similar response patterns to the HSCL-25 and the *tension* scale; in both cases, those who report more depression and anxiety symptoms also report more *tension* symptoms. Secondly, these results suggest that *tension* is related both to anxiety and to depression.

T-tests were used to examine differences in mean HSCL-25 score between individuals who endorsed or did not endorse the experience of each item on the locally developed *tension* scale. All 14 items in the *tension* scale were discriminant in relation to the HSCL anxiety and depression measures; in other words, those who endorsed no experience of a given item on the *tension* scale scored significantly lower on the HSCL than those who endorsed the item (in all cases, $p < 0.01$). This suggests that *tension* is related to both depression and anxiety. Bivariate correlation analyses demonstrated that women with more depression or anxiety symptoms consistently reported more *tension* in their lives. This association remained when the sample was stratified by diabetes status (for women with diabetes, $r = 0.8$ for depression and $r = 0.7$ for anxiety; and for women without diabetes $r = 0.7$ for depression and $r = 0.8$ for anxiety). This again suggests a similar response pattern between individuals with and without diabetes.

A principal components analysis identified one dominant component in the *tension* scale explaining 40.5% of the variance (eigenvalue = 3.96 see Table 2), and this component included items such as anger, blaming others or taking out one's anger on them, feeling generally troubled or upset, and feeling irritated or

Table 2 Principal components analysis of items on the tension idiom of distress screener: raw factor loadings in rotated component pattern matrix

Tension symptom	Component		
	1	2	3
Feeling angry	0.81		
Blaming others	0.58		
Feeling troubled/upset	0.62		
Feeling irritated/oversensitive	0.58		
Hitting or feeling like hitting someone			
Negative thinking			
Inability to sleep		0.66	
Thinking too much, worrying		0.59	
Feeling bad for no reason		0.48	
Not feeling like doing anything or talking to anyone			
Mood swings		0.41	
Stomach pain, gas, indigestion			0.61
Feeling weak or tired out			0.44
Restlessness			

Components extracted using principal components analysis with direct oblimin rotation. Only factor loadings with an absolute value equal to or greater than 0.40 are shown

oversensitive. The HSCL-25 had two dominant components, explaining 34.0 and 13.9% of the variance (results not shown). Further analysis of the two HSCL components suggested that component two most closely resembled depression, based on the loadings on different HSCL questions, while component one included symptoms of both depression and anxiety. A correlation analysis between the two HSCL-25 components and the *tension* summary scores for each individual revealed that component two of the HSCL-25 was significantly correlated with *tension*, but component one was not, potentially implying that the *tension* scale more closely resembles HSCL-depression than HSCL-anxiety.

Discussion

This study explored the idiom of *tension* among women in North India. In this group, *tension* appears to be a broad cultural syndrome that comes on quickly and involuntarily, involving feelings of anger, irritation, and being upset. Ethnographic evidence revealed the importance of rumination and the involvement of several accompanying somatic symptoms including the perception that one's blood pressure is increasing, insomnia, restlessness, and/or stomach pains.

Most of the literature that has explored idioms of distress in South Asia has focused on somatization, and indeed, somatization was a key part of *tension* for this group of women. The existing literature suggests that *tension* is part of a "hydraulic

physiology" (Cohen 1998:195) that associates the pressing-down motion of *tension* (a word borrowed from physics and thus implying physical sensations of being pressed or pushed) with diseases of pressure, including high blood pressure. This also includes the "embodied burden" of life hardships (Snell-Rood 2015:154), which are imagined as literally pushing down or weighing upon oneself, causing not only mental distress but also other problems such as high blood pressure or diabetes. This connection between *tension* and blood pressure was certainly evident in the present study, as were several other somatized symptoms.

Somatization was, however, only part of the puzzle. Narratively and in freelist interviews, women used *tension* to talk about a stunning range of affective and cognitive experiences, including profound sadness and even hints toward suicidal ideation, yet also superficial frustration about small everyday hassles. Among impoverished informants, frank worry about food, housing, and financial insecurity were also common complaints associated with *tension*. The rich variety of emotional states included under *tension* serves as a contrast with the strong emphasis in the literature on somatization of psychiatric conditions in South Asia (e.g. Kielmann and Bentley 2003; Nichter 1981; Pereira et al. 2007; Rashid 2008), as well as against the now stereotyped idea that Indians are "collectivist" in their identity (Derne 1995; Dumont 1966; Marriott 1976; Marriott and Inden 1977). Women describe these states as occurring at the level of the individual and consider them emotional, rather than somatic.

On the other hand, the most common cause mentioned for *tension* was problems in family relationships, especially between husbands and wives or between mothers and their children or daughters-in-law, a finding echoed by Pereira et al.'s (2007) and Rodrigues et al.'s (2003) studies of women in Goa. Elsewhere, I have written about how the expression of tension can be received with validation or, as in the cases of the mother-daughter pairs in my recent analysis (Weaver 2016), invalidation—a finding that also echoes Nichter's (1981) original conception of idioms of distress not simply as a way of expressing distress, but also as a codified invitation for a response from others. In this sense, *tension* reflects the priorities of the lives of the women who participated in the study, the vast majority of whom were middle-aged wives and mothers who worked exclusively in the domestic sphere. This indeed runs parallel to the early literature on ethnopsychology in India, which underscored the importance of social relationships (rather than individual attributes or achievements) for personal identity. Yet this does not, as mentioned above, mean that individual attributes and experiences are not valuable parts of identity for these women.

An additional noteworthy cause of *tension* emerging from general discussions with both women and men is the fast pace of life and the disintegration of social relationships that people associate with modern life in big cities. Although people almost never drew on these explanations to describe the *tension* in their own lives, they frequently used this framing when discussing the increase in *tension* and chronic diseases that are features of modern life in urban India.

Tension was related to depression and anxiety symptoms among women in the study; women who reported many symptoms of *tension* were more likely to have higher scores on the HSCL-25 for depression and anxiety than those who reported

fewer symptoms of *tension*, and vice versa. In qualitative discussion, women identified somatic, affective, and cognitive symptoms of *tension*. The "master list" of *tension* symptoms (Table 1) derived from freelist interviews and the principal components analysis (Table 2) illustrate that *tension* appears incorporate symptoms of both depression and anxiety, but does not map neatly onto either diagnostic category. Thus, *tension* may predict depression or anxiety, but it is not equivalent to either, and this is a very important distinction because it serves as a reminder of the culturally contingent nature of depression and anxiety categories, as well as the *tension* category. For instance, women frequently associated the onset of *tension* with specific events or circumstances, especially when those events or circumstances produced strained social relationships. This contrasts with biomedical etiologies of depression and anxiety, in which no precipitating event need occur for the disease entity to be recognized. In cross-cultural psychiatry there is increasing—though controversial—recognition of mental disorders specifically associated with stress, which require external events in order to be diagnosed and/or recognized (and not merely potentiated or exacerbated by stress, as anxiety and depression may be) (Maercker et al. 2013); *tension* might be one such condition.

Treatment Implications

Cultural syndromes are often sensitive but not specific to psychiatric diagnoses of depression or anxiety (Kohrt et al. 2016), and *tension* is no exception. Although *tension* does appear to be a cultural syndrome in its own right, the term is used so broadly that it might have limited clinical usefulness as a cultural syndrome. It appears to be highly sensitive but not specific to clinical diagnoses of depression or anxiety. However, this does not mean that elements of *tension* should not be used in diagnosis and treatment. Existing interventions employing a combination of idioms of distress with locally validated psychiatric symptom screeners suggest that even when a cultural syndrome is non-specific, the language around it can aid in the interpersonal communication and identification of pathological distress in places where biomedical psychiatry is not particularly common (Abramowitz 2010; Kohrt and Harper 2008; Kohrt et al. 2016; Thorpe et al. 2010; Tinkle et al. 2013). Incorporating *tension*'s emphasis on anger and feeling of rapid onset, for instance, could be useful additions to conventional depression and anxiety screenings.

Because *tension* serves as a common idiom of distress, its greatest clinical utility is most likely its ability to serve as a non-stigmatizing term for broaching discussions of distress. As one endocrinologist in the present study commented, it "is one of our tricks" to use the language of *tension* when a patient is suspected of suffering from clinical depression or anxiety. Another physician reported, "If you ask if they're depressed, they say, 'No, why should I be? My husband's great, kids are great.' If you tell them they have depression, they'll hate you. You have to do it delicately. If you say, 'You seem to have a lot of *tension*,' they love that. It's because of the stigma. If it's depression, then you are a patient. If it's *tension*, then it's something somebody else has done to you." This man, and most of the other physicians, reported regularly prescribing SSRI antidepressants such as sertraline and fluoxetine, as well as tranquilizers such as clonazipam, describing them to their

patients as medicines that reduce *tension*. "I tell them that it will help with their stress, help lift their low mood. Then they accept it," he explained. Because psychiatry is so stigmatized in North India, obtaining a prescription for psychoactive medications from a psychiatrist is quite rare, and uptake of psychoactive medications prescribed by general physicians is often met with great resistance (Ecks 2014). Although the prescription of psychoactive medications by non-specialists in the absence of a formal diagnosis may not be the standard of care, it might nevertheless help get medications into the hands of people who need them and would otherwise not get them. In another South Asian setting, Kohrt and Hruschka (2010) found that the use of idioms of distress was helpful for reducing mental health stigma; *tension* might also be quite valuable in this sense.

Cognitive behavioral therapy (CBT) has been used or recommended for use in the treatment of cultural syndromes in many settings, including among Cambodian refugees, Sri Lankans, Afghans, Ugandans with HIV, Haitians, and Nepali Bhutanese refugees (Ali et al. 2013; Frye and McGill 1993; Hinton et al. 2005; Kaiser et al. 2014; Okello et al. 2012; Ventevogel et al. 2012; WHO 2008). Because *tension* is associated with rumination and is often described among informants as being something one can address through "changing one's nature," as the Unani physician commented, CBT aimed at promoting positive cognition might prove useful in this setting as well. The lack of specialized healthcare providers in India to provide such therapy is a hurdle, but it appears to be feasible for lay health workers to administer CBT successfully (Bolton et al. 2003; Murray et al. 2011; Patel et al. 2010; Rahman et al. 2008).

Limitations and Future Directions of Study

This study was inherently limited by the constraints of the larger study in which it was nested. First, it engaged almost entirely with women, so the conception of *tension* presented here is highly gendered. Men also talked about *tension*, but a systematic investigation of the term among them might yield very different results, particularly in terms of perceived causes. There are potentially significant differences in usage of the term between gender, age, and socioeconomic groups, and this study was largely unable to address these. Second, this study engaged a clinical convenience sample, and this could have introduced bias into the study. The fact that response patterns were similar between women with and without diabetes, however, suggests it is unlikely that disease status affected women's characterizations of *tension*. Future studies of *tension* should examine its differing use across different demographic groups, as well as its potential connections to other aspects of the "hydraulic physiology" (Cohen 1998) in North India that associates the imagined pressing-down of *tension* with other diseases of pressure, including hypertension, which is increasing rapidly in North India (Mohan, Campbell, and Chockalingam 2013).

Conclusion

Tension is an idiom found widely across South Asian linguistic groups, and it appears to be associated with a cultural syndrome among women in New Delhi, India. In this group, *tension* is characterized by anger that comes on quickly and involuntarily, irritation, rumination, and several accompanying somatic symptoms including the perception that one's blood pressure is increasing, insomnia, and stomach pains. Although *tension* is indeed associated with somatic complaints, it nevertheless involves an equally if not more prominent affective component that contrasts with the strong emphasis on somatization in the existing literature on Indian ethnopsychology. *Tension* is often triggered by difficult family relationships and is associated with the stresses of modern urban life. It shares symptoms with both clinical depression and anxiety but does not correspond exactly to either diagnosis. A nuanced understanding of *tension* can aid providers of mental healthcare (many of whom, in India, are not psychiatrists or psychologists) to identify and communicate effectively with potential patients whose mental healthcare needs might otherwise likely go unaddressed because in this context psychiatric care is highly stigmatized.

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Compliance with ethical standards

Conflict of interest Lesley Jo Weaver declares that she has no conflict of interest.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from all individual participants included in the study.

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